Examining Clinician Differences that Influence Ratings of the Probability of Harm and Rehospitalization on a Standard Dangerousness Assessment

Christina M. Harris

University of Nebraska- Lincoln

Abstract

Standard forensic assessments of dangerousness are used in a number of clinical and legal settings and the results of such assessments can have a large impact on a patient's life. Since many individuals are only allowed one dangerousness assessment it is important that clinician differences don't affect the results of the assessments given. The current study examines how whether or not someone works in a forensic facility, how useful they find assessments of danger, and how frequently they conduct these assessments are related to probability of harm and rehospitalization ratings. The 1997 Dangerousness Survey was mailed to all members of Division 41of the American Psychological Association and results showed that clinician differences did have an effect on probability of harm and rehospitalization ratings. Differences in probability of harm ratings were present among those who do not work in a forensic facility; specifically if the respondent found these assessments of no use and gave them rarely/never they tended to report higher probability of harm ratings. There was also an interaction of facility and use such that those who do not work in a forensic facility and found these of no use gave higher probability of harm ratings. Differences in probability of rehospitalization ratings were present among those who don't work in a forensic facility, except here the differences are among those who found these assessments useful with those who gave assessments weekly giving higher ratings of rehospitalization than those who give them never/rarely and monthly.

Examining Factors that Influence Ratings of the Probability of Harm and Rehospitalization on a Dangerousness Assessment

In numerous clinical and legal contexts, professionals from different fields are often asked to determine a patient's risk of violence to themselves and those around them and dangerousness assessments are among the most common ways to do this. Danger assessments are required for many different situations that range from involuntary commitments or hospitalization, emergency psychiatric evaluations, seclusion/ restraint decisions, inpatient care discharges, probation/ parole decisions, domestic violence cases, fitness for duty, death penalty decisions, to after a threat is made. "Dangerousness", however, is not a diagnosis but rather a legal judgment based on policy and expands further than violent acts or dangerous behavior in that dangerous assessments indicate an individual's inclination to engage in dangerous behavior (Scott & Resnick, 2006).

Ideally the results of forensic assessments would reflect only the patients functioning and not the clinician who gave the assessment. This assumption is particularly important when dealing with assessments of danger because each of the above mentioned uses for these types of assessments can have a serious impact on the life of the patient taking it. When these assessments are used in court, defendants are legally allowed one evaluation and courts rely on these evaluations to help with decision making about competency, sanity, and sentencing which all have important consequences in the patient's life. If there is not a court hearing involved in the situation where the assessment is given it is likely that hospitalization or involuntary commitment can occur depending on the results which is an equally important consequence in a patient's life. Because of the impact these assessments can potentially have on a patient or defendant it is important that clinicians essentially be interchangeable such that any reasonable

clinician administering these assessments will obtain the same result as any other reasonable clinician (Harris, Boccaccini, & Murrie, 2014). Little research has been done on clinician differences as they relate to risk assessment and the present study aims to further uncover the effect clinician differences can have on ratings of harm and rehospitalization.

As mentioned above, dozens of clinical settings call for violence risk assessment meaning that not only health professionals who work in a forensic facility or setting are issuing these types of assessments. It is important to note that forensic professionals and clinical professionals have different roles and duties and receive different training (Hugaboom, 2002). According to Reid (2003) a competent clinical health professional cannot do proper forensic work even after having gone through a weekend course in the subject, as many clinicians do. Forensic health professionals have extensive training requirements and the field is not simply an extension of clinical expertise (Reid, 2003). However we still expect clinical and forensic professionals alike to score forensic assessments despite the differences among the two. The present study included this variable and hypothesized that there would be differences in ratings between those who work in a forensic facility and those who do not.

One way to show less variability among clinicians is to use standardized assessment instruments to minimize clinician differences (Harris & Boccaccini, 2014). Research supports this and shows that appropriate use of standardized risk assessment instruments do have advantages in clinical approaches (Carroll, 2007). Based on these results the present study expects to find little variability overall on the standard Dangerousness assessment. However despite this evidence, a common belief among clinicians is that risk assessment instruments are not useful and lack utility (Reid, 2003). Research has shown that clinical degree and professional discipline can be predictors of opinions of usefulness in standardized assessments and can affect

how often clinicians use a standardized assessment (Jensen-Doss & Hawley, 2010). The present study expands on this and expects to find that differences in how useful clinicians found dangerousness assessments also affect their probability of harm and rehospitalization ratings.

A factor that this study chose to include that has not been seen in other research is the frequency at which professionals provide formal assessments of dangerousness broken down by never/rarely, occasionally (about once per month), to very frequently (once/ more than once per week). It is hypothesized that all of these factors will interact with each other to produce different ratings of probability of harm and rehospitalization however since there is such little research done on the topic it is difficult to predict which direction the patterns will be in.

The present study looks at scores from a standard assessment, the 1997 Dangerousness Survey, in order to examine how whether or not someone works in a forensic facility, if they find these assessments useful, and how frequently they administer forensic assessments interact to have an effect on probability of harm ratings as well as likelihood of rehospitalization ratings.

Method

Subjects

A written questionnaire was mailed to all 1,487 members of Division 41 of the American Psychological Association, the American Psychology-Law Society. Completed questionnaires were returned by 470 individuals, a response rate of 42.6%. Seventy-two percent (*n*=339) were males and twenty-eight percent (*n*=131) were female at an average age of 49 years old with the youngest age recorded at 18 and the oldest at 85. The average year in which participants received their doctorate was 1978 and 86.4% (*n*=406) were currently in clinical practice, 9.1% (*n*=43) of

participants had previously been in clinical practice, and 1.9% (9) had never been in clinical practice but were excluded from analyses.

Materials

The 1997 Dangerousness Survey consisted of four case summaries representing a variety of disorders and a range of potential dangerousness. The cases were in the form of one-page discharge summaries taken from the records of actual patients discharged in 1996 from an inpatient facility in the northeastern United States and included information about the history of the present illness, family and social history, mental status examination, and hospital course (Slovic, Monahan, & MacGregor, 2000).

Procedure

The questionnaire was mailed to members of Division 41 of the American Psychological Association, the American Psychology-Law Society The questionnaire asked respondents to assume the role of a psychiatrist in an outpatient clinic who is evaluating a person recently released from inpatient hospitalization. Four questions were then asked about each case summary pertaining to likelihood of harm, risk, monitoring, and rehospitalization and the present study primarily focuses on probability of harm ratings and probability of rehospitalization ratings. In addition to the survey, several demographic questions were asked as well as "How frequently do you provide assessments of "dangerousness as part of your practice?" and "How useful do you find these types of assessments for making decisions about a patient?" Frequency was split into three groups including never/rarely, monthly, and weekly. Usefulness ratings were split into two groups, those with low usefulness ratings found these assessments not –slightly useful whereas

those with high usefulness ratings found these assessment somewhat-very useful. Probability of harm ratings and probability of rehospitalization ratings were aggregated across the four cases.

Results

Analysis of variance was used to explore the relationship between working in a forensic facility or not, usefulness ratings of these assessments and the frequency these assessments are given as they relate to probability of harm ratings and probability of rehospitalization/ involuntary outpatient commitment.

Probability of Harm Ratings

As hypothesized, there was a significant three way interaction of whether or not someone worked in a forensic facility, how useful they found these types of judgements for making decisions (usefulness rating), and the frequency of providing formal assessments (rarely/never, monthly, weekly) of "dangerousness" on total probability of harm ratings, F (2, 430) = 3.625, MSE= 1,694.271, p=.0270, r=.129, refer to Table 1 and Figure 1. Also as hypothesized, there was not a lot of variability in probability of harm ratings. Pairwise comparisons revealed that for those who work in a forensic facility, harm probability ratings were equivalent across the three levels of frequency whether the respondent had high or low usefulness ratings. Among those who do not work in a forensic facility, probabilities of harm ratings were also equivalent across the three levels of frequency but only if the respondent had high usefulness ratings. For those who did not work in a forensic facility and had low usefulness ratings, probability of harm ratings were equivalent for those who gave dangerousness assessments never/rarely to monthly and monthly to weekly and harm probability ratings were greater for those who gave assessments never/rarely than those who did weekly (r=.273).

Among those who had low as well as high usefulness ratings, probability of harm ratings were equivalent among those who worked in a forensic facility and didn't if they gave these assessments rarely/never and monthly. However among those who had low usefulness ratings and gave these assessments weekly, those who work in a forensic facility had higher probability of harm ratings than those who do not (r=.355). Results show the opposite effect for those who had high usefulness ratings such that if the respondent worked in a forensic facility and gave these assessments weekly, he/she reported lower probability of harm ratings (r=.262).

Those who provide assessments of dangerousness never/rarely and monthly gave equivalent ratings of probability of harm whether they worked in a forensic facility or not and found these assessments useful or not. Among those that provided assessments of dangerousness weekly, those who worked in a forensic facility and had low usefulness ratings gave higher probability of harm ratings that those who had high usefulness ratings (r=.252). We see the opposite effect for those who give these assessments weekly and do not work in a forensic facility, with those with low usefulness ratings giving lower probability of harm ratings than those with high usefulness ratings (r=.385).

There was not a significant two way interaction of frequency and whether or not participants worked in forensic facility as they relate to probability of harm ratings, F (2, 430) = .373, MSE= 1,694.271, p=.689, r=.042. This interaction was misleading for those who do not work in a forensic facility and had low usefulness ratings with those who give assessments never/rarely giving higher probability of harm ratings than those who give them weekly. This interaction was also misleading for those who had low usefulness ratings and gave these assessments weekly with those who work in a forensic lab giving higher probability of harm ratings than those who do not. It was misleading for those with high usefulness ratings and gave

these types of assessments weekly such that those who do not work in a forensic facility gave higher probability of harm ratings than those who do.

There was not a significant two-way interaction of usefulness ratings and frequency as they relate to probability of harm ratings, F (2, 430) = .970, MSE= 1,694.271, p=.380, r=.067. This interaction was misleading for those who do not work in a forensic facility and had low usefulness ratings with those who give assessments never/rarely giving higher probability of harm ratings than those who give them weekly. It was misleading for those who had low usefulness ratings and gave these assessments weekly with those who work in a forensic lab giving higher probability of harm ratings than those who do not. It was misleading for those with high usefulness ratings and gave these types of assessments weekly such that those who do not work in a forensic facility gave higher probability of harm ratings than those who do.

There was a significant two way interaction of whether or not participants worked in a forensic facility and how useful they found these assessments on probability of harm ratings (F (1, 430) = 8.746, MSE= 1,694.271, p=.003, r=.141) such that those who do not work in a forensic facility and had high usefulness ratings tended to have higher probability of harm ratings than those who had low usefulness ratings (r=.167). Refer to Table 2 for the means and standard deviations. Among those who worked in a forensic facility, probability of harm ratings were equivalent for those with high and low usefulness ratings. This interaction was misleading among those who give these assessments very frequently (weekly) and work in a forensic facility however it was descriptive for those who do not work in a forensic facility.

There was not a significant main effect of frequency of providing formal assessments of "dangerousness" on probability of harm ratings F (2, 430) = .320, MSE= 1,694.271, p=.726,

r=.039. This is misleading for those who do not work in a forensic facility and had low usefulness ratings with those who give assessments never/rarely giving higher probability of harm ratings than those who give them weekly.

There was not a significant main effect of whether a participant worked in a forensic facility or not, *F* (1, 430) = .001, *MSE*= 1,694.271, *p*=.971, *r*=.002, on probability of harm ratings. This effect is misleading for those who had low usefulness ratings and gave these assessments weekly with those who work in a forensic lab giving higher probability of harm ratings than those who do not. It was also misleading for those with high usefulness ratings and gave these types of assessments weekly such that those who do not work in a forensic facility gave higher probability of harm ratings than those who do.

There was not a significant main effect of usefulness ratings of these types of assessments on probability of harm ratings *F* (1, 430) = .006, *MSE*= 1,694.271, *p*=.937, *r*=.004. This is misleading for those who give these types of assessments weekly and work in a forensic facility, with those who had low usefulness ratings reporting higher probability harm than those with high usefulness ratings. It was misleading for those who give assessments weekly and do not work in a forensic facility with the opposite occurring, those with low usefulness ratings reporting lower probability of harm than those with high usefulness ratings.

Probability of Rehospitalization

As hypothesized, there was a significant three way interaction of whether or not someone worked in a forensic facility, how useful they found these types of judgements for making decisions (usefulness rating), and the frequency of providing formal assessments of "dangerousness" on probability of rehospitalization ratings, *F* (2, 436) = 3.625, *MSE*= 1.326,

p=.0270, *r*=.129, refer to Table 3 and Figure 2. As expected, there was not a lot of variability among ratings of rehospitalization. Pairwise comparisons revealed that for those who work in a forensic facility, probability of rehospitalization ratings were equivalent across the three levels of frequency whether the respondent high or low usefulness ratings. Among those who do not work in a forensic facility, probability of rehospitalization ratings were also equivalent across the three levels of frequency but only if the respondent had low usefulness ratings. For those who did not work in a forensic facility and had high usefulness ratings, probability of rehospitalization ratings were equivalent for those who gave dangerousness assessments never/rarely to monthly. However if they gave assessments weekly, respondents had higher probability of rehospitalization ratings than those who gave them never/rarely (*r*=.304) or monthly (*r*=.229).

Among those who had high usefulness ratings, probability of rehospitalization ratings were equivalent between those who work in forensics and those who do not across all three levels of frequency. Among those who had low usefulness ratings, probability of rehospitalization ratings were equivalent between those who worked in forensics and those who don't only if they gave assessment never/rarely and monthly. If respondents gave assessments weekly, those who work in a forensic facility gave higher rehospitalization ratings than those who do not (*r*=.305).

Those who provide assessments of dangerousness never/rarely and monthly gave equivalent ratings of rehospitalization whether they worked in a forensic facility or not and had high and low useful ratings. Among those who provide assessments weekly and worked in a forensic facility, ratings of rehospitalization were equivalent between those who had high and low useful ratings. However for those who gave assessments weekly and did not work in a

forensic lab, those who had high usefulness ratings gave higher rehospitalization than those with low usefulness ratings (*r*=.331).

There was not a significant two way interaction of whether or not someone worked in a forensic facility and how frequently they gave assessments of dangerousness as they relate to ratings of rehospitalization, (*F* (2, 436) = .294, *MSE*= 1.326, *p*=.745, *r*=.037). This was misleading for those who don't work in a forensic facility and had high usefulness ratings as those who gave assessments weekly reported greater likelihood of rehospitalization than those who gave them never/rarely and monthly. This interaction was also misleading for those who had low usefulness ratings and gave these types of assessments weekly with those who worked in a forensic facility reporting a greater likelihood of rehospitalization.

There was not a significant two way interaction of usefulness ratings and frequency as they relate to ratings of rehospitalization, *F* (2, 436) = .840, *MSE*= 1.326, *p*=.432, *r*=.062. This was misleading for those who don't work in a forensic facility and had high usefulness ratings as those who gave assessments weekly reported greater likelihood of rehospitalization than those who gave them never/rarely and monthly. This was misleading for those who gave assessments weekly and do not work in a forensic facility, with those who had high usefulness ratings reporting greater likelihood of rehospitalization than those with low usefulness ratings.

There was not a significant two way interaction of usefulness ratings and whether or not someone worked in a forensic facility, *F* (1, 436) = 2.603, *MSE*= 1.326, *p*=.107, *r*=.077. This interaction was misleading for those who had low usefulness ratings and gave these types of assessments weekly with those who worked in a forensic facility reporting a greater likelihood of rehospitalization. This interaction was also misleading for those who gave assessments weekly

and do not work in a forensic facility, with those who had high usefulness ratings reporting greater likelihood of rehospitalization than those with low usefulness ratings.

There was not a significant main effect of frequency of providing formal assessments of "dangerousness" on likelihood of rehospitalization ratings F (2, 436) = 1.885, MSE= 1.326, p=.242, r=.093. This was misleading for those who don't work in a forensic facility and had high usefulness ratings with those who gave assessments weekly reporting greater likelihood of rehospitalization than those who give them never/rarely and monthly.

There was not a significant main effect of whether a participant worked in a forensic facility or not, F (1, 436) = 1.996, MSE= 1.326, p=.158, r=.068, on likelihood of rehospitalization ratings. This was misleading for those who had low usefulness ratings and gave assessments weekly, with those who work in a forensic facility giving higher ratings of rehospitalization than those who do not.

There was not a significant main effect of usefulness ratings of these types of assessments on likelihood of rehospitalization ratings F (1, 436) =.027, MSE= 1.326, p=.870, r=.008. This is misleading for those who give these types of assessments weekly and do not work in a forensic lab, with those who had high usefulness ratings reporting greater likelihood of rehospitalization than those with low usefulness ratings.

Discussion

The present study examined how clinician differences interact to produce different ratings of harm and rehospitalization on a standardized forensic assessment of dangerousness in a large sample of Division 41 of the American Psychological Association. This study hoped to

expand upon the little research in the field therefore this analysis was more exploratory than focused on hypothesis testing.

A promising finding for both probabilities of harm and rehospitalization ratings -and consistent with what we expected to find- is that there was not a lot of variability among scores suggesting fairly good inter-rater reliability among clinicians across facility, usefulness ratings, and frequency of giving assessments of danger. This finding also supports Harris, Boccaccini, and Murrie (2014) notion that standardized assessments minimize the variability of scores. Interestingly, both probabilities of harm and rehospitalization ratings were equivalent among those who worked in a forensic facility, regardless of how useful or frequently they gave assessments of danger. Results only reveal differences in probability of harm and probability of rehospitalization ratings among those who do not work in a forensic facility. This could be a reflection the different training required of forensic professionals and the effectiveness of that training when it comes to standardized assessments. This finding could also support Reid's (2003) claim that even competent clinical professionals can't gain the necessary forensic skills needed to run a proper assessment in just one weekend class or after having read a book on the subject and also that forensic practice is not simply an extension of clinical practice. Further research is needed however these findings have implications that point to keeping forensic assessments among forensic professionals as a way to minimize clinician differences.

As hypothesized, there were differences in probability of harm ratings between those who work in a forensic facility and do not however the effect was only present among those who gave assessments weekly. Interestingly, whether or not the forensic professional gave higher or lower probability of harm ratings depended on their usefulness rating. If the respondent found the assessment to be of little to no use and worked in a forensic facility they gave higher probability

of harm ratings. Opposite of this, if the respondent found these assessments somewhat to very useful then those who work in a forensic facility gave lower probability of harm ratings.

There was an interaction of usefulness ratings and facility on probability of harm ratings and consistent with the above results that probability of harm ratings were equivalent among those who worked in a forensic facility regardless of usefulness. However among respondents who do not work in a forensic facility, those who believe these assessments to be useful gave higher probability of harm ratings than those who don't find them. This findings are a expansion of the findings of Jensen-Doss & Hawley (2010) that opinions of usefulness not only affect how often a clinician uses an assessment but also opinions of usefulness can affect how an assessment is scored, in this case through probability of harm ratings.

For probability of rehospitalization ratings there were also differences among forensic and clinical professionals but only if the respondent gave assessments of dangerousness weekly and found these assessments of no use such that those who worked in a forensic facility gave higher probability of harm ratings than those who did not. Probability of rehospitalization ratings showed much less variability than probability of harm ratings.

These findings contribute to a small body of research that needs to be expanded on and is very important to study as forensic assessments of dangerousness are so prevalent in numerous clinical settings. Not only are forensic assessments prevalent but they have a large impact on the individual who is being assessed such that they can impact sentencing to their release from a hospital. Since patients are typically only allowed one evaluation, it is important that clinician differences have as little of an impact on the scoring of these assessments/evaluations as possible. These findings show that while there was little variability, there are still clinician

differences that affect the scoring of a dangerousness assessment. These findings suggest that opinions of usefulness of assessments of dangerousness assessments can cause different probability ratings of harm and rehospitalization and perhaps it is important for clinicians to remain educated about the evidence there is which supports the utility of standardized assessments so as to minimize differing opinions of usefulness with the goal of getting professionals on the same page. These findings also suggest that the frequency at which a respondent gave assessments of danger only had an effect on ratings when the respondent was giving assessments very frequently (weekly) and more research is needed to examine the effect that frequency has on ratings since it was a new variable included in this analysis.

There are some limitations to the study. Although the study used actual cases, it was not conducted in controlled setting and therefore may lack internal validity and there may be confounds working. The study also did not collect demographic information such as ethnicity or the location of the respondent so it is difficult to assess generalizability and if regional and cultural differences would have had an effect.

As there is shortage of research regarding clinician differences in violence risk assessment, this study may serve as a beginning for more specific study in what constitutes difference ratings of violence as result of clinician differences. Further research is needed to gain insight on implications of moving forward in a manner that reduces clinician differences in scoring violence assessments. Future directions for study might include further examining the role the frequency a respondent issues assessments has on scoring violence assessments. Future research might also add an element of accuracy as well to see if differences indicate better or worse predictions of violence.

References

Carroll, A. (2007). Are violence risk assessment tools clinically useful? *Australian and New Zealand Journal of Psychiatry, 41*, 301-307.

Harris, P. B., Boccaccini, M. T, & Murrie, D.C. (2014). Rater differences in psychopathy measure scoring and predictive validity. *Law and Human Behavior, 39* (4), 321-331.

Hugaboom, D. R. (2002). The different duties and responsibilities of clinical and forensic psychologists in legal proceedings. *A Journal of Undergraduate Student Research, 5*, 26-32.

Jensen-Doss, A. & Hawley, K. M. (2010). Understanding barriers to evidence-based assessment: Clinician attitudes toward standardized assessment tools. *Journal of Clinical Child Adolescent Psychology, 36* (6), 885-896. doi:10.1080/15374416.2010.517169

Reid, W.H. (2003). Why nonforensic clinicians should decline forensic referrals. *Journal of Psychiatric Practice: Law and Psychiatry, 9* (2), 163-166.

Scott, C. L & Resnick, P. J. (2006). Violence risk assessment in persons with mental illness. *Aggression and Violent Behavior, 11*(6) 598-611. Retrieved November 1, 2016, from http://www.sciencedirect.com/science/article/pii/S1359178906000279.

Slovic, P., Monahan, J., & MacGregor (2000). Violence risk assessment and risk communication: The effects of using actual cases, providing instruction, and employing probability versus frequency formats. *Law and Behavior, 24* (3), 271-296.

Table 1
Mean and Standard Deviation for Probability of Harm Ratings by Facility, Use, and Frequency Conditions

Frequency Condition	Never/ Rarely (*SD*)	Monthly (*SD*)	Weekly (*SD*)	Total (*SD*)
Works in Forensic Facility				
Low Usefulness	76.5 (*51.551*)	60.6 (*33.767*)	76.84 (*42.55*)	71.85 (*42.24*)
High Usefulness	53.31 (*37.56*)	65.52 *(45.49*)	55.44 (*37.44*)	59.5(*41.12*)
Total	64.133 *(45.38*)	63.94 (*41.85*)	65.23 (*40.99*)	64.53 (*41.89*)
Does Not Work in Forensics				
Low Usefulness	66.9 (*39.32*)	62.26 (*39.69*)	43.53 (*46.55*)	61.77 (*40.95*)
High Usefulness	72.33 (*43.84*)	64.42 (*32.42*)	77.79 (*51.52*)	70.07 (*41.12*)
Total	70.36 (*42.19*)	63.68 (*34.87*)	64.62 (*51.86*)	67.10 (*41.18*)

Table 2
Mean and Standard Deviations for Probability of Harm Ratings by Facility and Use.

Usefulness Condition	None- Little Use *(SD)*	Somewhat – Very Useful *(SD)*
Forensic Facility		
Yes	71.315 *(5.36)*	58.095 *(4.61)*
No	57.563 *(4.658)*	71.511 *(3.571)*

Table 3
Mean and Standard Deviation for Likelihood of Rehospitalization by Facility, Use, and Frequency Conditions

Frequency Condition	Never/ Rarely (*SD*)	Monthly (*SD*)	Weekly (*SD*)	Total (*SD*)
Works in Forensic Facility				
Low Usefulness	6.86 (*.949*)	7.5 (*.946*)	7.47 (*.787*)	7.35 (*.894*)
High Usefulness	7.13 (*1.26*)	7.09 (*1.16*)	7.05 (*1.23*)	7.08 (*1.19*)
Total	7.00 (*1.11*)	7.22 (*1.10*)	7.25 (*1.06*)	7.19 (*1.09*)
Does Not Work in Forensics				
Low Usefulness	6.96 (*1.23*)	6.97 (*1.18*)	6.73 (*1.28*)	6.93 (*1.21*)
High Usefulness	6.81 (*1.21*)	7.00 (*1.14*)	7.54 (*1.11*)	6.98 (*1.19*)
Total	6.86 (*1.22*)	6.99 (*1.14*)	7.23 (*1.22*)	6.96 (*1.19*)

Figure 1. *Mean Probability of Harm Ratings Among Those Who Work in Forensics or do not for each condition of usefulness.*

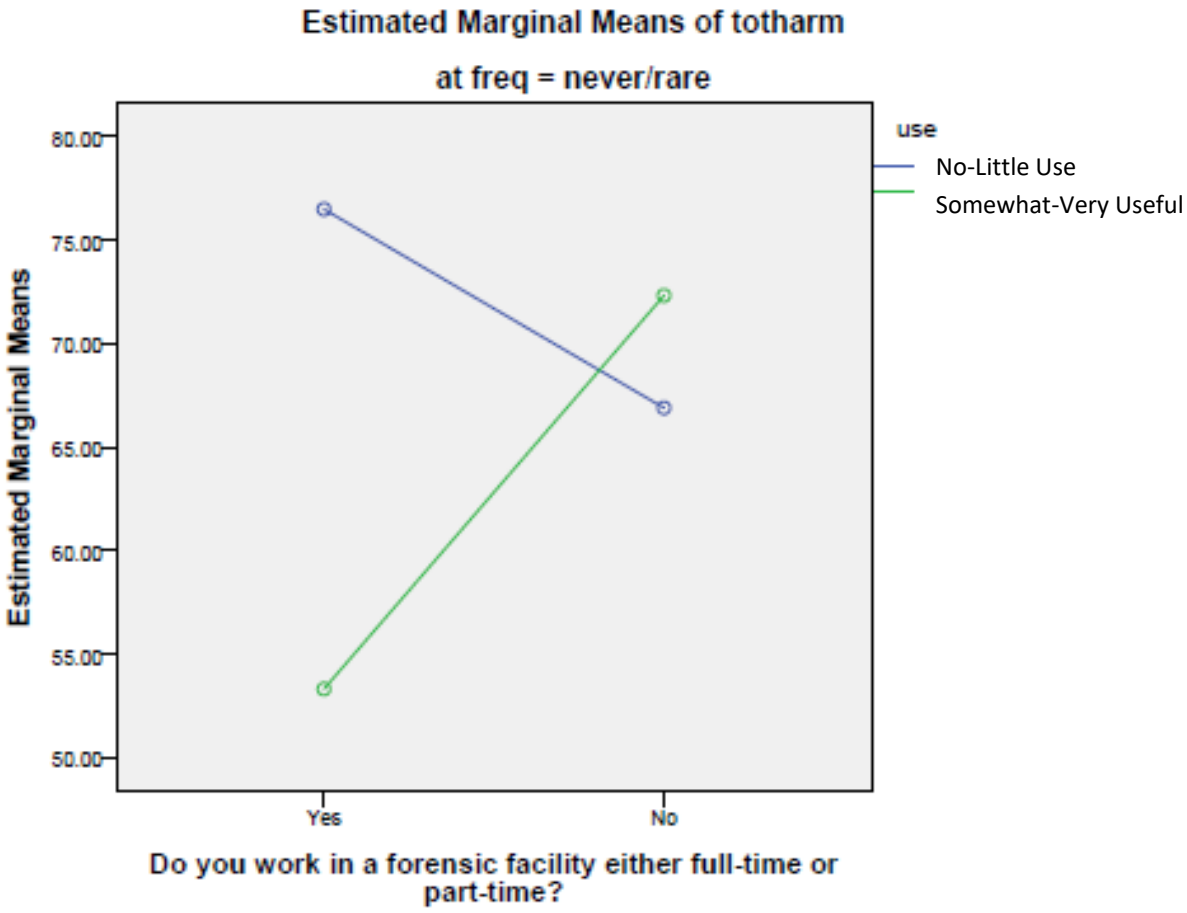

Figure 2. *Mean probability of rehospitalization ratings among those who work in forensics or do not for each condition of usefulness.*