Psychiatr Clin N Am 29 (2006) 725–741
PSYCHIATRIC CLINICS
OF NORTH AMERICA

An Overview of Juveniles and School Violence

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Over the past two decades, there has been growing attention to youth crime and violence in the United States. Although existing data suggests an overall decline in rates of youth violent crimes and juvenile homicides since the mid-1990s, youth violence is still a widespread problem [1–5]. According to the FBI, youths under the age of 18 accounted for approximately 16% of violent crimes in 2004 [1,4].

In the aftermath of the Columbine High School multiple-victim shooting in 1999, families, school officials, and policy makers were alarmed by the safety issues and lack of safety in US schools [4]. There was a need to identify students who might become violent and to develop methods for preventing future school shootings. Some resulting school interventions included (1) expanded counseling services; (2) creation of hotlines for students to phone in anonymous tips; (3) stricter school policies regarding dress codes; (4) increased security in the schools; and (5) the implementation of zero tolerance policies [6].

Many youth who make school-based threats or act violently are referred to clinical or forensic mental health professionals for further assessment. Clinicians and forensic evaluators can draw on the research about delinquency, youth aggression, and violence, but there are little empirical data regarding the evaluation and management of students at risk for school violence.

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0193-953X/06/$ – see front matter
doi:10.1016/j.psc.2006.04.006

METHODOLOGY

A search was conducted of LexisNexis Academic, Ovid, and PubMed using the keywords juvenile violence, school violence, targeted violence, targeted school violence, school-associated violent deaths, school shootings, and adolescent/child violence to identify articles pertaining to school violence, school-associated violent deaths, school shootings, and general juvenile violence as the topics may pertain to risk assessment for school violence.

DEFINITIONS

Incidents of youth violence include behaviors such as verbal abuse, bullying, hitting, slapping, fighting, assault, rape, robbery, homicide, and suicide. School-associated violence includes behaviors such as homicide, suicide, rape, sexual assault, robbery, assault, and theft that occur either inside the school building, on school property, or on the way to or from school [4], and may be either nonfatal or fatal.

In 1999, the US Secret Service and Department of Education developed the term "targeted school violence" to describe a specific type of school-associated violent death. "Targeted violence" is the term for any incidence or violence where a known attacker selects a particular target before their violent attack. Targeted violence is the result of the interaction among attacker(s), situation, setting, and target. In the case of targeted school violence, the perpetrator (a student) has selected the school, students, faculty, or administrators as a target of violent behavior [7].

There were 37 known incidents of targeted school violence, committed by 41 youths, from 1974 to 2000 in 26 states [7]. Given the limited incidence of school violence, and particularly targeted school violence [8–11], it is challenging to develop an effective risk assessment protocol and to validate any particular approach. The distinction between school-associated violence and targeted school violence is important in considering (1) the associated risk factors and precipitants to the occurrence of violent events, (2) the evaluation and disposition process, and (3) the implementation of prevention and prediction strategies.

RISK FACTORS AND "PROFILING"

Identifying and addressing the predictors of school-based youth violence is critical for prevention. Unfortunately, there are few high-quality longitudinal studies of the predictors of youth violence in general, and a paucity regarding school violence. Collaborative work among government agencies, educators, mental health, and primary care professionals have identified some important factors to consider when conducting a school violence assessment. Agencies such as the US Secret Service, the Department of Education, and the FBI have performed retrospective analyses of school shootings. Their data provide descriptive information and a theoretical framework to guide evaluators of school violence [7,12]. The extrapolation of common features from the analyses led to the development of lists of warning signs for use in identifying

dangerous students. The use of such checklists, known as profiling, is problematic for many reasons [13]. Targeted school shootings are rare phenomena, and so the sensitivity and specificity of existing profiles and checklists are inadequate, resulting in false positives and negatives for violence. Relying primarily on educational staff or parents to identify a potentially violent youth in a school setting is also problematic. If a school department, law enforcement professional, or evaluating clinician relies largely on a profile of potentially violent students, individuals who do not fit the profile (eg, gender, age, ethnicity, or color and style of clothing worn) would not be correctly identified. Because the profiles have been developed from retrospective data on violent students, it remains unknown what percentage of students manifest warning signs or profile characteristics but do not engage in violent behaviors. Finally, there is also no indication of how to weigh the significance of each identified risk factor [14].

In contrast to profiling, which is a static process, the threat assessment approach developed by the US Secret Service is a dynamic process that assesses stable and changing variables (eg, peer influence, school, and family). Similarly, the FBI recommends the use of a four-pronged assessment approach, including youth's personality, family, school, and social setting. This approach takes advantage of the fact that in many cases of completed school shootings, fellow students had critical concerns about dangerous students but did not feel compelled to share this concern with an adult [7,15].

PSYCHOSOCIAL VULNERABILITIES AND VIOLENCE

Youths with a psychiatric history, particularly depression, impulsivity, hyperactivity, and a history of suicidal or violent behaviors are also at risk for acting violently. Youths at risk for violence are more likely to have families with minimal capacity to provide emotional support, minimal understanding of their child's life, and difficulties with attachment. They may also experience peer rejection or teasing or be in a peer group that encourages violence [7,16–20]. One cross-sectional study of 15,686 students from grades 6 to 10 found that bullying, and particularly perpetrators of bullying behaviors, resulted in greater likelihood of involvement in more serious violent behaviors (ie, weapon carrying, frequent fighting, and fighting-related injury) [21].

Many youths with mental disorders can engage in impulsive behaviors that are violent, but the association between psychiatric illness and violence remains unclear. Other risk factors to consider include learning disorders, cognitive limitations, developmental disabilities, and acquired cognitive impairments (eg, head-injured youths and youths with frontal lobe and other impulse control disorders). Minority students and students with special needs are disproportionately suspended and expelled [22,23]. A study by Rappaport and colleagues found nearly all of the students in special education classes who were suspended had multiple and severe psychiatric disorders along with serious impairment in psychosocial functioning [24]. More detailed descriptions of associated features of youth violence can be found in the Office of Juvenile Justice and Detention Prevention's report titled "Predictors of Youth Violence" [25,26].

THE REFERRAL

The request for an evaluation of a juvenile engaging in or threatening school violence may be made in various settings (eg, emergency department, probation, court clinic, or an outpatient or inpatient setting). A primary care physician, mental health professional, or forensic evaluator may be asked to comment on violence risk and to assist in the creation and implementation of an intervention plan. The initiation of a violence risk assessment can occur as a result of a student's verbalized or nonverbalized threats, such as escalation of behaviors or symbols of violence (eg, in writing or electronic mail communication). Threats may be less obvious and veiled in artwork or essays with particularly violent and aggressive themes. Concerns may be raised about a student who has been identified as a bully, committed violent acts in school, or has been arrested in the past for violence. Alternatively, a student who is repeatedly teased, bullied, or similarly provoked may make threats of retaliation or revenge. A student who is noted to have a sudden change of behavior with sudden isolation or erratic behaviors may raise concern. Family and friends may note changes in personality with increased explosive anger or isolation, and family or teachers may also be concerned about youths who have a particular fascination with violent activities, including video games, movies, and music. In most cases, mental health professionals will not be consulted for cases of targeted school violence but rather asked to comment on less lethal but more pervasive types of school violence. School administrators typically ask for clarification regarding a youth's current potential for violence, while also preventing the youth from returning to school until a determination is made, as in the following case example.

Example of the Referral Request

A 16-year-old high school student is referred for a psychiatric evaluation after allegedly sending a threatening text message to a peer and posting slanderous material on the Internet about teachers and school administrators. The student has a history of receiving special education services to assist with a behavioral disorder and often wears camouflaged clothing and military boots to school. The school department requests "clearance" that the youth is safe to return to school.

School administrators, counselors, and educators, after identifying the perceived threat, and usually taking some administrative action (eg, meeting with youth or parent/guardian, suspension, expulsion), may refer a youth for further evaluation to a mental health clinician or forensic evaluator. The youth may present to an emergency department or outpatient setting for an evaluation. School department staff may place a youth in an alternative educational setting for a school-based diagnostic assessment or refer a youth for psychiatric consultation to clarify eligibility for special education services, alternative school placements, or assistance with development of or revisions to an individualized educational plan (IEP). In the family courts, a judge may ask that a psychiatrist or other mental health clinician make a determination about the

youth's acute risk to others. In each of these situations, the request is to identify the risk for violence, indicate whether the youth is safe to return to school, and determine what conditions should be instituted and in what time frame.

EVALUATION PROCESS

The consultant must clarify who has the authority to initiate the consultation request or referral. The first goal should be to identify and clarify a youth's imminent risk for violence. In these cases, immediate referral for an emergency psychiatric evaluation is warranted. When indicated by clinical necessity or school policy, law enforcement (local or state police, federal agents) involvement may be useful.

Mental health clinicians and forensic evaluators may also be faced with a zero tolerance policy from the school, where all threats or concerns for violence have predetermined consequences and are often handled by immediate suspension until further determination. The 1994 Safe and Gun-Free Schools Act specifically requires that for states receiving federal funding, expulsion occur for at least 1 year and a referral be made to a criminal or juvenile justice system for any student that carries a firearm to school. Though these zero tolerance policies are intended to have case-by-case exceptions, they are often extended to situations not concerning firearms, such as a student who is awaiting trial for a felony who may not be permitted back to school until the court judgment. One limitation of a zero tolerance policy is that it does not take into account the potential impact to the student who may not commit acts of violence but who has been prelabeled and is viewed by others as one who will commit an act of violence. Zero tolerance policies imply that an accurate prediction can be made, and they place the burden of determination on mental health professionals and forensic evaluators without the understanding that violence risk is determined by a set of dynamic factors and requires an integrated, multisystem approach.

An additional challenge for the clinical evaluator is that the youth, family, and school each have their own agenda. The family and student have their own opinions regarding the seriousness of the threat or act, the school's administrative handling of the case, the past or proposed new school placement, and the school in general. Some youths or families are resistant to any proposed mental health evaluations or interventions. Others are interested in seeking or maintaining specialized school placements. Many of these placements are costly to school departments, thus raising additional challenges for the clinical evaluator. Whenever possible, it is helpful to (1) identify potentially conflicting agendas, (2) gather information from multiple informants (including the youth, youth's family, and school staff), (3) attempt to identify whether a mental or substance use disorder might have initiated or exacerbated the school violence behaviors, and (4) focus on specific treatment or school-based interventions to increase the "goodness of fit" between the capacity of the student, the parents/legal guardians, and the expectations of the school [27,28].

Because special education students are often subjected to higher levels of discipline, it is important for the mental health professional to understand the youth's legal rights in an educational setting. There are federal mandates, such as Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Educational Act (IDEA), that protect students with disabilities and ensure that they may stay in the least restrictive environment that provides the appropriate level of care and support. Attention and behavioral problems generally qualify a youth to provisions under Section 504, and youths must have an extensive evaluation, usually including psychological testing, to determine eligibility for IDEA special education services. Under the IDEA, if a youth has 10 consecutive school days of suspension or 10 nonconsecutive days of suspension constituting a pattern, then a meeting must be conducted by the school to determine if the behavior causing suspension was related to the disability. In the event that it has been determined to be related to the disability, then the individual education plan and behavioral management plan must be revised [27].

ASSESSMENT PROCESS

The most useful assessment approaches include an assessment of individual, family, school, and social dynamics. These comprehensive assessments allow for the discussion of risk and provide guidance in disposition/intervention in a consistent way that does not promise an absolute prediction of future violence. These assessments examine the chronology of the presenting symptoms or behaviors across settings (eg, school, home, and social environments). For example, did the youth present with symptoms suggestive of a depressive, anxiety, substance use, disruptive behavior disorder, or an emerging psychotic disorder? Did the youth have a pattern of conduct disorder behavior, such as aggression to people and animals, destruction of property, deceitfulness, or theft, or serious violations of rules?

It is important to identify a youth's beliefs about violence, existing coping mechanisms, ego strengths, and ability to manage affect (particularly anger). Determining if a student has access to a weapon is critical. It is also important to identify whether there is history of or exposure to verbal abuse, sexual abuse, or physical violence. Substance abuse is another major risk factor, as it affects impulse control, insight, and judgment. As a case example, a 15-year-old adolescent had recently broken up with his girlfriend. His friends told a teacher that he had threatened to come to a school with a gun from his uncle. During an assessment, he confided that he was not going to hurt anyone but he had been contemplating killing himself for 3 days and had not had the courage to pull the trigger.

The clinician should assess the progression of behaviors and attempt to gain a better understanding of the identified threat. This process includes considering whether the threat is direct, indirect, veiled, conditional, or specific in determining whether the threat itself is of high, medium or low risk. This means that the clinical evaluator must identify direct, specific threats with plausible, concrete, and prepared plans; medium-level threats with no plan or active

preparation; and low-level threats that are indirect, implausible, and inconsistent in detail [3,15,19].

There are several other cognitive and behavioral areas to assess. It is important to assess for learning disorders and other school-based difficulties that may have not been previously identified. For example, a youth with a nonverbal learning disorder might have difficulty interpreting or reading social cues. Individual coping skills should be explored, such as (1) the developmental level of the youth, (2) triggers for the aggressive response, and (3) reaction to the actual or perceived challenge, such as loss, abandonment, failure, and rejection (eg, peer teasing, bullying). It is also helpful to assess the likelihood of a violent response to a perceived hurt using a framework: What are the preexisting (eg, emotional, cognitive, neurodevelopmental, and psychosocial factors) problems? When diagnostic questions remain, a thorough review of past evaluation and treatment records (eg, school, pediatric, and mental health) and contact with collateral historians is particularly useful.

THE USE OF STRUCTURED ASSESSMENT TOOLS

The most important element of any risk assessment for future dangerousness is a comprehensive psychiatric evaluation and mental status examination. There are numerous existing structured rating scales and diagnostic interview measures available for parents and teachers, and many self-report items for youths. The use of these complementary assessment measures [29,30], when clinically indicated, may assist with the diagnostic evaluation process. Unfortunately, it remains unclear how to best use these instruments in assessing school violence.

The SAVRY (structured assessment of violence risk in youth) is modeled after existing guided assessment protocols for adult violence risk, such as the HCR-20 (historical, clinical, and risk management), but the item content is focused specifically on risk in adolescents. It is composed of 24 risk items (eg, historical, social/contextual, and individual) and 6 additional protective factors and is designed for use as an aid or guide in professional risk assessments and intervention planning for violence in youths between the ages of 12 and 18. It has shown some early promise as a supplementary instrument and may have applications in mental health/substance abuse services, social services, schools, and juvenile and criminal justice systems [31].

TESTING

Additional evaluation strategies include a thorough review of supporting documents and relevant information, including report(s) of the incident, academic transcripts, educational evaluations, and other documents (eg, special education testing, school psychological and social work evaluations, and individual education plans) and psychological/neuropsychological testing if available.

COLLABORATION

When indicated, the consultant may need to speak with the school psychologist and other relevant school personnel, probation officers, therapists, and other

collateral historians. Although this collaboration is standard for any psychiatric evaluation, the importance of corroborative material is critical for risk formulation. This need is highlighted by an evaluation in the emergency room of a 17-year-old adolescent who allegedly threatened to harm his girlfriend. Although his mother presented a fairly benign portrait of a devoted subdued son, it was only when the evaluator talked with school personnel did the evaluator find out that the youth had recently thrown his backpack through a large glass window and his mother had to pay $500 to repair the damage. The student would also get so angry that he would throw himself down the stairs, and he was withdrawn and failing most of his classes.

HOME VISITS

Some experts have suggested that a home study or home-based evaluation may be useful to the overall assessment [27]. Information obtained from home visits can help (1) provide a better understanding of the home and family setting, (2) clarify if a youth is safe to be returned home, and (3) validate the parents' authority at a time when they may feel disempowered, ashamed, or defensive about their youth's behavior. A particularly useful question for the evaluator to consider, regardless of the evaluation setting, is "What has changed since the behavior (eg, threat or act of school violence)?" or, alternatively, "What is substantially different now in the home, school, and peer environment?"

CONSTRAINTS IMPOSED BY SETTINGS

In an emergency department setting or when a youth is evaluated emergently in any outpatient setting (clinical or forensic), the mental health clinician will typically be asked to assess acute safety risk. There are major time constraints in these situations that often result in a limited and brief interaction with the youth and difficulty in gaining access to other relevant collateral historians. This often makes it difficult to adequately assess the relevant information to determine if the youth can return safely to school. The clinician will determine initially whether a youth can return home or needs to be admitted to an inpatient facility or placed into an alternate setting for further evaluation.

The inpatient, court clinic, and residential settings provide the mental health clinician with the advantage of additional time to observe the youth's interactions with peers, staff, and family members and to recognize other behavioral and cognitive patterns. These settings provide containment while also allowing for more detailed assessment of relevant psychiatric, medical, and developmental pathways. The evaluator can establish collateral contact with the family, school, and past-treating clinicians and begin appropriate interventions [32]. Regardless of the setting, mental health professionals' risk assessments of youths are not long-term predictions, and they cannot make definitive predictions regarding an individual juvenile's long-term risk for violence.

ASSESSING RISK AND PROGNOSIS

Most violence risk assessment protocols concur that a history of violent, aggressive behavior is the strongest predictor of future violence in similar ways as a history of suicide attempts can predict the potential for future suicidality.

Current studies on general youth violence view the potential for violence as a result of the interactions between a child's predispositions and the environmental circumstances [33,34]. The clinical or forensic evaluator should assess the plausibility and specificity of the threat in considering the imminent risk for violence. One useful approach is to stratify the risk for school violence to determine whether there is a high versus low threshold for action, access to weapons [35], current substance use, and other risk factors. The evaluator should attempt to better understand relevant cultural issues, the youth's internal world, and how the youth relates to his external world.

Assessment of risk and protective factors includes developmental history and past medical and psychiatric history. Particularly important are birth trauma; child abuse or neglect; exposure to violence; delayed acquisition of cognitive, motor, and verbal skills; and substance abuse history [36]. Additional factors include anger and impulsivity and maladaptive personality traits, such as narcissistic, avoidant, and antisocial traits [37,38]. Other areas include parental involvement/practices, peer groups, and other available psychosocial supports. One should consider the circumstances surrounding the request for an evaluation, including the severity, range, and frequency of aggressive and violent behaviors, possible triggers to aggressive behavior, weapons history, and presence of an empathic environment [34,35,39–41].

Rappaport and Thomas reviewed the existence of aggression subtypes in violence assessments, particularly when there is a history of violent behaviors. They suggested the need to differentiate between childhood-onset (prepubertal) from adolescent-onset violent behaviors in the assessment of risk for future, more severe violent behaviors. Though childhood-onset behaviors are rarer than adolescent-onset behaviors, they are more likely to be associated with future progression of violence in youths as a result of likely deficits in the youth's understanding of and ability to alter behaviors. Aggression in youths may progress or abate with time, and thus it is important to consider the developmental stage of the youth and the pattern of aggression over time. In addition, another subtype of aggression includes the differentiation between proactive and reactive aggression. Proactive aggression involves the youth's use of aggressive behaviors to obtain specific rewards and establish dominance. With proactive aggression, there is a relationship to predatory aggression, and youths with this form of aggression are more likely to progress to subsequent criminal behaviors. Reactive aggression or affective aggression involves the use of force as a defense against a perceived threat. Reactive aggression may be more amenable to interventions, particularly those that assist the youth in identifying triggers and altering behaviors to cope with these triggers. Rappaport and Thomas also highlighted the importance of assessing insight and motivation, namely the youth's willingness to change behaviors and the ability to

accept responsibility. Without a youth's willingness to participate and ability to engage in cognitive restructuring and behavioral alterations, interventions will be minimally effective [42].

DISPOSITION

The consultant should attempt to clarify how and where the findings or final report will be forwarded and how the information will be used. For example, if a psychiatrist is performing a school-based consultation of a youth with pending legal charges from the alleged school violence, could the evaluator's report/findings be used in the present court proceedings? Alternatively, can a court-ordered psychiatric evaluation be shared with school systems?

Interventions should incorporate family, other support systems, outpatient mental health or substance treatment, and improved communication patterns with school educators, counselors, and administrators. Some useful community-based strategies may include individual, family, or group psychotherapies. The particular therapy modality should be individualized but may include cognitive behavioral therapy or explorative psychotherapy and, if needed, anger management and impulse control approaches. For some youths, the judicious use of psychotropic medications for a distinct mental disorder may complement ongoing psychotherapies and other psychosocial interventions. Many youths will benefit from social skills training and more peer group activities.

It is not uncommon for necessary, mandated interventions or measures to be perceived as coercive. These include psychiatric hospitalization (by civil commitment if necessary), out–of-home placement, mental health/substance use treatment, and mandated reporting to law enforcement officials. Other such measures include home confinement, requiring cooperation with mental health/substance abuse treatment, urine testing, probation involvement, and the family being reported to social services or juvenile protective services. Additionally, multisystemic therapy (MST) is an intensive community- and home-based intervention strategy that targets individual, family, and environmental factors. MST goals include improving communication, parenting skills, peer relations, school performance, and social networks [43].

Evaluators should determine if the school system has school-based mental health services [44]. In certain cases, the youth may need to be referred to a more specialized school program or long-term residential facility to better target developmental or behavioral deficits. Interventions should enhance the youth's strengths and support systems while further exploring and potentially remediating deficits. Communication between all supports is essential, and frequent monitoring is critical in identifying when students may be more vulnerable or at risk for aggression. Another useful postdisposition recommendation is for periodic follow-up and reassessment of the youth and family. This can be helpful in ensuring that the recommended interventions have been implemented and that effective communication across systems is maintained [44,45].

THE FORENSIC EVALUATOR

There is no current research describing the type, frequency, or characteristics of youths that are referred for independent forensic evaluation as a result of school violence. This may be an area of future study in the development of guidelines for assessment and management of youths at risk for school violence. Forensic psychiatrists, by nature of their additional subspecialty training and expertise, are skilled in assessing and understanding an evaluee's psychological and mental health issues, but in the capacity of a forensic evaluation, they focus on providing an objective evaluation with findings that can be used in a legal setting (eg, court clinic, probation, attorney) to answer a legal question or in specialized clinical consultation to aid clinicians with risk assessment. A treating clinician may consider referring a youth to a forensic evaluator when there are pending legal issues, time and resource limitations, or potential role conflicts for the treating clinician. Similarly, when a treating clinician is attempting to clarify future treatment, placement, and supervision for a youth, forensic consultation may be particularly useful. The forensic evaluation may be conducted on an outpatient basis or when the youth is in an inpatient, juvenile justice, or residential setting. These out-of-home settings typically provide additional opportunities to conduct a more detailed forensic assessment (Table 1).

In the first contact with the retaining agency (eg, school department, probation, family court, or attorney/law firm) that is providing compensation for the forensic evaluator's time rather than the child's family or insurance carrier, the forensic psychiatrist must identify potential role conflicts, boundaries, and expectations of the consulting relationship to ensure that the evaluator will complete an objective and comprehensive forensic evaluation. The forensic services may include record review only, examination of youth, preparation of a written report, or deposition or court testimony. The forensic evaluator and the youth do not develop a traditional doctor-patient relationship. The evaluator acts as a fiduciary to the court or retaining agency, and unlike the treating psychiatrist, holds no fiduciary duty to the patient [46].

The forensic evaluator must follow certain principles to perform an evaluation that will meet the legal standard of within reasonable medical/psychiatry certainty. The appearance of bias, lack of neutrality or objectivity, prior involvement with any of the parties, or the failure to perform a competent evaluation can be problematic. It is rarely appropriate for a psychiatrist to act as a forensic expert and treatment provider for the same youth or family [47–49]. Absent a court order, psychiatrists should not perform forensic evaluations for the police, prosecution, or the government on youths charged with a criminal act, or being held in custody or detention, who have not consulted with legal counsel [50].

At the outset of the interview, the evaluator should review the following with the youth: (1) the purpose and process (solo evaluator versus team interview) of the evaluation, (2) the evaluator's agency (eg, the forensic psychiatrist is not the youth's doctor), (3) whether the evaluation is being videotaped, (4) what

Table 1
Differences between Clinical and Forensic Evaluations of Juveniles

	Traditional diagnostic ''clinical evaluation''	Forensic evaluation
Purpose	Relieve suffering	Answer a legal question
Relationship	Doctor-patient	Evaluee-evaluant
Client	The patient/the family	The court or retaining agency
Agency	Fiduciary duty to the patient/duty to the patient's best interests patient's welfare first	Fiduciary duty to retaining source (eg, attorney, court)
Objective	Help heal the patient	By report or testimony: inform and teach the fact-finder (eg, judge, jury) or retaining agency
Confidentiality	Essential	Lack of confidentiality
Process	Establish diagnosis and treatment plan	Conduct objective evaluation; diagnosis may be nonessential
Treatment	Treatment rendered	No treatment rendered
Sources	Self-report, on occasion some collateral records	Exhaustive attempt, including serial interviews, interviews of additional historians, and review of collateral data
Bias	Therapeutic bias exists: desire for patient to get better, serve as patient advocate	Attempt to be neutral and objective, lack of bias; no investment in outcome
End product	Establish a therapeutic relationship	Answer the referral question either in the form of a verbal or written report to retaining source, deposition, or testimony

Adapted from Penn JV. Child and adolescent forensic psychiatry. Med Health R I 2005;9:310–17.

will happen to the information obtained, and (5) that the evaluation is not for treatment. Although not legally required, it is advisable to obtain a youth's assent to the interview, and whenever possible, to offer the same explanation to the parent or legal guardian [48]. Notice of reasonably anticipated limitations to confidentiality should be given to evaluees, third parties, and other appropriate individuals [50].

PRACTICAL POINTS

For the Educator and Primary Care Physician

Schools should have available outlets for students to inform school staff and administrators of their concerns for safety. Effective prevention and intervention strategies require that school administrators, educators, and primary care practitioners maintain open communication with the mental health professionals involved [51].

Because there are typically delays between the initial identification of a youth making a threat of school violence and the outpatient or emergency room evaluation of the youth, school staff can assist mental health professionals by

providing supporting documentation, descriptions of the incident, other concerns, and after-school-hours contact information. If the identified student is not of imminent risk for violence and does not necessitate an emergency evaluation, the school administrator should initiate discussions with the student and his family, peers, teachers, and other involved staff. School counseling services as well as mental health clinicians connected with the school community should be used in the school-based evaluation process.

For the Mental Health Professional or Forensic Evaluator

Role clarification and role maintenance in a juvenile risk assessment, whether it is in an emergency, clinical, or forensic setting, is often a challenge. For example, one must navigate a balancing act between assisting the school with the identification of appropriate mental health services, educational placement, programming, and supervision but also suggest where current resources are inadequate. The mental health professional should first identify the primary question posed in the referral and clarify whether the evaluator has adequate time and resources to effectively answer the question. Whenever possible, additional nonexplicit questions or competing interests of others involved, such as pending criminal (eg, legal charges against youth), civil (eg, custody, visitation disputes between parents, other litigation), or administrative issues (eg, seeking of special education designation, placement, or other disability benefits), should also be identified.

RISK MANAGEMENT ISSUES

Many individuals are fearful of liability stemming from their failure to prevent a youth from continuing with previously threatening or violent behaviors. A legal cause of action might arise under the expectation that, because of the unique nature of the therapeutic relationship, a mental health professional had a Tarasoff-like duty but failed to warn, protect, or take appropriate steps to prevent harm to the victim(s) [52]. Alternatively, many are also fearful that they may be held accountable for medical malpractice or negligence. A plaintiff suing for medical malpractice has the burden of proof to show the establishment of a standard of care and the following four elements necessary to prove negligence: (1) a duty of care, (2) a breach of duty, (3) damage/injury (physical or emotional), and (4) proximate cause (eg, that the psychiatrist's dereliction of their duty to the patient was directly related to the current damage/injury). Generally, the standard of care is defined as how a reasonable, careful, or prudent practitioner would behave in similar circumstances.

There are several risk management approaches for the evaluation of youths at risk for future violence. In all cases, it is essential to carefully document the process, findings, and limitations of an evaluation. Careful notation of the evaluation, materials, or sources of information and the decision-making process that resulted in the actions taken or recommendations generated are crucial. The evaluator should fully document the threat, the evaluation, assessment process, the choice of intervention, and the rationale for the intervention taken

as well as alternatives and why they may have been rejected. Then, in documenting and understanding the rationale, the psychiatrist must remember that they are expected to demonstrate a process where thoughtful assessment allows rational selection of a reasonable course of action [53].

The courts expect the clinician or forensic evaluator to conduct a reasonable determination of risk. The expectation is not for prediction, and it is therefore important for the evaluator to not be pressured to provide false security by predicting long-term or absolute risk. It is also not possible for an evaluator to comment with a reasonable degree of certainty regarding long-term risk for violence or to guarantee a prediction of acute risk for violence. An evaluator who attempts to make absolute determinations of risk may be held accountable for faulty predictions. When there is a bad outcome after an assessment, this does not automatically imply malpractice. However, if an evaluator made a statement of absolute determination or failed to demonstrate that they had conducted a comprehensive assessment with a reasonable rationale for their determination, then this could be problematic.

Additional challenges to clinical and forensic evaluators include their duty to warn and/or protect (eg, providing Tarasoff warnings to a potentially identifiable victim(s)). When a youth is admitted into an inpatient psychiatric unit, there is typically more time to address this decision. By hospitalizing the youth, the evaluator has initiated steps to further evaluate and treat the youth, and simultaneously protect the victim. The decision of whether and how to make effective Tarasoff warnings typically present more of a challenge in an outpatient setting. In these instances, clinicians are encouraged to seek forensic consultation or review their particular state mental health statutes or seek other professional consultation [52].

Maintaining confidentiality in cases of acute risk of harm to others is not absolute and may require the evaluator to act without the assent/consent of the youth involved. For example, in an emergency setting, an evaluator may attempt to seek information from collateral sources without a release of information (due to the emergency nature of the situation). Whenever possible, signed releases are preferable. All threats of harm should be taken seriously. If a youth's past or current treatment clinician declines to provide relevant information that may have an impact on the evaluator's assessment and decision-making process, this should be carefully documented.

SUMMARY

Despite the relative rarity of school shootings, targeted violence, and school-associated violent deaths, any youth who presents with words, gestures, or actions of a threatening or violent nature in a school setting should be assessed and referred for further evaluation by a mental health professional and, if clinically indicated, a forensic evaluator.

The request for a juvenile risk assessment for future dangerousness requires careful delineation of role and agency; confidentiality issues; a comprehensive diagnostic evaluation of the youth; and a detailed assessment of the youth's

perceived threat or problematic behavior. Various protective and risk factors and consideration of other individual, family, school/peer, and situational factors should also be explored.

There is still much information that is unknown when considering school violence or targeted school violence. There is clearly a need for additional research on the identification of at-risk youths, the contributions and significance of various protective and risk factors, the impact of peer relationships, and perceived rejection, socioeconomic status, subtypes of aggression, and developmental stages. Examples of future research direction might include difference by gender, presence of affective or psychotic disorders, substance abuse, emerging characterologic disturbances, and physiologic markers, such as cortisol or serotonin. Additional research regarding best practices and the development of clinical guidelines or practice parameters is also needed.

Acknowledgments

The authors especially acknowledge Lois Flaherty, MD and Milly Krakow, PhD for their assistance with this article.

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