The Canadian Contribution to Violence Risk Assessment: History and Implications for Current Psychiatric Practice

Hy Bloom, LLB, MD[1], Christopher Webster, PhD[2], Stephen Hucker, MB[3], Karen De Freitas, MD[4]

Over the past quarter-century, Canadian researchers, clinical practitioners, and policy specialists have made several notable contributions to the broad field of violence risk assessment and management. In part, these contributions have been fostered by major changes in law over this period; in part, they have been spurred by findings from large-scale Canadian prediction–outcome studies. This paper offers references for a range of Canadian-inspired assessment schemes designed to evaluate psychopathy and potential for violence against others.

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Information on author affiliations appears at the end of the article.

Clinical Implications

- Mental health professionals who are called on to evaluate individuals thought to be at risk for violence against others should draw upon Hare's definition of the construct of psychopathy.
- Professionals should appreciate the contribution of actuarial approaches to the prediction of violence. The extent to which it is possible to attenuate risks assessed as high on such measures remains unknown.
- Professionals should also take note of an emerging literature on structured clinical approaches to risk assessment.
- That there are appreciable limitations to any approaches to risk assessment must be accepted. This being so, a gradual approach to the release of accused persons and offenders with mental disorders is usually the safest.

Limitations

- This review is largely restricted to Canadian contributions to this area of research and practice.
- This paper deals only with assessing general risk of violence against others, not violence toward self or suicide. It does not consider nonviolent recidivism or specific types of violence, such as sex offending or spousal assault.
- This paper does not cover studies of the reliability and validity of various actuarial and structured clinical guides or current assessment schemes.

Key Words: *risk assessment, violence, Hare Psychopathy Checklist-Revised, PCL-R, Violence Risk Appraisal Guide, VRAG, Historical/Clinical/Risk Management-20, HCR-20*

Introducing a book that he described as placing considerable emphasis on the topic of assessing and predicting violence, the distinguished American psychologist John Monahan drew attention not long ago to the "remarkably strong international presence of Canada in forensic psychology and psychiatry, a presence out of all proportion to relative population size, not to mention relative crime rate" (1). Canadian researchers and mental health practitioners indeed exert a notably disproportionate influence on the world's risk assessment literature. Although it may be comforting to receive such accolades from afar, it is important to consider how recent developments in violence risk assessment actually affect daily practice at home. What may seem at first glance to be a nationally aggrandizing approach to the present topic can be more aptly

justified on the ground that Canadian clinicians conducting risk assessments must inevitably frame them within the context of the Criminal Code of Canada, the Corrections and Conditional Release Act, the Dangerous and Long-Term Offender Act (2), the new Youth Criminal Justice Act, and the various provincial and territorial mental health acts (3). This paper is divided into 3 sections. The first is included to remind readers why assessing the risk of violence against others is such an important clinical, research, and policy topic. The second explicates the Canadian contribution to the subject from a historical perspective. The third draws on the first 2 to outline a set of broad principles that may help psychiatrists as they undertake violence risk assessments in emergency, civil, forensic, and correctional psychiatry. Another purpose is to mention the seemingly bewildering array of structured risk assessment devices now evolving, with which clinicians and researchers are increasingly expected to have at least a passing acquaintance.

The Importance of Assessing Risk of Violence Against Others

Evaluating violence risk in various people and places is an inherent dimension of psychiatric practice. It is not a responsibility that can be abrogated or set aside. The duty is not solely confined to the domain of tertiary level consultants, although it will almost invariably fall to the latter to assess violence and recidivism risk in a criminal context, as follows:

- to determine the risk an accused would present to public safety, if released on bail.
- to advise the courts when called upon to do so about how future risk considerations should figure into the rehabilitative and incapacitation aspects of sentences being imposed by trial judges.
- to give expert opinion as to whether the accused poses a risk of physical or psychological harm to the public so substantial that he or she should be designated a long-term offender, or so great and seemingly immutable that the he or she merits the designation of dangerous offender.
- to assess whether an inmate can be safely managed in the community on parole.
- to inform derestriction and release decisions in regard to accused persons' being held under the jurisdiction of a provincial review board following a finding of not criminally responsible by reason of mental disorder (NCRMD) or unfit to stand trial (UST).

Civil commitment under provincial or territorial mental health acts is undoubtedly the most essential and onerous risk decision-making area for psychiatrists in hospital and other day-to-day clinical settings; it is a responsibility that most clinicians cannot avoid. Decisions about involuntary detention are almost always predicated on a dangerousness standard, which requires that risk assessments be informed and focused. On the one hand, false negatives can result in serious harm or death and, potentially, subsequent legal liability. Conversely, false positives can result in temporary or even more permanent abrogation of a patient's right to move about freely in society (4). Not only may the victim of a clinician's inaccurate risk appraisal be traumatized, such penalizing can also lead to legal challenges against the professional. Occasionally, forensic psychiatrists are expected to use civil commitment procedures to continue the postsentence detention of supposedly dangerous mentally ill offenders. The appropriateness of using civil commitment proceedings for what has been referred to as "psychiatric gating" is currently a contentious issue (5).

Several kinds of risk assessment skills are required in daily clinical practice. One of these is the ability to characterize the types of problematic conduct that patients are capable of. Such estimates have implications for diagnosis and management. Psychiatrists must help guide colleagues in their own and associated disciplines toward defensible, professionally sound judgments about risk—judgments that are relevant and based on well-established principles. Clinicians may be found liable for failing to assess competently the degree of risk for violence that persons represent toward third parties, as well as the degree of risk for suicide or self-harm: clinical pronouncements, no matter how apparently weighty, do not suffice when professional and civil liberty issues are at stake. Clinicians must also be able to respond effectively and with alacrity in high-risk situations wherein the ordinary doctor–patient relationship must be set aside and wherein they are obliged to alert authorities to the risk of impending violence by the client toward a third party (6,7). Disclosure of clinical information to protect the public is permissible, or even required, when there is a clear and inmiment risk to an identifiable person or group (that is, risk of serious bodily harm or death).

Historical Background

In the Canadian context, any consideration of dangerousness or, as it has evolved over time, risk assessment begins with the foundational work of Dr Kenneth Gray. Writing in 1947, Gray was acutely aware of the risks faced by nursing and other staff members working in the psychiatric hospitals of the day (8), a time long before psychotropic medications were added to the violence management armamentarium. He and his nursing colleagues offered sensible and practical advice to mental hospital staff and drew attention to the idea that interdisciplinary cooperation is vital for the safe management of aggressive and violent conduct. Under his direction, forensic psychiatry gained its foothold in the Toronto Psychiatric Hospital. Subsequently, Mohr, Turner, and Jerry showed how particular problems such as pedophilia, voyeurism, and exhibitionism could be researched and understood (9). This early groundwork laid the basis for the subsequent Clarke Institute of Psychiatry research and practice in the field of sexual offending. In due course, sexology was strengthened and expanded by the inspired theoretical and practical contributions of Kurt Freund (10) and Ron Langevin (11,12). It continues today in the sex offender assessment and treatment research of Blanchard (13) and Barbaree (14).

The Oak Ridge Division of the Mental Health Centre, Penetanguishene

Oak Ridge, a free-standing, maximum-secure building on the grounds of the Mental Health Centre at Penetanguishene, Ontario, has long been the facility for detaining the most severely ill male patients found NCRMD. It came to international prominence in the 1960s with the reporting of the Oak Ridge staff's determined efforts to treat patients suffering from severe mental and personality disorders. Inspired by Dr Elliot Barker and others, including former patients (15), Oak Ridge came to be seen as a place where positive changes could be wrought, even under difficult circumstances. Such was the influence of this pioneering work that it actually began to alter the courts' interpretation of the Canadian insanity defence (16).

In 1975 the hospital administration appointed Vernon Quinsey, a psychologist, to create a research department at Oak Ridge. Under his leadership, the small unit expanded and soon showed itself capable of attracting external research funds. Some of the new projects concentrated on phallometric testing and so complemented work occurring in Toronto (17); some dealt with the practicalities of managing highly violent behaviours of the kind especially apt to occur in maximum security units (18); and some dealt with assessing risk for violence (19).

Quinsey and colleagues conducted studies that revealed the then awkward-seeming findings that clinicians' assessments of risk are no more valid than those of nonprofessionals (20) and that clinicians in interdisciplinary teams tend not to agree with one another in their judgments about the kinds of treatments most beneficial for individual patients (21). At the same time, members of this group were beginning to question the US experience (22) that it is wholly impossible to predict the future violent behaviour of persons institutionalized for having committed serious acts of violence while suffering from mental illness (23).

In 1993, a key paper to emanate from Oak Ridge on the topic of general violence risk assessment was published (24). This introduced the now well-known Violence Risk Appraisal Guide (VRAG). The paper's authors, Harris and colleagues, linked file information from some 600 persons assessed at Oak Ridge with actual outcome 7 years later. About one-half of those assessed were treated at the institution for at least 2 years; the rest were channelled through the correctional system. Two separate sets of research assistants were employed: one set to extract pertinent pieces of information from the voluminous Oak Ridge files and one set to collect actual outcome data (that is, new violent offences or returns to hospital for aggressive acts). Harris and his group then integrated the 2 sets of data statistically. By doing this they were able to achieve prediction–outcome correlations of around 0.50 in some of their computations. This was above a threshold or "sound barrier" purported to exist by Toronto-based researchers working on similar projects at about the same time (25, see following section).

The VRAG scheme is built on 12 items. Some items are loaded more heavily than others. The most strongly weighted is the Hare Psychopathy Checklist-Revised (PCL-R, see below). Other heavily weighted items are "early childhood maladjustment" and "employability." A history of mental illness is weighted negatively (that is, it serves a protective function in the scheme). The VRAG is an example of an actuarial device in that its pooled data offer a likelihood figure regarding possible future violent offending. On a probabilistic basis, those with a high VRAG score have an increased risk of offending violently, and those with a low score are likely to be relatively insulated from future offending. The VRAG has now been contextualized with the publication in 1998 of a book on the topic (26); it has also been reinforced through subsequent research (27). In this research, the authors provide data for their study group at 10 years' follow-up, give detailed VRAG scoring instructions, and include an expanded version specifically geared toward sex offenders—the Sex Offender Risk Assessment Guide (SORAG). Generally speaking, Quinsey and his colleagues argue strongly for the superiority of actuarial prediction over clinical judgments about risk.

The Metropolitan Forensic Service

The Metropolitan Forensic Service (METFORS) was established in Toronto in 1977. Administered by the then Clarke Institute of Psychiatry, situated at the then Queen Street Mental Health Centre, and funded by the Ontario Ministry of the Attorney General, METFORS was created to facilitate interdisciplinary fitness-to-stand-trial assessments of persons being held in the 3 Toronto-area correctional remand centres. Though fitness was the major issue, "dangerousness" soon emerged as a second researchable line in forensic psychiatry and psychology (28). Clinicians worked with researchers to create assessment schemes. One of these was a 23-item device called the Dangerous Behaviour Rating Scheme (DBRS). Its strength as a predictor was gauged against follow-up via hospital and police records, first, after 2 years (29) and later, after 6 years (30). The authors concluded that, although possessing some power to predict in specific contexts, the sizes of correlations between DBRS scores and actual outcome did indeed fail to cross the 0.40 "sound barrier" they themselves had posited. One of the METFORS research group, Robert Menzies, offered a penetrating analysis of possible iatrogenic effects inherent in some multidisciplinary risk assessments—a contribution of considerable importance in this line of research. Menzies was able to show from his data that, unless they are on guard, clinicians may unwittingly "construct dangerousness" in the course of completing evaluations and that evaluations can also be subject to sex and other biases (31).

Changes in the Law Concerning Mentally Disordered Offenders

In the 1970s, the Law Reform Commission of Canada reviewed the status of mentally disordered offenders in Canada. At that time, the Criminal Code of Canada required trial judges to order that accused persons acquitted by reason of insanity be "kept in strict custody . . . until the pleasure of the Lieutenant Governor is known"(32). Similar provisions dealt with those found UST. This system had several shortcomings, among which was the fact that length of time spent in custody was indeterminate. As a result, many individuals spent far longer under the restrictions of a Lieutenant Governor's Warrant than they would have if they had been found guilty of the

offence and sent to prison. Detention was also automatic. The law assumed that all offenders suffering from mental illness were dangerous and had to be detained to protect the public. There was no codified requirement to differentiate between offenders who were dangerous and those who were not. The standard (or test) justifying continuing detention in fact had seemingly little to do with dangerousness or risk and was instead predicated on whether the accused had "recovered."

In its 1976 report, the Law Reform Commission recommended the abolition of the Lieutenant Governor's Warrant. It also recommended that "the present verdict of 'not guilty by reason of insanity' become a real acquittal, subject only to a post-acquittal hearing to determine if the individual is civilly committable" (33). This hearing to determine whether the individual was civilly committable included assessing the level of risk to self and to the public. With this report released, the federal government of the day established the Mental Disorder Project. This gave the researchers at Penetanguishene, METFORS, and the Institut Pinel de Montréal, as well as those in provincial and federal corrections, a chance to meet with bureaucrats, administrators, and clinicians. Canadian social scientists had access to persons responsible for making changes to policy and law, and the resulting report of the Mental Disorder Project reflected their expertise and opinions. The report's recommendations were incorporated into a 1986 draft bill, which, however, languished until a decision by the Supreme Court of Canada forced the government to make some of the recommended legislative changes. In R v Swain, the Supreme Court of Canada found that the requirement to order the accused into strict custody to await the pleasure of the Lieutenant Governor was contrary to the Charter of Rights and Freedoms because it was an arbitrary rule that did not take into account the circumstances of the particular case (34). The Supreme Court gave the government 6 months to change the law. As a result, the proposed amendments, known as Bill C-30, were passed and proclaimed into effect on February 4, 1992.

The changes wrought by the new law were too many and too complicated to discuss in detail here (35). However, one major alteration was that persons acquitted by reason of insanity were no longer automatically detained. Rather, they could be held only as long as they posed a "significant threat" to public safety (36). In effect, automatic detention was deemed to be contrary to the Charter, and provisions for it were replaced with clauses that allowed detention only when an individual posed a risk to the public. This made risk assessment a crucial and indispensable part of the approach to offenders suffering from mental illness.

Ontario's Reaction to the Bill C-30 Changes

Bill C-30 brought together those with key interests in public protection and the accused's rehabilitation by naming the accused, the hospital, and the attorney general of the province (and potentially any designated interested person) as parties to the proceeding. The new law made it quite apparent that the quality of clinical evidence brought before review boards would have to improve. In anticipation of the proclamation, Mr Justice Thomas Callon, then chair of the Ontario Lieutenant Governor's Review Board, established a small committee to suggest how risk assessments should ideally be conducted. This committee comprised representatives from several interested sectors, including experienced clinicians, administrators, and researchers. In due course, the research members of the committee published a short text on the topic of risk assessment (37). The lynchpin of this publication was the VRAG, and the publication also included a chapter on clinical (that is, dynamic) considerations organized according to a mnemonic device called ASSESS-LIST. The authors suggested that predictions of future violence be based on VRAG scores but that the scores could be modified upward or downward if circumstances warranted, provided that the adjustment did not vary by more than 10%. This notion—that actuarial scores should be open to modification based on clinical opinion—was later, and emphatically, set aside by Quinsey and colleagues (26). They argued that the actuarial prediction is what it says it is, no less and no more, and that, if dynamic clinical considerations are to enter the overall calculus in a risk assessment, they must do so in a different way.

Psychopathy

It will be recalled that psychopathy is the prime predictor of the 12 employed in the VRAG, or to be more precise, the Hare PCL-R score (38). As many readers will know, Hare's inventive work began with a consideration of the American psychiatrist Hervey Cleckley's 1941 text, *The Mask of Sanity* (39). In rich literary style, Cleckley describes several cases of persons who seem to skate over the surface of life, lack conscience, act deceitfully, do not form meaningful connections with others, and have a marked propensity for early and continuous entanglements with the law. Hare consolidated these observations, guided by his own emerging clinical experience in Canadian correctional facilities. This early version of the checklist had 22 items (40); its subsequent forms had 20 (38,41). The Hare PCL-R is an example of a structured clinical judgment device. It is remarkable for its 2 main characteristics: first, it is supported by a manual that gives full item descriptions along with precise scoring instructions; second, it includes standardization data (now, with the 2003 version, for women as well as men). Each item in the Hare PCL-R is scored either 0 (not present), 1 (may be present), or 2 (definitely present). With 20 items, the total possible score is therefore 40. A score of 30 is the normal cut-off for an ascription of psychopathy.

The MacArthur study on the fate of some 1000 patients released to the community (42) inspired the development of a 12-item Screening Version (PCL:SV, 43) that is particularly suited to community samples. A version specifically adapted and standardized on adolescent populations has now been published (PCL:YV, 44).

British Columbia's Reaction to the Bill C-30 Changes: Structured Approach to Risk Assessment

In the 1980s and 1990s, Dr Derek Eaves was the lead forensic psychiatrist and administrator on the Forensic Psychiatric Services Commission of British Columbia. Faced with implementing Bill C-30 in 1992, Dr Eaves, like his colleagues in Ontario and across the country, began to realize that advances were needed in the area of risk assessment. Although aware of the VRAG research, he opted for a different strategy, namely,

to engage in detailed consultations with British Columbia's forensic and other clinicians in the various mental health disciplines. The eventual project was hosted by the Mental Health, Law and Policy Institute of Simon Fraser University and entailed individual interviews with some 20 professionals across various settings, including forensic, civil, and psychiatric emergency services. The idea was to isolate and define the important variables to consider when undertaking risk assessments for courts, review boards, and other tribunals. Influenced by the outcome of these individual consultations and the basic structure of the Hare PCL-R, he and others produced a first version of a violence risk assessment device in 1995, called the Historical/Clinical/Risk Management-20 (HCR-20, 45). As the HCR-20 evolved, its authors came to realize that, aside from accurately predicting risk, evaluators are absolutely required to base their reports and opinions on processes that are well informed and available to close legal examination.

The HCR-20 scheme employs the same basic idea of 20 items (each scored 0, 1, or 2) as is used in Hare's device. Ten of the items are historical, or "static," (that is, largely obtainable from the record and not apt to change much over time). One of the 10 is the Hare PCL-R score; some of the others are loosely similar to the VRAG. Five of the clinical items are allotted to current conditions dealing with insightfulness, severity of psychiatric symptoms, impulsivity, treatability, and attitudinal issues. The remaining 5 are future-directed and take into account the extent to which the subject has the ability to create and follow a rehabilitation plan, avail himself or herself of support, cope with anticipated stressors, comply with prescribed medications and rules, and avoid becoming destabilized by external influences. The scheme was reviewed in an influential 1996 US publication (46) and attracted the attention of Swedish and German colleagues. It was modified with their help in 1997 (47). Since then, it has been considerably researched (for example, 48), and it has found a place in various forensic, civil, and correctional services. Of some note, too, is the 2001 publication of a separate *Companion Guide* (HCR-20CG, 49), which, being remediative in orientation, shows how clinicians ought to be able to help patients and parolees gain insight, become treatable, and create plans. The idea is to use the basic HCR-20 to index change following the interventions suggested in the HCR-20CG.

The basic format (20 or so defined items, each scored 0, 1, or 2) has been extended to the creation of specific-to-purpose devices to assess assaultive spouses (Spousal Assault Risk Assessment, 50) and sex offenders (Sexual Violence Risk-20, 51; Risk of Sexual Violence Protocol, 52).

Mirroring the publication of the PCL:YV for assessing psychopathy in youth is the Structured Assessment for Violence Risk in Youth (SAVRY, 53), which actually followed the publication of 2 structured schemes—one for assessing violence risk in boys aged under 12 years (the Early Assessment and Risk List for Boys [EARL-20B], 554) and the other a similar but separate version for girls (EARL-21G, 55). The most recent development in this series has been the publication of a manual designed specifically to focus on short-term violence risks (including self-harm and suicide) in adult forensic, correctional, and civil populations. Titled the Short Term Assessment of Risk and Treatability (START, 56), the scheme presumes the prior completion of a historical analysis (as with the 10 historical items of the HCR-20 or the VRAG). It defines 20 dynamic variables cast both as risk markers and as possible protective factors. It is as yet untested. Table 1 summarizes the gradual evolution of these "decision support tools" (57).

A 20-item guide for evaluating adolescent sex offenders, the Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR, 58), has been published. Attempts have also been made to deal with workplace violence, both with respect to employees (the Employee Risk Assessment-20 [ERA-20], 59) and with respect to the situational aspects that may contribute to the genesis of such violence (the Workplace Risk Assessment-20 [WRA-20], 60). These are at an early consultative stage of development. Figure 1 shows how these schemes have evolved over time.

Contemporary Risk Assessment Principles

Canadian psychiatrists might like to consider the following principles as they conduct risk evaluations in emergency, civil, forensic, and correctional psychiatry.

1. Assessments must accord with the pertinent legal test or professional standard. Decisions about violence risk are inevitably bounded by statute and case law. Psychiatrists and other mental health professionals need to review frequently the constantly evolving pertinent federal and provincial law. "Duty to protect" considerations must be weighed carefully and acted on if need be.

2. Assessment conditions must be satisfactory, and the evaluations themselves must be thorough. Dr Barry Boyd made this point many years ago, with respect to physical circumstances (61). With the accumulation over the last 2 decades of research evidence on the salience of actuarial risk predictors, an absolute requirement now exists for psychiatrists to obtain and review large amounts of historical information (62,63).

3. Assessments must be specific to the risk issue at hand. Opinions offered years earlier by other practitioners, on diverse issues that are only marginally related to current violence risk considerations, may be irrelevant and misleading. Predictions, when offered, should be specific. Of interest to courts, parole authorities, and the like is to know what type of violence might occur, under what sort of conditions, to whom, with what effects, and in what space of time. Jackson has ably summarized this point (64). Conclusions about risk assessments should be expressed in clear and intelligible terms.

4. Assessing risk for violence is a broader task than predicting it. Psychiatrists and other mental health professionals may or may not be faulted for an erroneous prediction, but more certainly, they will be censured for producing assessments that do not meet accepted standards for completeness, thoroughness, accuracy, and objectivity (65). Second opinions, as in other areas of medicine, are indispensable in some cases.

5. Actuarial information obtained from records can focus and strengthen risk assessments. Prior violent behaviour is a predictor of future violent behaviour (66). Helpful information in

Table 1 Contemporary structured guides for assessing psychopathy and violence risk: a listing

Year of publication	Abbreviation	Number of items	Scope	First author
Psychopathy				
1985 (prelim)	PCL-R	22	Psychopathy	Hare
1991		20	Adults	
2003 (V2)		20		
1995	PCL:SV	12	Psychopathy	Hart
			Adults	
2003	PCL:YV	20	Psychopathy	Forth
			Youth	
Violence risk—adults				
1995	HCR-20	20	Violence	Webster
			Adults	
1997 (V2)	HCR-20	20	Violence	Webster
			Adults	
2001	HCR-20 CG	10	Violence	Douglas
		(Dynamic)	Adults	
2003	START	20	Violence	Webster
		(+ 20 protective)	Adults	
Violence risk—children and adolescents				
2000	EARL 20B	20	Violence	Augimeri
2001 (V2)			Boys	
2001	EARL 21G	21	Violence	Levene
			Girls	
2002	SAVRY	24	Violence	Borum
2003 (V1.1)		(+ 6 protective)	Youth	

PCL-R = Psychopathy Checklist Revised; PCL:SV = Psychopathy Checklist: Screening Version; PCL:YV = Psychopathy Checklist:Youth Version; HCR-20 = Historical/Clinical/Risk Management-20; HCR-20 CG = Historical/Clinical/Risk Management-20 Companion Guide; START = Short Term Assessment of Risk and Treatability; EARL 20B = Early Assessment Risk List for Boys; EARL 21G = Early Assessment Risk List for Girls

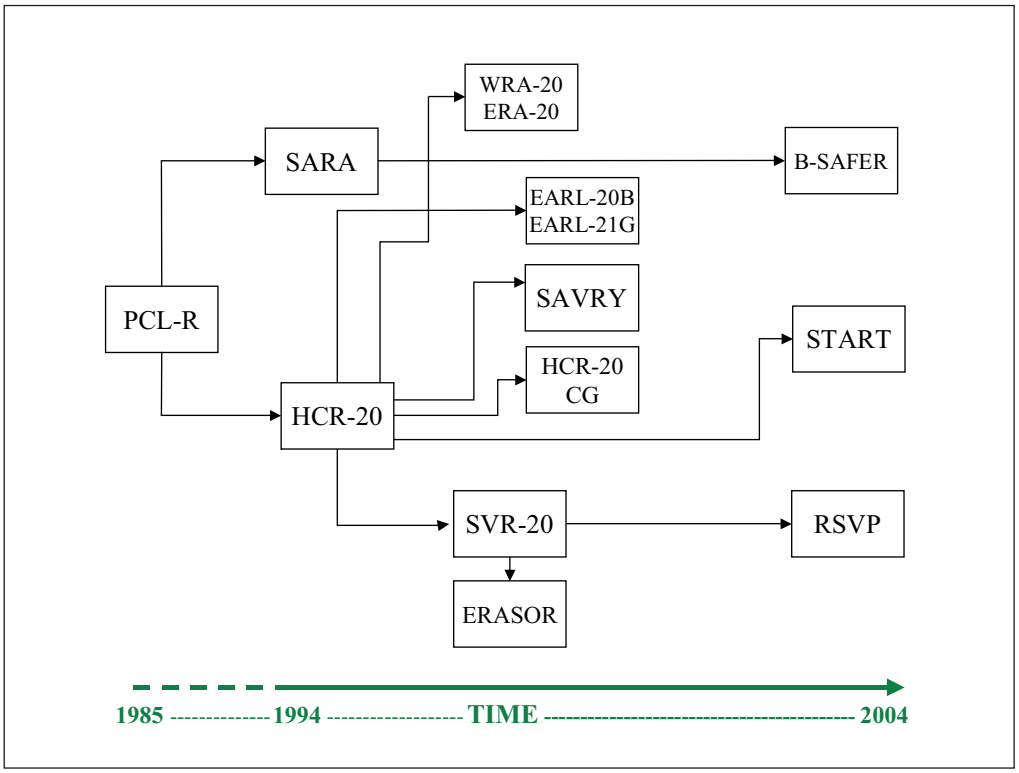
clinical reports often comes to light in the course of completing the VRAG and other such schemes (for example, the Offender Group Reconviction Scale, 67; see 68). When these devices form part of the evaluation, they must be completed fully and accurately. Prompted by the case at hand, it is also incumbent on practitioners to search out relevant baseline statistical recurrence data. This would apply even where the published data are somewhat impressionistic (69).

6. Reports, whether based on published structured schemes or not, should identify key risk factors and offer a plausible theory as to how such factors conspired or intersected in a particular instance. The courts expect psychiatrists to offer explanations that transcend common sense (70). It is increasingly recognized that convincing psychological theories have to invoke intersecting factors operating in concert; more or less static conceptualizations are insufficient (3). It needs to be clear what factors in what combinations increase risk and how stipulated interventions may be expected to reduce defined risk.

7. Over the past quarter-century, the Hare PCL-R has emerged as a lead variable in risk prediction (71). The psychopathy construct provides a platform on which to build risk assessments (71,72).

8. The use of structured violence risk assessment guides can improve practice. It is often mistakenly thought that schemes like the HCR-20 rob psychiatrists of their clinical individuality and prowess. This is not so. These various schemes depended heavily upon clinical consultation during their development and ensuing testing. They act as aides-mémoire, helping to ensure that crucial items are not overlooked. They also improve consistency in communication among colleagues. Certainly, it is recognized that, because all items have equal weight (being limited to ratings of 0, 1, or at maximum, 2), some persons with low overall scores (out of, say, 40) will nonetheless have a high risk of harming others (see 73 for some recent clear individual case examples in the Canadian context). If structured guides are used, they should be used properly (74).

Figure 1 Evolution of structured professional judgment guides for violence risk assessment



9. Risk assessments should link directly to risk management practices. This is implied in the HCR-20CG. Courts, review boards, and other tribunals are interested in what concrete steps should follow from a risk assessment. They need to know not only what the risk is but how it can likely be attenuated so that the individual can be reintegrated into society. Psychiatrists need to be aware of the rapidly growing literature on community treatment (75).

10. Attempts to establish risk factors in individual cases need to be matched with efforts to find particular strengths or "promotive" factors (76). Especially important is the idea that patients' goals mesh with those proposed by psychiatrists and other mental health professionals.

Conclusions and New Directions

It is to be hoped that this paper will give readers unfamiliar with the emerging specialty of risk assessment a clearer idea of the purpose of recently evolved assessment schemes like the Hare PCL-R, VRAG, HCR-20, HCR-20CG, SAVRY, EARL-20B, EARL-21G, and START. Not particularly stressed in the paper was the debate about the validity and usefulness of actuarial, compared with clinical, prediction. Like others (66), our view is that this distinction is unhelpful because, in the end, it not only pays to have as much knowledge about statistical base rates for particular subgroups as can be obtained but also to have as much thoughtful and well-reasoned scientific clinical opinion as possible about the case at hand. This is particularly so because many established actuarial variables are in fact ultimately based in clinical knowledge and expertise (for example, psychopathy, personality disorder, mental disorder, and substance abuse).

As explained above, the forces that propelled Canadian risk assessment research and practice to the fore internationally had some of their roots in the legal and policy debates that occurred in Canada during the 1970s and 1980s. These foundations need to be acknowledged, since research and clinical practices in risk assessment and management have been forged in part by these developments. They provide the general framework within which is decided what evidence is fair to consider in a particular case and what is not. In Canada, a partnership has recently emerged between research and clinical practice. The key roles of administrators and policymakers have also become evident. Needed now is the fuller inclusion of patients and incarcerated persons themselves as we continue to evolve the kinds of clinical protocols that play such a large role in determining their fates.

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[1]Assistant Clinical Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario; Assistant Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario; Coordinator of Psychiatric Resources, Ontario Review Board, Toronto. Ontario.
[2]Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario; Department of Psychiatry, University of Toronto, Toronto, Ontario; Senior Research Consultant, workplace.calm inc, Toronto, Ontario.
[3]Academic Head, Forensic Program, St. Joseph's Healthcare Hamilton, Hamilton, Ontario; Professor and Chair, Forensic Division, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario.
[4]Forensic Service, St. Joseph's Healthcare Hamilton, Hamilton, Ontario; Assistant Clinical Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, Hamilton, Ontario.
Address for correspondence: Dr H Bloom, workplace.calm inc. Suite 1202, 1200 Bay Street, Toronto, ON M5R 2AS
e-mail: hy.bloom@utoronto.ca

Résumé : La contribution du Canada à l'évaluation des risques de violence : historique et implications pour la pratique psychiatrique actuelle

Au cours des 25 dernières années, les chercheurs canadiens, les médecins cliniques et les spécialistes des politiques ont fait plusieurs contributions notoires au vaste domaine de l'évaluation et de la gestion des risques de violence. D'une part, ces contributions ont été favorisées par des changements législatifs importants durant cette période; et d'autre part, elles ont été éperonnées par les conclusions d'études canadiennes à grande échelle sur la prédiction des résultats. Cet article offre des renvois à une gamme de méthodes d'évaluation d'inspiration canadienne, destinées à évaluer la psychopathie et le potentiel de violence dirigée contre autrui.