



Family &
Community
Services

Violence Risk Assessment Practice Guide

Practice Guide for Practitioners who Support
People with Disability



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1 Introduction

1.1 Introduction and Purpose

Welcome to the Violence Risk Assessment practice guide. This resource was developed by Clinical Innovation and Governance, within the Department of Family and Community Services (FACS), New South Wales, Australia.

This practice guide is designed to assist FACS psychologists in their work supporting individuals with an intellectual disability who exhibit violent behaviour. It sets out good practice in violence risk assessment that can help to mitigate the risk of future violence. Comprehensive assessment contributes to good support planning. When both are in place services are better able to support a person to pursue personal goals and have their needs met whilst at the same time managing and reducing violence risk. All this can be done within an environment that is free of unnecessary restrictions.

In this practice guide key information is presented about violence risk assessment to assist practitioners in their work. The guide looks at what is meant by the term violence risk assessment. It then sets out some of the advantages of conducting violence risk assessments in intellectual disability services, and introduces some of the main measures that are in use. Finally, it considers how violence risk assessment can help services to reduce risk over time.

A challenge for any large organisation is the translation of policies and procedures into practice. By having a practice guide in violence risk assessment to help psychologists in their work the consistent application of good practice can be enhanced across different regional areas and settings. Agencies that use standardised violence risk assessments have a greater impact on reducing future risk than those that do not. Re-assessment with standardised instruments also positively affects outcomes (Lowenkamp and Latessa, 2004).

For the purposes of this document the definition of violence is the same as that used in the most widely adopted violence risk assessment measure in the world, the HCR-20. Violence then is defined as, 'actual, attempted, or threatened infliction of bodily harm of another person. The focus is on behaviours that may cause physical or serious psychological harm. Behaviour that has the potential to cause mild to moderate psychological harm is not included (Douglas, Hart, Webster, & Belfrage, 2013).

This practice guide is designed to complement organisational policies and procedures, rather than replace them. This practice guide supports psychologists in their clinical work and can be used by them in a number of different ways:

- alongside clinical knowledge, skills and experience to guide clinical practice
- as a basis for self directed learning

- as part of FACS core standards learning
- for reference and clarification
- for part of the induction of new staff
- in conjunction with professional supervision
- with student psychologists in FACS placements

Although specifically designed for psychologists, sections of this practice guide may be of interest to other practitioners; for example behaviour support practitioners, occupational therapists or speech pathologists in the context of the practitioner's scope of practice, their organisational policies and procedures, and their professional obligations.

This practice guide forms part of a number of documents, which are supports for psychologists and other staff; for example occupational therapists, physiotherapists, speech pathologists, dieticians, therapy assistants and nurses, working in FACS. There are a number of other practice guides available on our website that could be read in conjunction with this practice guide. Some of these packages provide more general information to guide practice. They also provide a context for practice; for example implementation of evidence based practice, supervision and underpinning philosophies, values and beliefs.

This practice guide forms part of the supporting resource material for the [Core Standards Program](#) developed by Clinical Innovation and Governance. Please note that some of the information contained in this practice guide is specific to practitioners working with people with disability in New South Wales, Australia.

Feedback on this practice guide is welcomed by Email at CIGCoreStandards@facs.nsw.gov.au

Please include the title of the Core Standard in the 'Subject' box.

1.2 Copyright

The content of this practice guide has been developed by drawing from a range of resources and people. The developers of this guide have endeavoured to acknowledge the source of the information provided in this practice guide. The guide also has a number of hyperlinks to documents and internet sites. Please be mindful of copyright laws when accessing and utilising the information through hyperlinks. Some content on external websites is provided for your information only, and may not be reproduced without the author's written consent.

1.3 Disclaimer

This resource was developed by the Clinical Innovation and Governance Directorate of the Department of Family and Community Services, New South Wales, Australia.

This practice guide has been developed to support practitioners¹ who are working with people with disability. It has been designed to promote consistent and efficient best practice. It forms part of the supporting resource material for the Core Standards Program developed by FACS.

This resource has references to departmental guidelines, procedures and links, which may not be appropriate for practitioners working in other settings. Practitioners in other workplaces should be guided by the terms and conditions of their employment and current workplace.

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The package is not considered to be the sole source of information on this topic and as such practitioners should read this document in the context of one of many possible resources to assist them in their work.

Whilst the information contained in this practice guide has been compiled and presented with all due care, FACS gives no assurance or warranty nor makes any representation as to the accuracy or completeness or legitimacy of its content. FACS does not accept any liability to any person for the information (or the use of such information) which is provided in this practice guide or incorporated into it by reference.

1.2 Background and policy links

1.2.1 Background and policy links

Over the last twenty years there have been significant advances in the evidence base for the assessment of violence risk. It is important that FACS practitioners are familiar with good practice in this area. This can help to ensure that intellectual disability services provide responses to violence that are not purely reactive or overly restrictive and that help to reduce violence risk in the future.

A core part of the work of a FACS practitioner is to support people with a disability to meet their personal goals and needs, to participate as fully as possible in their communities. Violence can significantly affect how much a

¹ The term practitioner as used here includes dietitians, speech pathologists, occupational therapists, physiotherapists, psychologists, behaviour support practitioners and nurses.

person is able to integrate into their community. It can also present a significant risk to others within that community.

Every working day, practitioners are getting to know, understand and support individuals with an intellectual disability who present with behaviours of concern. Behaviours of concern are defined here as any behaviour that jeopardises the safety of the person exhibiting it, or the safety of others, and/or that limits the person's access to services. Violence is one such behaviour.

People with an intellectual disability have a right to receive strengths oriented evidence-based psychological supports that are non-aversive, least restrictive and that derive from valid assessment. Psychologists are one group of practitioners who because of their training are in a position to help ensure that this occurs. An example of an evidence-based least restrictive approach is positive behaviour support (LaVigna and Willis 2012). Positive behaviour support combines behavioural analysis with a person-centred philosophy. Instead of focusing only on reducing behaviours of concern positive behaviour support has an emphasis on skill building that can help a person achieve his or her goals in pro-social and more adaptive ways. It often includes supports that are provided in naturalistic community-based settings (Carr, Dunlap, Horner, et al., 2002).

Australia is a signatory to the United Nations Convention on the rights of the Person with Disabilities Protocol. This states that people with disability have the right to 'freedom from exploitation, violence and abuse' (United Nations, 2006). Ensuring services are fully informed about positive and least restrictive approaches helps to reduce the likelihood of abusive practices.

Practitioners considering the issue of violence risk assessment now have at their disposal a wide array of measures. For a thorough review of violence risk assessment in the non-intellectual disability population see Otto and Douglas (2010). Up until quite recently the majority of research into violence risk assessment was conducted with forensic psychiatric populations and also those in correctional settings. However, it cannot be assumed these measures are equally valid when used with a person with intellectual disability.

This practice guide brings together information about violence risk assessment in intellectual disability that usually has to be accessed via a variety of publications. It was developed in consultation with the psychology practice reference group of Ageing, Disability & Homecare, FACS. This group consists of the agency's senior specialist psychologists, senior management representatives and the ADHC psychology practice leader.

This practice guide needs to be considered in association with ADHC's Client Risk Policy and Procedures (2008) document, amended April 2012, available at [Client Risk Policy](#) and the also refer to safeguarding framework [Person Centred Approach to Risk Assessment for Clients of Community Support Teams](#) and the Person Centred Clinical Risk Assessment Practice guide

(Gadow and Riches, 2014) developed by the Centre for Disability Studies, Sydney.

Finally, it is not expected that a practitioner will become proficient in violence risk assessment after reading this practice guide. It is for the individual practitioner, in consultation with his or her supervisor and line manager to decide whether additional training or supervision is required in order to obtain, maintain and enhance competence in this area. It is also recommended that a practitioner consults the manual of any assessment prior to its use to ensure that they have the appropriate level of training and experience to utilise that assessment tool.

2 Definitions

The table below is a list of terms, keywords and/or abbreviations used throughout this document.

Term	Definition
Violence	Actual, attempted, or threatened infliction of bodily harm of another person.
Violence risk assessment	The collection of information about a person or their environment that research has demonstrated is predictive of future violence. The assessment includes an analysis of the information and making appropriate recommendations to assist in mitigating the level of risk predicted.
Evidence-based decision making	Decision-making based on a systematic review of relevant information in the form of observation, research, statistics, and/or well validated theory.
Risk	A threat or hazard that is incompletely understood and the occurrence of which cannot be predicted with certainty.

3 Legislation

In most territories, workplace health and safety legislation requires employers to ensure the prevention of foreseeable risk. When violence risk is an issue practitioners have a role to play in helping services to identify the extent and nature of any risk, the factors that contribute to that risk, any changes required to eliminate or control that risk, and the monitoring and evaluation of any risk control processes.

When a potential for violence is known and the matter comes to the attention of the court, the court may expect to see evidence of a valid risk assessment process as well as a prevention program based on that assessment. Thus, in addition to performing violence risk assessment a practitioner's role will often extend to risk management planning and support.

4 What does the research tell us about violence risk assessment and people with intellectual disabilities?

4.1 Prevalence

A major role of FACS practitioners is to help support individuals with intellectual disability who present with violence. This requires both adequate assessment skills as well as skill in developing appropriate support. Although only a minority of individuals with intellectual disability exhibit violence, the number can still have significant effects on the quality of life of the person with disability. Emerson, Kiernan, Alborz, et al, (2001) studied all individuals with intellectual disability involved with health, education and social services in two regions in the United Kingdom. The authors noted violence was demonstrated by 7% of the sample.

4.2 Evidence Base

Although there are many violence risk assessment measures available, most of these have not been validated for the intellectual disability population. It cannot automatically be assumed that all measures will be equally valid when used with people with an intellectual disability as risk factors may differ between these populations. Over the last decade research has begun to focus on people with an intellectual disability to determine whether measures are valid for use with this population. Some of that research has been considered in the development of this guide. It is the responsibility of ADHC psychologists to be familiar with this evidence when conducting violence risk assessments.

5 What is violence risk assessment?

Assessment is the collection of information to help with decision-making (American Psychological Association, 1999). In violence risk assessment the primary information that is gathered relates to known risk factors. Risk factors refer to a condition or characteristic of the person or their environment that research has demonstrated is predictive of future violence i.e. it is evidence-based.

Hart and Logan (2009) define evidence-based assessment and management of violence risk as, "...the process of gathering information about people in a way that is consistent with and guided by the best available scientific evidence and professional knowledge to understand their potential for engaging in violence in the future and to determine what should be done to prevent them from doing so."

Hart and Logan's definition assists practitioners to understand that identifying known risk factors is only one phase of thorough violence risk assessment. Also important is a second phase that seeks to identify protective factors either within the individual or their environment that may reduce this risk. The consideration of the risk and protective factors can then be used to develop a plan for intervention and support that has a focus on these factors.

Although in a legal context a psychologist may be asked by a court to consider only the issue of future violence risk, psychologists in a support context can be expected to address both violence risk and its management.

6 What are the advantages of conducting violence risk assessments in intellectual disability services?

There are a number of advantages for practitioners to be able to conduct violence risk assessments that are evidence based. These include being able to target support to individuals who present a risk and the services that provide support, ensuring consistency in assessment across diverse settings and services, matching support to a person's level of risk, and finally valid monitoring of the effectiveness of any support aimed at reducing risk.

Support services can be overly cautious when considering risk in the absence of objective risk assessment. This can lead to overly restrictive practices being used in the mistaken belief that such management responses are necessary and helpful (Harris and Tough, 2004). By learning what factors actually relate to increased risk misconceptions can be addressed and hopefully changed. For example, in treatment for sexual offending many hold the belief that denial of offending behaviour is a risk factor for future offending. Perhaps surprisingly it is not, and targeting it in treatment does not seem to be particularly important for reducing risk (Yates, 2009).

Prior to the development of valid risk assessment instruments, psychologists had to rely on their own individual approaches to assessment. These usually had not been empirically tested and thus were not evidence-based. This inevitably meant that comparisons between individual evaluators were unreliable. When unreliable assessment measures are followed by the use of different evaluators it can lead to serious errors in judgement. Unreliable

assessments can result in one service judging a person to be at high risk whilst another service might judge the same person to be at low risk (Lindsay and Beail, 2004).

Reliable and valid violence risk assessment allows for better use of resources to support a person with intellectual disability. This means that treatment and supports can be included that are tailored approaches to address known risk factors for the person. It also means programs can be matched against the degree of risk that a person presents. The importance of matching treatment and support intensity to the degree of risk identified is discussed in more detail towards the end of this guide.

Finally, valid violence risk assessment should also be used for ongoing monitoring to identify changes in a person's level of risk. Re-assessment of this type allows services to make changes to support and management programs at the right time. Re-assessment also allows services to determine whether the support they are providing is effective at reducing risk and thus can be an important measure of service quality. It will also identify when they are able to reduce and restrictive measures that are in place to manage the risk as it decreases.

7 The evolution of violence risk assessment

Since the 1990s violence risk assessment has evolved through four generations. The first three generations are usually referred to as the unstructured clinical approach, the actuarial approach and the structured professional judgement approach. These three approaches usually focused on internal and personal risk factors relating to the person being evaluated. More recently, a fourth generation of violence risk assessment measures has sought to include an additional focus on external and environmental risk factors. These include support staff knowledge and service management plans. Each of the four generations is considered briefly below.

7.1 The unstructured clinical approach to violence risk assessment

Early approaches to violence risk assessment were based on clinical opinion and intuition. In this approach the person conducting the assessment chose the type of information to gather and how much weight to attribute to it when considering the likelihood of future violence. This type of unstructured violence risk assessment therefore produced opinions informed by personal clinical expertise and experience. As noted above, this approach was problematic in that different evaluators are likely to have very different ideas about what might be a risk factor. In addition, these types of assessments weren't particularly effective at accurately predicting violence although it was

considered more accurate than chance (Mossman, 1994). Finally, unaided clinical prediction is biased towards over-prediction, i.e. it leads to more people being considered at risk of violence than is truly the case (Monahan, Steadman, Silver, et al., 2001).

7.2 The actuarial approach to violence risk assessment

Actuarial instruments focus on specific criteria that are linked to future violence. However, they can be limited to a small set of criteria. Actuarial instruments also require evaluators to use strict cut-off criteria. As such, these instruments have received criticism for excluding other potential important risk factors. There is an overemphasis on static risk factors. Static risk factors are those that cannot be changed, for example a history of violence, male gender, or younger age at first offence. Static factors are robust predictors of risk. Age of onset of behaviour and past behavioural history are a feature of many risk assessment scales because they are among the most reliable predictors.

In the actuarial approach to violence risk assessment, a formal method is followed using a formula or an actuarial table to arrive at a probability estimate or score for future violence. This approach uses predictor variables and assigns weights that have been validated as predictive through empirical research. Over the last 15 years a number of meta-analyses have been conducted examining actuarial approaches to violence risk assessment. When these were compared with earlier research, reviewers noted that there was a consistent though modest advantage in accuracy for actuarial prediction over clinical prediction (Heilbrun, Yasuhara, and Shah, 2010).

There are a number of examples of actuarial risk assessment tools available and these are each considered below.

7.2.1 Violence Risk Appraisal Guide (VRAG; Harris, Rice and Quinsey, 1993)

The VRAG measures static risk factors such as elementary school maladjustment, age at index offence and severity of victim injury. Use of the VRAG has been validated in a wide variety of populations including civil psychiatric patients (Harris, Rice & Camilleri, 2004), sex offenders (Harris, Rice, Quinsey, Lalumiere, Boer, & Lang, 2003) and offenders with intellectual disability (Gray, Fitzgerald, Taylor et al., 2007). In its original construction sample it was as accurate with offenders who had intellectual disability as with those who did not (Quinsey, Harris, Rice and Cormier, 1998). This study substituted a measure of psychopathy with another measure of childhood antisocial behaviour due to difficulties with scoring the psychopathy measure with this population.

7.2.2 STATIC-99 (Hanson and Thornton, 1999)

This is a ten item actuarial measure for use with adult male sexual and violent offenders who are at least 18 year of age at the time of release into the community. It is a widely used sex offender risk assessment instrument and is

used extensively in the United States, Canada, the United Kingdom, other European countries and in Australia. Validity of the Static-99 has been demonstrated in the intellectual disability population (Lindsay, Hogue, Taylor et al., 2008).

7.2.3 Limitations of static risk factors

The large focus on static risk factors in actuarial violence risk assessment means they are not particularly useful in providing guidance on the development of recommendations for reducing risk. This has therefore limited practitioners in their ability to include other factors that might be changed to reduce risk, for example the effects of severity of a mental illness, substance misuse, or antisocial attitudes. Factors such as these that are associated with increased risk and that may change over time are called dynamic risk factors.

7.2.4 Dynamic risk factors

A dynamic risk factor is a variable that influences the likelihood that the behaviour will occur and that can be manipulated for example via treatment (Andrews and Bonta, 2006).

Dynamic risk factors have been further broken down into stable and acute factors. Stable dynamic risk factors are those that appear fairly consistent over time such as difficulties with self-regulation whilst acute factors change more rapidly e.g. mood state (Thornton, 2002). The identification of dynamic risk factors can provide direction on the type of areas that services might target in interventions. So, whilst static risk factors provide important information about baseline level of risk, dynamic risk factors can influence risk either positively or negatively over time.

7.3 The structured professional judgement approach to violence risk prediction

The concerns noted above with actuarial assessment approaches led other researchers to suggest an alternative way of assessing violence risk. This newer approach considers both static and dynamic risk factors and became the third generation of risk assessment known as structured professional judgement (SPJ).

The SPJ approach to violence risk assessment combines the objective evidence-based selection of pre-set and predetermined risk factors of second generation instruments (i.e. actuarial assessment) with the subjective, professional interpretation of the severity, frequency, or duration of dynamic risk factors identified by the evaluator in each case. SPJ measures generally consider three sets of factors covering the past (historical), the present (clinical) and the future (risk management).

Third generation SPJ measures include the assessment of violence risk (HCR-20 version 3, Douglas, Hart, Webster, and Belfrage, 2013), and the

Sexual Violence Risk-20 for the assessment of sexual violence risk (SVR-20, Boer, Hart, Kropp and Webster, 1997).

7.3.1 Historical-Clinical-Risk Management-20 for the assessment of violence risk (HCR-20 Version 3)

The HCR-20 was first published in 1995 and was well received by practitioners and researchers. Further work by its authors led to the release of a second version in 1997 (Webster, Douglas, Eaves, & Hart, 1997). The HCR-20 version 2 was adopted for use by many health care, criminal justice and social service agencies around the world. A supplemental guide to the HCR-20 for offenders with intellectual disability (ID) was proposed to increase the standardisation and reliability of risk assessment for offenders with intellectual disability. A recent survey showed that the HCR is the most widely used risk assessment measure in the world (Singh, 2013).

The HCR 20 was revised again in 2013 to incorporate the rapid growth in the scientific literature on violence risk assessment (Douglas, Hart, Webster, and Belfrage, 2013). In addition to risk assessment, this tool may also be used in the development of risk management planning and monitoring. A further advantage of the HCR-20 is the publication of the companion volume, 'The HCR-20 Violence Risk Management Companion Guide' (Douglas, Webster, Hart, Eaves and Ogloff, 2001). The purpose of the companion guide is to assist practitioners in the development of case management plans to help reduce risk following assessment.

Most violence risk assessment measures were intended for use with offenders and forensic patients in institutional settings. An advantage of the HCR-20 is that it is intended to assess risk in both institutional and community settings. Thus, it can assist with decisions relating to the courts as well as to aspects of community supervision and support. The HCR-20 provides a list of core risk factors, both static and dynamic that ought to be considered in any assessment. The authors acknowledge that an evaluator may also wish to go beyond this list to consider individual factors that may also have relevance. The HCR-20 can also be used to monitor changes over time with regards to risk.

Many of the studies conducted using the HCR-20 focused on psychiatric inpatients and outpatients following discharge into the community, as well as forensic psychiatric patients. The HCR-20 has also been studied with people with intellectual disability. The HCR-20 is a good predictor of violent reconviction in a group of offenders with intellectual disability (Gray, Fitzgerald, Taylor, MacCulloch and Snowden, 2007). Another more recent study considered community-based offenders with intellectual disability with a history of violent offending. The researchers examined predicted risk and actual reoffending over a minimum of two years, using the HCR-20, the HCR-20 with ID Supplement and the VRAG. Predictive validity was generally good. Although statistical significance could not be determined, use of the intellectual disability supplement resulted in a small improvement in predictive

validity relative to the HCR-20 and VRAG (Verbrugge, Goodman-Delahunty and Frize, 2011).

7.3.2 Sexual Violence Risk-20 for the assessment of sexual violence risk (SVR-20,1997)

The Sexual Violence Risk – 20 (SVR-20; Boer, Hart, Kropp and Webster, 1997) is a structured clinical assessment for sexual violence risk. The SVR-20 was developed from a thorough review of the empirical literature. In order to identify relevant risk factors, there were three general principles: The risk factor had to be (a) supported by scientific research, (b) consistent with theory and professional recommendations, and (c) legally acceptable, that is, consistent with human and civil rights. The SVR-20 consists of 20 items, divided into three domains, Psychological Adjustment, History of Sexual Offences, and Future Plans Validity has been demonstrated with people with intellectual disability. Blacker et al. (2011) found the SVR-20 had moderate predictive validity for violent offending in a group of individuals with intellectual disability and also borderline intellectual disability.

It is important note that in both the HCR-20 and the SVR-20, psychopathy is rated using the Psychopathy Checklist Revised (PCL-R, Hare, 1991). Although the PCL-R is not a risk assessment measure in itself, it has been shown to be a significant factor in violence risk assessment in both the general population and those with an intellectual disability (Morissey, Hogue, Mooney, Allen et al., 2007).

7.4 Fourth generation violence risk assessment

The above overview considers briefly the first three generations of risk assessment, unstructured clinical judgment based largely on practitioner opinion, actuarial assessment based on static risk factors, and structured professional judgement that includes both static and dynamic risk factors. Risk assessment has thus traditionally considered a person's internal or personal risk factors as critical when evaluating risk for violence. However, more recently there has been a growing awareness of the importance of social factors and physical environments where a person lives that can also either increase or decrease risk. Recent research in this area has led to the development of a fourth generation of violence risk assessment measures.

In addition to personal static and dynamic risk factors, fourth generation risk assessment is concerned with environmental factors, including support staff. It is particularly concerned with reassessment, service planning, support and delivery, as well as intermediate outcomes. These other factors may be positively influenced to improve support and reduce risk, for example by including stages of change theory and motivational interviewing (Andrews, Bonta and Wormith, 2006).

By focusing upon the environment where violence may occur, support agencies can begin to target contextual dynamic factors that may increase or

decrease risk as well as the contextual factors that may reduce risk, i.e. protective factors. Thus, fourth generation violence risk assessment looks at the person's dynamic and static risk factors whilst also considering contextual risk factors. In this way these tools are better able to inform a service's intervention and supports by reducing both the person's internal risk factors and the service's external risk factors. In addition, like the structured professional judgement approaches, these types of assessments can be used for re-assessment to identify changes in risk and to determine efficacy of ongoing programs.

One particular fourth generation assessment measure that was specifically developed for use in intellectual disability, is the Assessment of Risk Manageability for Individuals with Developmental, Intellectual, or Learning Limitations who Offend (ARMIDILO). It was developed through clinical expertise and a review of the literature (Boer, Tough and Haaven, 2004). This instrument aims to link assessment and intervention by having a greater focus on external variables including support staff (Boer, McVilly and Lambrick, 2007). Boer, McVilly and Lambrick, (2007) noted that this greater scope in assessment is consistent with the model of assessment proposed by the American Association of Intellectual and Developmental Disabilities (formerly known as the American Association on Mental Retardation, 2002). The ARMIDILO is consistent with the bio-psycho-social model of assessment as adopted by the International Classification of Functioning Disability and Health, (World Health Organization, 2001).

8 Other considerations in the assessment of risk

There are many other factors present in the person's environment that impact on the assessment of risk. One example is the person's support staff (Boer, McVilly and Lambrick, 2007). The authors suggested that staff factors such as client knowledge and staff support skills should be assessed in order to provide a more accurate picture of current dynamic risk. The manner in which support staff interpret and respond to violence may have implications for violence risk in intellectual disability services. One explanation as to why this is particularly important relates to attribution theory. This theory suggests that our beliefs about the causes of behaviour mediate how we feel about it and how we respond to it (Weiner, 1995). These causal attributions are especially important in behaviour support with individuals who exhibit violence as they influence subsequent helping behaviour by significant others.

In intellectual disability services, staff members who consider concerning behaviour to be under the individuals control are more likely to experience anger towards that person and therefore may withhold any assistance. Those who see the cause as less controllable conversely feel more sympathy and

offer more help. In intellectual disability services, staff sympathy was found to be the single best predictor of helping intentions (Dagnan and Cairns, 2005).

Behavioural attributions also influence staff optimism regarding the efficacy of support. For example, staff in a forensic setting exhibited less optimism when they perceived behaviours as being under the person's control. Staff responses are also influenced by their expectations of whether the intervention is likely to be successful. Helping behaviour has been shown to be more likely to occur when staff members are feeling optimistic (Sharrock, Day, Qazi and Brewin 1990). Staff attributions and response styles can be considered potential risk factors for behaviours of concern, including violence. In particular, attributions of blame and subsequent support for aversive responses are likely to increase risk as they can increase feelings of angry arousal and provoke impulsive aggression in the person with disability. This is not a new observation. Hastings and Remington (1994) noted over 20 years ago that the behaviour of support staff and other carers can inadvertently trigger violence in services for people with intellectual disability.

Improving staff's understanding of the possible causes of violence in intellectual disability (e.g. childhood trauma, reduced opportunity) may reduce blame-related attributions and enhance helping behaviour. Many services have become more trauma-informed in response to learning about individual histories, and are more aware that restrictive responses to behaviour can serve to re-traumatise the person (Jennings, 2004).

By expanding risk assessment items to cover the above factors the assessment is designed to assess risk more accurately which in turn can better inform risk management plans.

8.1 How the ARMIDILO addresses these factors

The Assessment of Risk Manageability for Individuals with Developmental, Intellectual, or Learning Limitations who Offend now incorporates environmental variables covering a wide range of external issues for consideration (Boer, Haaven, Lambrick, Lindsay, McVilly, Sakdalan, and Frize, 2012).

These include:

- Staff attitudes towards the person with intellectual disability
- Communication amongst support staff
- Client specific knowledge by support persons
- Consistency of supervision/intervention

The predictive validity of a later version, The Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend - Sexually (ARMIDILO-S) was assessed by Blacker, Beech, Wilcox and Boer, (2011). This research concerned a population of individuals

with intellectual disability and borderline intellectual functioning. Three other measures used in this study had all been previously validated in non-intellectual disability populations. These were the Rapid Risk Assessment for Sexual Offence Recidivism, (RRASOR; Hanson, 1997), the Sexual Violence Risk Scale, (SVR-20; Boer et al., 1997), and the Risk Matrix 2000/Violent (RM2000-V; Thornton, Mann, Webster, et al., 2003). In this study, the ARMIDILO-S was the best predictor of sexual reconviction among offenders. Lofthouse, Lindsay, Totsika et al. (2013) added further evidence for the predictive accuracy of the ARMIDILO-S as a dynamic intellectual disability specific risk assessment tool. Using a larger sample size than the Blacker study they found the ARMIDILO outperformed another well performing static risk assessment measure for violent reoffending, the STATIC-99 (Hanson and Thornton 2000).

More information on the ARMIDILO-S including user requirements and research summaries can be found at the website <http://www.armidilo.net/>

9 The Risk-Need-Responsivity Model

In their highly influential model regarding behaviour change strategies in offender rehabilitation, Andrews and Bonta (2003) discuss the concepts of risk, need and responsivity (RNR). The RNR model recommends that treatment intensity should be guided by the magnitude of risk an individual presents (Risk). The greater the level of risk the more intense the support provided. It also suggests that support should target dynamic risk factors linked to recidivism (Need). Finally, the model identifies that factors impacting upon engagement with support, and also the fidelity of that support, should be included as targets for change when these are suboptimal. The RNR model has been used around the world to help assess and rehabilitate offenders including those who present with violence. For a recent review of the model, see Andrews (2012).

Risk, need and responsivity principles are also important for the work of practitioners when supporting individuals with intellectual disability who exhibit violence. The material covered in this guide indicates that all three can be assessed following the structured approaches outlined above. Level of risk can be assessed by identifying the person's static and dynamic risk factors using valid measures. This assessment can then help to identify the person's treatment and support needs to reduce their future risk. Fourth generation assessment measures allow responsivity issues to be addressed by identifying contextual environmental factors (including staff behaviours and support fidelity) that can increase or decrease a person's risk for violence. Once identified, difficulties can be addressed via changes to management planning and violence risk re-assessed via continued monitoring.

10 Which assessment measure should a practitioner use?

Which violence risk assessment measures to use is ultimately a matter for a practitioner to answer him or herself. However, general factors to consider as outlined by Boer (2011) provide a useful guide.

Boer suggests the measures chosen should be guided by:

- The purpose for the assessment
- The degree to which the instrument is supported by relevant data for your client
- The degree to which the instrument gives you information relevant to the referral question
- The degree to which the instruments contribute to a comprehensive risk “picture”
- Summary

In summary then, practitioners can find it helpful when carrying out a violence risk assessment to use a structured approach that includes analysis of static and dynamic risk factors that have been validated as predictive of violence with people with intellectual disability (such as the HCR-20 and SVR-20). By identifying a person’s dynamic risk factors, evidence-based supports can then be offered in a targeted way that seeks to reduce these risk factors.

In addition, by incorporating fourth generation risk assessments such as the ARMIDILO, that focus on contextual risk and protective factors, practitioners can help services to proactively change environmental risk factors. In this way violence risk can be further reduced. Finally, practitioners can re-assess violence risk using valid measures to help services monitor the quality of support being provided to people with an intellectual disability. Any changes required can then be made proactively.

11 Support and advice

You can get advice and support about this practice guide from by emailing CIGCoreStandards@facfs.nsw.gov.au with the title of this core standard in the subject line.

If you are reviewing a printed version of this document, please refer to the internet to confirm that you are reviewing the most recent version of the policy. Following any subsequent reviews and approval this policy will be uploaded to the internet and all previous versions removed.

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