Management of the Mentally Abnormal Offender

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Discussions about the prediction of dangerousness, a legal or social construct, often extend beyond forensic psychiatry into the general practice of psychiatry. Dangerousness can drive the entrance to and exit from the mental health and forensic system. Better conceptualized as risk prediction, it has been seen as a core skill for forensic psychiatry and an increasing requirement for general psychiatrists. Yet, for all the expertise in and the usefulness of risk prediction, it is the daily management of the mentally abnormal offender that taxes the clinical skills of the forensic psychiatrist. This article will address what we know about this area and suggest a model for managing mentally abnormal offenders. [Brief Treatment and Crisis Intervention 8:15–26 (2008)]

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Forensic psychiatrists occupy a unique position in psychiatry, regularly offering up expert opinion to various courts, lawyers, and other bodies, with many of the assessments that inform their expert opinion taking place outside of the physician/patient relationship. That expert opinion often addresses specific legal questions such as fitness to stand trial, not criminally responsible (NCR) or not guilty by reason of insanity (NGRI), and dangerousness. Dangerousness has long been thought to be an unhelpful concept in risk prediction as its basis is legal and social, rather than clinical (Grisso & Appelbaum, 1992). “Risk prediction” is viewed as a better term. Risk, the likelihood of an event occurring, requires a number of qualifiers before it can be measured and discussed. Qualifiers include the type of acts that may occur, the severity of the act, the likelihood of the act, the frequency of the risk, and who is at risk. The literature on risk assessment has grown to include a host of instruments such as the Psychopathy Checklist-Revised, Violence Risk Appraisal Guide (VRAG), Structured Assessment of Violence Risk in Youth, the Historical, Clinical, and Risk Management (HCR-20), Level of Service Inventory-Revised, and more recently the Short-Term Assessment of Risk and Treatability (START) (Andrews & Bonta, 1995; Bloom, Webster, Hucker, & DeFreitas, 2005; Hare, Clark, ...
Grann, & Thornton, 2000; Webster, Miller-Isberner, & Frannson, 2002). These tools encompass not only both actuarial methods of risk prediction but also those requiring structured professional judgment. Despite the superficially elegant product of some of these tools, the utility of these at the clinical interface has been unclear. That is, although these tools assist in the determination of risk, they provide little guidance or input into treatment or risk management strategies for the mentally abnormal offender (Gunn, 1977, 2000). The awkward sounding term “mentally abnormal offender” encompasses those individuals whose mental state (illness and disorders) brings them into contact with the criminal justice system.

**Risk Assessment—An Overview**

The pressures on psychiatrists to predict risk have never been greater. The apparent openness of our society, the rapid transmission of news and information, closing of the asylums, and the resultant juxtaposition of untreated mentally ill with the voting public increase the expectation that psychiatrists, especially forensic psychiatrists, predict (and presumably reduce) the risk of violence. The prediction of risk is an interesting area with its own (and shared) mythology. The more entrenched practice of suicide prediction highlights the difficulties in risk assessment in general. Suicide risk assessment is one of the core domains of psychiatry and as such has an inordinate amount of resources and attention directed toward it. Despite academic expertise, patients being involuntarily detained because of their “risk of suicide,” and many inpatient units admitting suicidal patients, our ability to reduce the suicide rate remains poor. The specific tests, instruments, or methods that have been used to predict suicide have yet to actually reduce the suicide rate. Yet, suicidal risk assessment, prediction, and management are regarded as hallmarks of psychiatric practice.

For the prediction of violence in mentally abnormal offenders, there are such robust instruments as the Static-99 and the VRAG. Both are well tested and extensively used, and both profess to provide a statistical likelihood of violence occurring (Hanson & Thornton, 1999; Harris, Rice, & Camilleri, 2004). Widely used and relied upon in risk assessment, these tools are excellent examples of actuarial risk assessment tools. Although heralded by some as being superior to clinical judgment, these tools have problems in their application. There is a fatal flaw in these tools when it comes to the prediction of risk in the individual: they actually cannot do that. That is, they cannot predict what any one individual is likely to do. Rather, such measures make determinations about risk by comparing the similarities between the individuals with a group of offenders who have offended violently. The idea being that the more characteristics the individual has in common with the offender group, the greater the risk. Although seemingly logical in their methods, they all but ignore more subtle individual differences often seen in offending behavior. For example, the VRAG does not adequately predict the likelihood of domestic violence although it is touted to be one of the best tools for the prediction of violence. In fact, having a female victim, according to the VRAG, lowers one’s risk of engaging in violence (Nussbaum, Saint-Cyr, & Bell, 1997). Clinicians have countered supporters of actuarial risk assessment tools by suggesting that a better mechanism to assess an individual’s risk would be to combine clinical judgment with actuarial methodology, a process termed structured professional judgment. In fact, it has been argued that the purists on both sides of the actuarial versus the clinical risk assessment debate are arguing from false premises in as much as actuarial instruments rely on clinical inputs, and clinicians draw on actuarially derived information (Litwack, 2001).
Webster, Hucker et al. (2002) in reviewing the debate between actuarial versus clinical prediction says the following:

Both clinical and actuarial projections are important when it comes to assessing the individual case around issues of future violence. This becomes apparent routinely when members of review boards and tribunals have to reach decisions periodically about the award of precise kinds of freedoms and the institution of supervised rearrangements. In this practical circumstance, it seems absurd to say the actuarial consideration should carry the day, or vice versa. The question, surely, in such context is which kind of information should we take into account and at which stages in the release or detention process. Previous rubrics, such as allowing the clinical projections to be varied upwards or downwards by no more than 10% from the actual base, now seem ill founded. (p. 660)

Another difficulty permeating the risk assessment arena relates to what to do with a patient with a high score on a test instrument predicting violence. Severe violence is a low-base-rate event, so low that needing to act on a patient with a high violent recidivism score will result in a number of false-positive interventions with consequences such as loss of liberty (Monahan et al., 2002). One of the examples frequently cited addresses what would happen if we had a test that had a 95% accuracy—that is, 95% sensitivity and specificity—in predicting who could murder. This may then be applied in a low-base-rate situation such as murder where perhaps one in a thousand people kills. For a large population, for example, 100,000 people, our test can then identify 95 of the 100 people who potentially will murder, but misses 5. On the other hand, we would produce 4,995 false positives in our 100,000 populations. That is, in order to isolate the 95 out of the 100 potential killers, we would also have to segregate from the society almost 5,000 people, not potential murderers. This socially unacceptable consequence would occur with any such seemingly accurate test directed toward a low-base-rate event such as murder. Current risk assessment schemes are far from being perfect predictors of violence, but psychiatrists continue to be asked about serious violence prediction and weigh in with their predictions.

Aside from the noted limitations, actuarial risk assessment tools require training and are sometimes extensive and time consuming for the clinician. Also, most of these tools do not assist in the day-to-day management of a forensic patient as they do not address many of the variables that confront psychiatrists when trying to manage risk in the real world (Tardiff, 1992). However, society, courts, and boards of review continue to demand that forensic psychiatrists assess and manage the risk posed by mentally abnormal offenders. Forensic services are usually responsible for large numbers of patients who have been found unfit to stand trial or NGRI/NCR—many of whom have been deemed to pose an ongoing risk to the society. Addressing risk can be a complicated process as not only does one have to identify the specific risk the mentally abnormal offender poses but also one must identify methods to manage and ultimately ameliorate risk. Day-to-day management of mentally abnormal offenders calls for skills that may reduce future risk but more importantly focus on here-and-now issues. The day-to-day assessment and management of risk is a much different context to what the courts or tribunals require for risk prediction.

Tower of Babel Phenomenon: Challenges in Developing Better Systems for the Management of Mentally Abnormal Offenders

In general psychiatry, academic conversations between clinicians from different parts of the
world are possible because of common manifestations of illness and converging diagnostic systems. The nature of psychiatric illness lends to common global base rates and similar symptom manifestation. The occasional atypical presentation makes for focused study and heightened conversation. Comparative research is possible, and the field advances.

At the interface where psychiatry touches the legal or the criminal justice system, the language of communication becomes little more difficult. Different countries and jurisdictions have differing systems by which they deal with psychiatric patients who run into legal difficulties or conflict with the law (Heilbrun & Griffin, 1993; Hoyer, 1988; Williams, Bloom, & Joseph, 1989). The law of the land generally defines who the patient population will be and governments define where ill individuals will be served and by whom. With differing jurisdictional definitions of fitness to stand trial and NGRI/NCR, the intake filters are set to include patient populations with varying characteristics. Tribunals and (case) law define the exit criteria from the system, further impacting the patient base. Patients found that NGRI/NCR may be treated in hospitals or correctional facilities. In addition to different patient populations, the ethos of the clinicians assessing and caring for them varies from country to country. In countries such as the United States and Canada, forensic psychiatrists attend to those found unfit to stand trial and NCR/NGRI, typically in a hospital setting. In the United Kingdom, the domain of forensic psychiatry also includes civilly detained patients. In Canada, forensic psychiatry is separated from correctional psychiatry, whose mandate is to care for incarcerated offenders who may also have mental health issues. Political events can shape not only the law but also the clinical practice, so that forensic psychiatry can appear more custodial at times and more rehabilitation focused at other times.

Although there is a perception that forensic psychiatrists can move easily between systems, managing mentally abnormal offenders, in any one system, is complicated by different patient characteristics, different legal environments, and different orientations of treating clinicians. Even dealing with descriptions of groups such as mentally abnormal offenders can produce confusion. It is well understood that individuals detained within forensic settings often have a complex array of psychopathology outside of any major mental illness alone. Sometimes it is these other mental abnormalities that prevent the patient from exiting the forensic system. These issues may include, but are not limited to, personality disorders, psychopathy, substance use disorders (SUDs), traumatic brain injury, and even organic syndromes. What this has meant is that academic discourse about managing mentally abnormal offenders, both oral and written, requires further critical refinement to make it useful in other jurisdictions. If this is not done, one runs the risk of adopting methods inappropriately or implementing unsafe interventions.

Management of the Mentally Abnormal Offender

Forensic programs typically take responsibility for the management of mentally abnormal offenders. This population usually includes patients found unfit to stand trial and NCR/NGRI whose care is delivered by forensic programs under the jurisdiction of a board or tribunal of review. Care is usually but not always delivered in some form of secure setting within a hospital system. Loosening of liberty restrictions and decision-making around release is predicated on risk. In order to ameliorate risk in the long term, one must address immediate and short-term risk (Glancy & Chaimowitz, 2005). Critically evaluating and identifying risk variables
specific to the individual assist in the process of managing risk. Consequently, if treatment interventions target the specific drivers of risk (e.g., psychotic symptoms, substance abuse), long-term risk may be impacted. The individual’s need for freedom, the physician’s obligation to treat, and the legal imperative to rehabilitate patients fuel the therapeutic process, opposing a more conservative or “safer” custodial method of operation.

Snowden (1997) provides a useful template when he describes risk management. According to him, risk management requires three steps: risk identification, risk assessment, and clinical risk management. The authors would add a fourth step, risk release titration.

Risk Identification

This is probably the easiest step, although it is important to recognize that not all patients, found unfit to stand trial or NCR/NGR, are considered to pose a risk to others. As in non-forensic clinical work, the risk (of violence, relapse, and suicide) needs to be identified in each patient if the likelihood is higher than “normal”. “Normal” here refers to rates in the general population or public at large. Unfortunately, clinicians’ fear of confronting or dealing with violent patients makes this a step often overlooked in general psychiatry. Not identifying risk terminates the risk management process.

Risk Assessment

Assessing risk of violence in forensic populations is usually a major enterprise involving multidisciplinary teams and utilizing a variety of actuarial instruments. The output deals with the nature of the risk, its anticipated severity, and the frequency in which it will occur and the likelihood of occurrence (Snowden, 1997; Webster, Hucker et al., 2002).

It is here that the first of a common series of management errors can occur. Even if the risk assessment considers both actuarial and clinical elements and is individualized, it must also take into account the context or situation the patient is in. In other words, the system which takes responsibility for the patient cannot be blind to the patient and his level of risk. Risk variables are managed, treatment is given voluntarily or with substitute consent, and privileges are given or withheld by the treatment team, all in real time. Risk varies depending on how well risk factors are addressed or even controlled. Risk assessors usually opine on what the risk would be absent the variables being controlled and do not usually consider the treated and managed in-patient situation. Risk assessment does not always address the risk the patient poses on a daily basis and does not always inform treating staff of the patient’s acute risk or factors influencing the management of that risk (Björkdahl, Olsson, & Palmstierna, 2005).

Risk assessment methods include actuarial tools and structured clinical assessment schema or protocols. Many of these tools are created utilizing retrospective research designs that tease out factors associated with some type of offending behavior and then attempt to “postdict” risk. They are often normed on a specific population, limiting their efficacy in other settings. These tools tend to provide predictions about long-term risk, often over periods of years, but are not able to speak to immediate or short-term risk.

There is now a growing body of literature in the area of short-term risk prediction. This literature, at least for now, tends to be focused on the assessment of risk within an acute care or inpatient setting. It appears that the need to understand and ultimately predict short-term risk is increasing, with a variety of instruments being developed such as the Overt Aggression Scale, Broset, and the START. These have achieved variable adoption across forensic institutions but have been welcomed in acute care psychiatric settings (Almvik, 2000; Silver & Yudofsky,
Clinical Risk Management

In general, where psychiatric services are provided, clinical “risk management is nothing more than the development of treatment strategies (medical, psychological, social involving the clinical team, family, and significant others) to reduce the severity and frequency of identified risks” (Snowden, 1997, p. 33). Management of the mentally abnormal offender involves the same process, except that the risk is usually related to violence and public safety, and other factors may come into play.

Despite one’s position on the usefulness of, or scientific basis for, risk prediction, there is a dearth of literature describing its utility in clinical management. That having been said, the risk factors embedded in risk assessment instruments are the basis for most risk reduction strategies.

Although some view risk as being static and contend that some of the variables that contribute to the determination of risk cannot be impacted, others recognize that risk is a much more fluid concept (Dvoskin, 2002, 2005; Harris et al., 2004; Webster, Hucker et al., 2002). The literature identifies a variety of factors seen as impacting risk and debates the inclusion and exclusion of these factors in any one risk measure. Again, however, this polemic, albeit useful, does not sufficiently guide the mechanism required to manage risk (Glancy & Chaimowitz, 2005; Webster, Hucker et al., 2002)

Many checklists and schema have been produced, both commercially and at a clinical team level, utilizing various combinations of risk factors or variables. Often, under institutional pressure to create a formalized process for managing risk of violence in psychiatric patients, especially forensic psychiatric patients, these checklists or schemas have become the main feature in addressing day-to-day risk. Unfortunately, this checklist management process often misses the mark and then can be a foolhardy approach to this important issue.

Clinical risk management is the next logical step after the risk has been identified and described. Once the nature of risk has been described, a general assessment of the elements of risk, the factors driving the risk, and the likelihood of the acts occurring needs to be done. When the factors contributing to the risk are identified, risk reduction strategies can be put in place.

There are several broad groups of factors that appear to impact risk in most mentally abnormal offenders. These groups include the major mental illnesses of the patients, concurrent problems such as personality disorders and SUDs, insight, and medication/program adherence.

Mental Illness. The links between violence and mental illness have been well studied and established. Schizophrenia and other psychotic disorders increase the likelihood of violence, commonly related to the nature and acuity of symptoms (Arango, Calcedo Barba, González-Salvador, & Calcedo Ordóñez, 1999; Bartels, Drake, Wallach, & Freeman, 1991; Buckley et al., 2002). Paranoid delusions, command auditory hallucinations, and the general disorganization of thinking and associated agitation all have been linked to increased violence (Steinert, 2002; Steinert, Sippach, & Gebhardt, 2000). The acuity of the symptoms impacts risk while the containment associated with in-patient care can lead to increased risk in some conditions and a reduction in risk in others (Webster, Hucker et al., 2002). Different types of Schizophrenia tend to respond differently to either containment or freedom from containment. In mentally abnormal offenders, as with civilly detained patients, control of the acute symptoms of mental illness in and of itself reduces the risk of both violence and self-harm. It should be noted that some major mental disorders, even when treated, are associated with a generally
higher incidence of violence (Andrews & Bonta, 2003). As well, curiously, one risk predication scheme, the VRAG, considers a diagnosis of Schizophrenia to actually lower the risk.

**Mental Disorders, Including Personality Disorders and Substance Abuse.** Certain personality disorders, specifically antisocial and borderline personality disorders, are associated with increased violence (Andrews & Bonta, 1995; Monahan, 1992; Monahan et al., 2002). Both of these conditions have violence or elements of self-harm as part of their actual diagnostic criteria, forever linking these conditions to aggression. Certain circumstances further increase the risk of aggression in these disorders, although both are associated with an increase in violence above the baseline. Psychopathy, although not a Diagnostic and Statistical Manual of Mental Disorders-IV Text Revision diagnosis, has a strong correlation with violent recidivism. Certain personality disorders are generally considered static and nonmodifiable. Other mental disorders, such as SUD, also are associated with high rates of violence. In fact, from a criminogenic perspective, personality disorders and SUDs are probably higher predictors of violence than are any other psychiatric illnesses or disorders.

Given that mental illnesses can be treated with medications and therapy, mental disorders such as SUDs and personality disorders can have their risk modified with attention to either abstinence or prosocial behaviors. Medication or program adherence is another significant factor defining risk outcome.

There is a significant overlap between substance abuse and personality disorders in a forensic setting. Both these types of disorders are highly represented in forensic patient populations and in individuals with major mental illnesses. Antisocial attitudes, attitudes that impact medication or program compliance or adherence, clearly increase risk. An acute major mental illness amplified by substance abuse and characterological difficulties brings all these factors together in a not uncommon comorbid grouping found in forensic populations.

**Insight and Medication Nonadherence.** Poor insight has been shown to be positively correlated with violence, independent of its effect on medication adherence. According to Amador and David (2005), both anecdotal evidence and multiple studies link medication nonadherence with violence. Insight often appears as denial of illness, although considered perhaps to have neurophysiological and neuroanatomical deficits. They state that although poor insight negatively impacts medication or treatment compliance, both insight and treatment adherence are independent contributors to the risk of violence. Mechanisms to improve insight and treatment compliances can and do reduce the risk of violence.

In managing acute mental illness, the usual combinations of psychiatric medications and psychotherapy are indicated. Additionally, in managing mentally abnormal offenders, attention needs to be given to the following:

1. Safety issues include controlling the environment, having the ability to seclude or restrain, being able to make adjustment in staffing to provide close monitoring of patients.

2. Medications may also be required for agitation or violence. Aggression and impulsivity are noted to be elevated in certain patients over and above that found in their core major mental disorder. Several medications have been known to be effective in reducing aggression and impulsivity. These include antipsychotics, with certain standouts such as clozapine and some of the atypical preparations. Benzodiazepines have also been shown to reduce aggression, although one always needs to be alert to the potential for
disinhibition in certain individuals. Mood stabilizers such as lithium, carbamazepine, valproic acid, and even phenytoin have long been known for their anti-aggressive and anti-impulsivity components. Other drugs such as beta-blockers have been shown to be effective in some trials.

3. Programs are widely used in forensic services. These have been implemented as logical consequences to the identification of risk factors. Although there have been some studies pointing to their effectiveness, both efficacy and effectiveness have yet to be measured.

Behavioral treatment programs targeting problematic behaviors are widely used. Substance abuse programs are usually considered essential elements of forensic programs. Not attending programs is usually equated with poor insight and attitudinal difficulties in substance-abusing patients. Despite this, the results from patients who have actually completed substance abuse programs, especially in coercive/forensic environments, remain equivocal.

Cognitive behavior therapy and an offshoot, dialectical behavioral therapy, have been shown to be effective with respect to certain behaviors in selected populations such as patients with borderline personality disorder (Landenberger & Lipsey, 2005; Linehan, 1995). Psychotherapy, ranging from supportive or directive through to insight oriented, has been used in a variety of patient populations. There are studies to show psychotherapy’s effectiveness, but it still takes a leap of faith to interpret them as risk reduction interventions. Motivational enhancement therapies have had encouraging results, engaging patients with concurrent disorders to initiate behavioral changes or abstinence.

On the other hand, more is being learned about the benefits of focusing treatment on a patient’s strengths (Heilbrun & Griffin, 1993). Developing skill acquisition in a broad range of areas through group involvement and psychoeducation has improved coping strategies of patients. In fact, some of the more recent assessment tools focus not only on risk factors but also on some of the protective factors that may be successfully acknowledged and bolstered in the management of the mentally abnormal offender (Dvoskin & Steadman, 1994). Assertive community treatment teams and community treatment orders have been utilized to provide additional supports to forensic patients.

The mere identification of risk factors in individual patients is not enough. Once in hospital, the patient’s risk needs to be managed. Risk factors posed by mentally abnormal offenders can be divided into dynamic or static or in a very similar division:

1. Modifiable factors.
2. Nonmodifiable factors.

Modifiable factors have historically included:
   i) active symptoms of major mental illness,
   ii) substance use,
   iii) medication adherence,
   iv) insight into illnesses/disorders,
   v) anger management issues, and
   vi) involvement with criminal associates.

Nonmodifiable factors have included:
   i) criminal history,
   ii) presence of certain personality disorders (especially antisocial personality disorder and borderline personality disorder),
   iii) history of substance abuse,
   iv) low intelligence, and
   v) cognitive disorders, including acquired brain injury, developmental delay, and dementias.

These divisions have their use but much like the boundaries between guilty and NCR/NGRI
or fit to stand trial and unfit to stand trial, the closer one looks at the boundaries or divisions, the less clear the divisions are. Certain major mental illnesses, even if treated, are associated with chronic increases in the risk of violence. SUDs, even if in remission, pose a life-long risk. Insight is a complex multilayered concept, more logically useful than practical. New research suggests that there is hope for modification of some of the more problematic aspects of both borderline and antisocial personality disorders. Life is also being breathed into that ultimate domain of hopelessness in psychiatry, the treatment of psychopathy. Cognitively impaired individuals can also be taught skills to better problem-solve, and cognitive enhancers are being introduced to assist with mild cognitive disorders and dementias.

Given the usual combination of modifiable and nonmodifiable factors, risk elimination is both impractical and virtually impossible. Risk reduction thus becomes the realistic aim of most treating forensic psychiatrists. Human behavior being what it is, a manifestation of a complex set of genes, neurotransmitters, chemicals, illnesses, and circumstances set in time and place, it remains extremely difficult to predict. Bearing that in mind, what we can then hope for is to reduce and manage risk in mentally ill offenders. Once the risk is identified and once risk factors are defined and described, risk management strategies need to be put in place. These should be directed at both modifiable and nonmodifiable elements but clearly weighted toward the modifiable.

**Risk Release Titration**

Attentive clinical treatment teams that address risk factors appropriately will likely be faced with a mentally abnormal offender who is now managed at the correct level of security and with the correct treatments. Such patients will likely not act out violently in hospital, and serious acts of violence in hospital are rare (Stüblner, 2006).

Once the patients are well managed and controlled, what is the next logical step? We do know that risk factors for recidivism and violence after discharge from hospital are not necessarily equivalent to those factors that predict violence in hospital (Steadman & Morrissey, 1981; Steinert, 2002). In-patient predications of violence also are weighted more heavily toward dynamic factors rather than static (Steinert, 2002; Taylor & Schanda, 2000).

Release decision-making and restriction-easing, goals inherent in most forensic systems, tend to incorporate actuarial instruments in predicting violence. As a consequence, some patients considered to pose a high risk on actuarial instruments remain detained in secure settings despite years of problem-free behavior. It remains extremely difficult for clinicians to find the balance between helping patients move into the community while at the same time protecting the safety of the public. It is the generalization that actuarial tools encourage that creates some of the stigma that our patients experience and that the public sees. There may be other ways of categorizing patients that may be less discriminatory and incorporate the patient’s strengths. Custodial responses with increased controls, punishment, and all the associated negativity may ultimately be found to be of less use than encouragement, support, kindness, and the provision of individualized treatment. As patients who pose risk succeed in mastering their unique situations, it makes sense to proceed with relaxation of controls in small increments while providing more freedom.

Depending on the risk the patient poses, these steps can be minute or more substantial but need to be continually titrated against response. In this way, patients can learn to trust, and ironically, staff can also learn to trust patients, recognizing and acknowledging change in those they care for.
Conclusion

The risk prediction literature, until recently, has been disconnected from the day-to-day clinical aspects of managing the mentally abnormal offender within the forensic system. As a mainstay, in forensics one must balance risk with the rehabilitation needs of the mentally abnormal offender. Thus far, current risk assessment strategies provide us with little assistance in this regard. Although some discourse has been initiated in this area, there has yet to be any notable progression. It is argued that as the field evolves, so should the manner in which we manage the risk posed by a mentally abnormal offender. We have moved beyond the notion that custodial measures are the only way to manage risk and must now endeavor to find less conservative procedures to contain and possibly even alter the risk that mentally abnormal offenders pose. Long-term predictions of risk, with all their imperfections, are too crude a set of tools to manage the risk posed by the individual mentally abnormal offender under the care of a forensic team. Liberal societies promote rehabilitative imperatives, and when combined with the ethical questions raised about clinicians being involved in risk prediction demand a more balanced approach to managing risk and promoting recovery.

The notion of risk assessment, although considered fundamental in the forensic system, continues to be a rather contentious and debated topic among professionals and academics alike. Some argue that clinical opinion has no utility in the determination of risk, while others argue that expert opinion is fundamental in the risk assessment process. At the bases of both these arguments is the mentally abnormal offender who has come into contact with the criminal justice system and must now be managed. The question then becomes, how do we best manage this individual in the here and now, keeping in mind his risk, his liberties, and the community at large? Because of our obligation to each of these elements, risk management cannot be a discrete venture. It is proposed that the notion of risk management is a multifaceted endeavor during which the clinician should consider not only long-term risk but also short-term risk. In order to do this effectively, one must consider the different facets of risk (severity, frequency, likelihood of occurrence), as well as the individual factors or variables that impact risk for any one offender. Once these individual factors are identified, developing strategies to manage, remedy, or impact risk becomes a natural progression in the process. Risk can then be better managed and better understood, and consequently, decision making and risk release titration are driven not by subjectivity but by methodology that is empirically grounded yet clinically oriented. The arena of risk assessment and risk management is ever evolving, with new methods of practice being proposed regularly. We are making gains in the endeavor to calculate, manage, and reduce risk but more work needs to be done in terms of how to best link these areas so that the mentally abnormal offender’s and the community’s needs are adequately met.

References


Williams, M. H., & Bloom, J. D. (1989). Mental health services research with forensic populations. *New Directions for Mental Health Services, 44*, 84–95.