

## Artikel

# Ethical dilemmas in structured professional judgements

## Ethical issues in risk assessments in forensic psychiatry: What does a prediction based on group data say about an individual in his specific context?

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The narrative constructs the identity of a character, what can be called his or her narrative identity, in constructing that of the story told. It is the identity of the story that makes the identity of the character. Paul Ricoeur

### 1. Introduction

Discussions about the quality of care in forensic psychiatry often concern the quality of risk assessment decisions in relation to the safety of society. In the Netherlands forced detention in a psychiatric hospital, i.e. *ter beschikking-stelling* (TBS), is focused on treating inpatients who have committed serious crimes.<sup>(1, 2)</sup> In this treatment each patient is offered an ‘opportunity’ to learn from his past, to change his risk behaviours and to return to society if his or her risk behavior has been evaluated by forensic professionals as reduced sufficiently. Dilemmas for forensic professionals are: Which forensic inpatient (TBS’er) is competent enough to permit leave? Whom should the hospital order be extended to and who can rehabilitate? It is therefore important to accurately assess risk behaviors of patients to get an estimate of the potential danger to society.

In forensic psychiatry, it is crucial to weight ‘all’ interests concerning such safety questions. It is (at least) about the interest of the patient and the interests of society, including victims and their family members. Obviously interests of the patient and society may conflict. An ongoing ethical dilemma for a professional is: what do you consider as more important in your decisions, the safety of society or the liberty of a person? And how can one assess whether someone is (still) dangerous? Making assessments in terms of possible future violent behavior entails a great responsibility.

In forensic psychiatry there are several procedures to achieve accurate assessments of possible criminal behaviour, but it remains difficult to predict a possible new offence.<sup>(3)</sup> A distinction is usually made between an unstructured clinical evaluation, an actuarial or statistical prediction and a structured professional judgement.<sup>(4)</sup> The quality of risk assessment is not only in the interest of a safe society, but also in the interest of the patient whose freedom is being curtailed.

In this essay we explore to what extent these different risk assessment

methods have positive and negative ‘side effects’ and discuss whether a narrative approach may contribute to cope with these side effects. To explore the extent to which a narrative approach may contribute to risk assessments, current risk assessment methods are described in section two. Section three deals with mistakes that can be made in predicting risk behavior by applying group data on individuals. This section includes a discussion about misclassifications like false-negative and false-positive decisions. The fourth section is about the role of narrative identity in structured professional judgements. The goal is to try to understand the patient in a more individual, contextual way. The last section contains some conclusions of this essay. It is about the question how to deal with the dilemma that risk assessment instruments are scientifically validated, but also lead to a certain amount of misclassifications in terms of risk at the individual level. We argue that structured professional judgements may be improved by also focussing on the narratives of a patient.

This essay is not specifically about absolute levels of predictive values of current risk assessments. It is necessary to explore a view about how to deal with risk assessments, because it is important to reflect on methods practitioners apply to decide about freedom of patients. Making choices about leave or no leave, rehabilitation or not, should concern us.

## **2. Risk assessment methods in TBS**

Risk assessment methods are elaborated to support assessments on the probability of criminal behavior in the unknown future. In the Netherlands TBS is one of the most freedom constraining measures in the penal code. A person is literally separated from society to undergo treatment. But, unlike imprisonment, it is uncertain how long this separation will last. Basically, every two years the court decides whether the TBS-measure for a patient should be extended or not.<sup>(5)</sup> The opinion of the court is for a (large) part based on the advice of the hospital / institution and their risk assessment.<sup>(6)</sup> This section briefly discusses the different methods in forensic psychiatry to evaluate potential future criminal behavior of patients.

### *2.1 Clinical prediction*

A clinical prediction of future criminal behavior is solely based on a clinical assessment by a practitioner in forensic psychiatry.<sup>(7)</sup> This prediction is based on the treatment relation with the patient, combined with theoretical and practical background of the practitioner. On an individual level this type of prediction of risk-behaviour takes typical aspects of the person of its own specific context into account. However, clinical predictions lead to questions as ‘how unprejudiced is a practitioner?’ Is a clinical prediction not too much influenced by the personal biases of the practitioner, and might another practitioner have another opinion on that same patient? Clinical assessment has repeatedly made mistakes and appears less reliable than actuarial risk

assessment.<sup>(8)</sup> One could say that a clinical prediction is tailor made, but has no benefits from scientific developments. Because of this unreliability of clinical assessment, practitioners increasingly make use of other risk assessment methods.

### *2.2 Actuarial- or statistical prediction*

Methods that are based on solely statistical data and used in risk assessment are called actuarial valuations, like the STATIC99.<sup>(9)</sup> In this method the practitioner values some well defined risk indicators, which are known to correlate at a group- or category level with risk. By applying a predefined counting rule (most times the sum score of the items) the practitioner gets an indication of the degree of dangerousness of the patient. This implies that at the individual level the dangerousness of a patient is expressed by a number which stems from group level norms. Other possible relevant aspects of this patient are ignored. As an example consider patient William for whom some scientifically validated actuarial instrument has been completed. William has sexually abused several underage boys before his detention. Suppose all items indicate no risk except the item sexual preoccupation. Nowadays William tells his psychologist that he still dreams about immature boys which makes him sexually aroused. It will be obvious that the total sum of the actuarial instrument will be low, leading to a conclusion of low risk, while the dreams of William can be understood as a high risk. In other words the fact that William dreams about little boys does not influence his final risk actuarial assessment judgement. Actuarial methods are based on static indicators such as past detentions and a psychiatric history.<sup>(10)</sup> An actuarial- or statistical prediction concerning William generates a low risk (with all risks that entails this). So an actuarial based prediction has benefits of science, but the specificity of the individual case is ignored.

### *2.3 Structured clinical assessment or a structured professional judgement*

A third method is called structured clinical assessment or structured professional judgement (SPJ). This is a hybrid of actuarial- and clinical assessment.<sup>(11)</sup> There is a scientific consensus that structured professional judgements are the golden standard for risk assessments. In this method a practitioner has to value a set of risk indicators of which correlations with future criminal behaviors are known from earlier studies. The set of risk indicators concern historical but also dynamic and future indicators. Dynamic indicators are usually defined as risk behaviors in the last 12 months for the evaluation moment. Future indicators are defined as possible risk behaviours or social contexts which the patient will meet in the future. In the structured professional judgment method the practitioner must base his final risk judgement by weighing the available information with the typicality of the individual case. The final judgement is usually categorized as low, middle or high risk on future criminal behaviour. In the Netherlands structured professional judgement methods are imposed by the Department of Justice. For instance, at FPC Dr. S. van Mesdag a

practitioner as well as an independent researcher completes independently of each other the risk assessment. After a discussion on each indicator, they try to reach a consensus score, on each item based on arguments. Following this discussion, they will reach an overall consensus conclusion on the risk for recidivism, on a five-point scale that runs from low to high. Although one works with a standardized list of risk factors, the final assessment is a clinical assessment in the sense that it is not a sum of the items. For example, a score of 40 points on the HKT-30 might imply a low risk on recidivism for one patient and a high risk for another, i.e., a score of 40 for William whom is still dreaming about underaged boys must be interpreted different than a score of 40 for Peter who has a job and a supportive network.<sup>(12)</sup> For each individual patient there is a “sauce” of individual perception placed on the outcome of the group data. An advantage of using the SPJ method is the structuring of thoughts and arguments to reach the best possible insight into the possibility of reoffending. Often there is a lot of information about a patient and such a procedure helps to organize this information. A restriction of the SPJ method is that the dynamic items are bound to behaviors the last twelve months.

### **3. Undesirable situations**

Information extracted from group data is obviously useful for risk assessments procedures because it gives the practitioner insight into scientific knowledge. For example, from literature it is known that about 70% of people with a first psychosis will experience more psychotic episodes during their lifetime.<sup>(13)</sup> But how to decide whether the patient sitting in front of you belongs to the 70% that become psychotic again, or to the 30% that do not? One may argue that this decision is basically a random judgement because no one can predict the future. Applying structured professional judgements methods may support such decisions because it is a combination of actuarial knowledge, the individual risk behaviors of a patient the last twelve months and the professionalism of the practitioner. It remains unknown which specific part of information of the SPJ is most influential in the final decision. Theoretically in a group study with an SPJ instrument the total sum of the items of the instrument (actuarial data) must correlate with recidivism. One can define some cut-off point in order to make individual decisions. However whatever level of cut-off point is chosen in actuarial data, there will always be patients who are classified as non-risk but turn out to be recidivist (a false-negative decision) or classified as risk but turn out to be a non-recidivist (a false-positive decision). Weighing the other two parts (individual risk behaviors and professionalism) in the decision must theoretically lead to a reduction of the amount of false-positive and false-negative decisions.

The process of combining actuarial data with individual risk decisions leads to a number of ethical dilemmas such as: how to weigh the fact someone uses

his medication as prescribed in the TBS-setting, or the fact that someone has a partner that offers social and emotional support. Such circumstances can easily change as the TBS measure is ended.

Practically in decisions about granting freedom to TBS detainees the dilemma is how influential the role of statistics should be. While it appears to be difficult to estimate the recurrence risk for a patient, this prediction is very important to the judge or the ministry, as they need to decide whether an individual is allowed to have (un)supervised leave or to rehabilitate. Two misclassifications can be made in decisions of risk. It is possible that a patient is mistakenly granted leave (false-negative decision), and it is possible that a patient is mistakenly not granted leave (false-positive decision). It is clear that both errors produce undesirable situations. The ethical question is whether you have a preference to reduce false-negative or a false-positive errors. Should our primary concern go out to welfare of an individual, or should our first concern be about the safety of society? What does one want to emphasize? What error do we 'prefer'? A false negative prediction is a prediction that behavioural scientists and researchers want to avoid because it has a direct negative impact on society; it concerns a new offence. A false negative prediction also may have a negative impact on the patient. It is known that after a relapse a patient is placed back in another treatment phase and therefore his treatment will last longer.

On the other hand, a false positive prediction may result in limiting a patient's freedom which is not justifiable. One could argue that keeping people locked up inside a psychiatric clinic simply because they do belong to a risk group is a frightening idea. Going on leave is an essential part of TBS treatment because the aim of TBS is to return to society after a sufficient reduction of risk. Leave is required in order to practice new behavior in the 'outside world'. The patient may show, first under guidance, to what extent he can apply what he has learnt. Is he able to display acceptable behavior? Thus, leave is important for both, the patient and society. When no 'freedom' is allowed, which might be the case when one is overly afraid of making false-positive errors, one negatively influences the patient's present situation as well as his future. In summary, although the SPJ methods are the golden standard in risk assessments and the instruments are scientifically validated, the dilemma remains that a certain amount of false decisions are made. In order to improve the SPJ method we argue that adding a more narrative approach may lead to better risk assessments.

#### **4. The role of narrative identity in structured professional judgement**

Practitioners in forensic care need to formulate a view on how to deal with SPJ procedures. In a SPJ procedure one must also pay more attention to ethical issues, like the identity of a single person, his life story and his individual contexts. In other words, the person must also be understood in a

narrative way.<sup>(14)</sup> Attention to the other one is needed if we want to try to understand the other in a concrete way. A constructionist approach to narrative sees it as a key organizing principle, helping us to make sense of events and people.<sup>(15)</sup>

When applying the narrative approach on a patient one takes his individual life story into account. By recognising the other, by having 'an eye' for the other, by being attentive, one does more justice to the unique other. The narrative identity of a patient, both; embodied and socially embedded, is recognised. Having attention for the concrete, individual life story that 'runs like a red thread straight through the patient', might help in the final SPJ decision on risk. In this sense a narrative can be helpful to understand an individual. The narrative approach helps to theorize how social formations and personal biography interact<sup>(16)</sup> Attentiveness to the individual is a central value and narratives also help to identify the other as a specific individual. In practice, this means that a risk assessment should not only reflect a patient's behavior of the last 12 months. The assessment should be rather seen as a part of the life of an individual, as a part of the 'theme running straight through the patient.'

An example of a narrative based method to improve the quality of SPJ decisions is the Forensic Social Network Analysis (FSNA), which is described in another contribution in this book.<sup>(17)</sup> In the FSNA method the network of a patient is analysed in terms of protective and risk relations and understand in relation to the patient's life history. This way another piece of information to support the SPJ decision is added in which the patient is seen as a person influenced by the codes of his social network.

## **5. Conclusion: we should have to care about our care**

Clinical assessment has repeatedly resulted in mistakes and appears to be not very reliable. Methods that are based solely on statistical data like the actuarial- or statistical prediction have some benefits of science, but the individualised view is ignored. Structured professional judgements have benefits of science and the individualised view, but still have some ethical dilemmas. Although actuarial and SPJ methods are scientifically validated, these dilemmas remain. A possible approach to better cope with these dilemmas might be using narrative approaches in the SPJ procedures. Narrative based methods, like Forensic Social Network Analysis, provide practitioners in forensic care with other information about an individual patient. Interestingly, narrative approaches to support SPJ decisions reflect a direction in ethics that focuses on good care, which is ethics of care or relational ethics. According to Paul Ricoeur it is the task of ethics to ensure 'le meilleur humain possible'. Being attentive to the narrative identity of a singular person more justice is done to a patient than only using group and treatment data. The significance of identifying narratives lies on their direct and indirect effects on a person and how that person might act. Narratives

might help to ‘explain’ a person, and also to ‘predict’ certain behavior of an individual person.

SPJ based decisions are the best validated decisions that can be made when deciding about and for the future of a patient. However, by taking a closer look by the use of a narrative approach one may gain a lot. Not only does one more justice to another person, it also helps to fine-tune the results of a risk assessment. To turn a workplace into a better workplace, it is necessary to make use of new developments, so this new knowledge may lead to reflection on the practice of treatment evaluation. And as statistician Dr. W. Edwards Deming said: ‘It is important that an aim is never defined in terms of activity or methods. It must always relate directly to how life is better for everyone...’

## Notes and references

- 1,5 In the Netherlands, a person who is convicted for committing a crime can be given the sentence of ‘Terbeschikkingstelling’ (disposal to be treated on behalf of the state, subsequently referred to as ‘TBS’) if the person in question could not grasp the full consequences of his/her actions at the time he/she committed the crime, and therefore cannot be held fully responsible for committing the crime (Hildebrand, Hesper, Spreen, Nijman, 2005, Van Marle, 2002).
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- 4 Bonta; as cited in Harris & Hanson, 2010, A.J.R. Harris, & R.K. Hanson, ‘Clinical, actuarial and dynamic risk assessment of sexual offenders: Why do things keep changing?’ *Journal of Sexual Aggression*, 16(3), 296-310, 2010.
- 6 T.H.A.M Deenen, Van risicotaxatie naar risicomangement in de TBS (From risk assessment to risk management in TBS). Houten: Bohn Stafleu van Loghum, 2007.
- 7 Nederlands Instituut voor Forensische Psychiatrie en Psychologie (NIFP) (Dutch Institute Forensic Psychiatry and Psychology) 2010. NIFP, Risicotaxatie tbs alleen is niet zalmakend, maar het helpt wel (Risk assessment TBS solely is not everything, but it helps), 2010.
- 8 M. Hildebrand, H. Schönberger, M. Spreen, Onttrekkingen en recidives tijdens verlof gedurende de TBS-behandeling nader bekeken (Withdrawals and recidives while on leave during the TBS treatment, a closer look). *Actuele kennis* 8, Expertisecentrum Forensische Psychiatrie 2007.

- 9 The Static-99 is a ten item actuarial assessment instrument for use with adult male sexual offenders.
- 12 HKT-30: Risk Assessment in Forensic Psychiatry. There are 30 items, 11 H (historical) items, 13 K items (clinical) and 6 T items (future). Each item can be scored from 0-4.
- 13 Trimbo institute, Multidisciplinaire richtlijn Schizofrenie (Multidisciplinary guideline for Schizophrenia), [www.trimbos.nl](http://www.trimbos.nl), 2010 Utrecht, 5 juli 2010.
- 14 P. Ricoeur, *Oneself as Another*, translated by Kathleen Blamey, Chicago: The University of Chicago Press, 1992.
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- 17 S. Kremer & L. Pomp, *Do we (have to) care or just say 'beware'?* Published in this bundle, 2012.

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