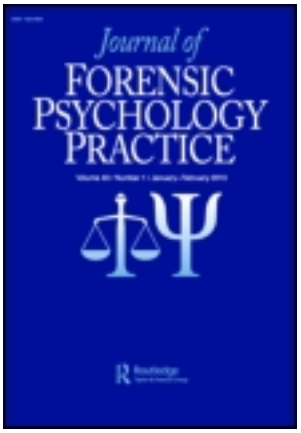

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Assessing Risk of Violence Using Structured Professional Judgment Guidelines

Laura S. Guy PhD [a], Ira K. Packer PhD ABPP [a] & William Warnken PsyD ABPP [a]

[a] Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts

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Assessing Risk of Violence Using Structured Professional Judgment Guidelines

LAURA S. GUY, PhD, IRA K. PACKER, PhD, ABPP, and WILLIAM WARNKEN, PsyD, ABPP
Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts

Violence risk assessments are conducted routinely in psychiatric and correctional settings. One method with demonstrated reliability and validity for assessing risk of violence is the structured professional judgment (SPJ) model. In this article, we provide an overview of the SPJ model and a brief review of the empirical literature supporting its use. We present a clinical case example to demonstrate the use of the HCR-20, the most well-researched SPJ tool, with a psychiatric patient being considered for increased hospital privileges and discharge to the community. We conclude with recommendations for clinical practice using an SPJ tool when assessing risk of violence.

KEYWORDS structured professional judgment, HCR-20, risk assessment, forensic assessment, violence

Mental health professionals (MHPs) working in psychiatric hospitals routinely make decisions about whether a particular patient should be granted increased liberties, such as access to less secure parts of a hospital or off grounds on a pass. Eventually, because most patients will be discharged to the community, MHPs ultimately are tasked with deciding whether a given patient will be released from the hospital. An important component of such decisions is a careful assessment of factors that impact risk of harm to self or others. Decades of research have demonstrated that clinical decision making in the absence of any scientifically grounded structure or guidance (referred to as "unstructured clinical judgment") is unreliable and invalid. To conduct

Address correspondence to Laura S. Guy, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 0165. E-mail: laura.guy@umassmed.edu

violence risk assessments in an empirically informed way, clinicians may use either actuarially based schemes or structured professional judgment (SPJ) tools. Although meta-analytic evidence indicates that both approaches are capable of *predicting* violence with similar (and moderate) degrees of accuracy (e.g., Guy, 2008; Yang, Wong, & Coid, 2010), only the SPJ approach provides guidance for managing the identified risk. As such, SPJ tools offer distinct advantages over actuarial tests when one's goals include identifying salient risk factors for a given patient and devising ways in which to intervene to manage or reduce that risk.

Much has been written describing the SPJ approach to violence risk assessment (e.g., Douglas, Cox, & Webster, 1999; Douglas & Kropp, 2002). SPJ tools essentially are recommendations for best practice and comprise factors that have a demonstrated empirical association with increased risk for violence. Tools developed according to the SPJ approach share distinct characteristics. Items are identified after a systematic review of the existing scientific research and consideration of professional and legal literatures. Judgments about degree of risk are made without a numeric formula; instead, the decision maker assesses the weight to be given to the specific items and typically communicates conclusions in a categorical manner (e.g., low, moderate, high). Although it generally is true that risk is greater when relatively more risk factors are present, an additive model of risk is overly simplistic; critical to the foundation of the SPJ approach is the importance of considering the individual *manifestation* and *relevance* of each item for the particular individual. Specific clusters of risk factors, or even a single risk factor, may play a disproportionate role in increasing an individual's level of risk, even in the absence of numerous risk factors (see also Monahan et al., 2001).

Hart (2008) and Hart and Kropp (2010) elaborated on the principles underlying the SPJ approach (see also Douglas & Reeves, 2010). Guidelines developed within the SPJ framework are distinguished in terms of being preventive, structured, and flexible. Schemes are *preventive* (i.e., not only predictive) in that they guide evaluators first to consider the individual and contextual factors that are believed to increase or decrease risk for violence and, second, to identify specific interventions that may be useful for managing or reducing that risk. Schemes are *structured* in that they provide general guidance regarding how to carry out the assessment, present specific factors to consider, provide a description of and instructions for rating each item, describe how to make and communicate the final risk judgment, and provide explicit recommendations about how to select appropriate risk management strategies. As a result of such structure, decisions are more consistent, and the decision-making process is more transparent than it otherwise would be, thereby enhancing accountability. SPJ schemes are *flexible* in the sense that assessments are individualized and contextualized; the evaluator's discretion is valued. Flexibility also is apparent in that SPJ tools contain factors that are

expected to change over time in saliency and relevance in different ways for different individuals. More generally, because they are based on current discourse in the empirical, professional, and legal spheres, SPJ schemes also are flexible in that that they may be considered as "works in progress."

The amount of research conducted on the 19 existing SPJ tools varies greatly (see Guy, 2008). The most well-researched tool is the HCR-20. The HCR-20 (see Douglas, 2008) initially was published in 1995 (Webster, Eaves, Douglas, & Wintrup, 1995) and was the first SPJ measure developed to assess general violence among adults. Since the current version was published (Webster, Douglas, Eaves & Hart, 1997), approximately 90 studies have investigated its reliability or predictive validity. The HCR-20 has been validated for use in inpatient and outpatient settings with forensic psychiatric, civil psychiatric, and correctional populations (for an annotated bibliography, see Douglas, Blanchard, Guy, Reeves, & Weir, 2010).

The HCR-20 is so-named for its inclusion of 20 risk factors in Historical, Clinical, and Risk management domains. The instrument contains 10 historical, largely static, risk factors that fall into three general categories (problems in adjustment or living, problems with mental health, and past antisocial behavior) and 10 potentially changeable, dynamic risk factors. Five of these concern current clinical status such as negative attitudes and active symptoms of major mental illness (the Clinical scale), and five concern future situational risk factors such as lack of plan feasibility and treatment noncompliance (the Risk Management scale). Because they are sensitive to change, the dynamic risk factors are intended to facilitate development of risk management and intervention plans (Belfrage & Douglas, 2002). Each item is rated on a 3-point scale, with 0 indicating that *available information contraindicates the presence of the item* or *there is no information to suggest the presence of the item*, 1 indicating *available information suggests the possible or partial presence of the item*, and 2 indicating *available information definitely indicates the presence of the item*. MHPs are encouraged to communicate level of risk using categorical levels of low, moderate, and high. Estimates are based on (a) the assessment of the previous, current, or anticipated future presence of the risk factors; (b) the relative importance of the risk factors for a given individual; and (c) the degree of intervention estimated to be necessary to prevent violence.

Because items on an SPJ tool are intended to reflect broadly the current state of scientific and professional literature, such schemes will require periodic updating. The HCR-20 was published just more than a decade ago; since then, thousands of studies on violence have been published (Guy & Wilson, 2007). For that and other reasons, a revised version of the HCR-20, called the *HCR:Version 3*, is being developed (HCR:V3; Douglas, Hart, Webster, Belfrage, & Eaves, 2008, draft version). In the case report below, the HCR-20 was used to structure a violence risk assessment conducted for an individual in an inpatient civil psychiatric setting.

CASE REPORT[1]

Overview

Mr. S, a 27-year-old man, initially was admitted to High Security Forensic Hospital (HSFH) for a court-ordered examination of his competency to stand trial related to two counts of assault and battery on a police officer, one count of resisting arrest, and one count of disturbing the peace. He was adjudicated incompetent to stand trial and committed to HSFH for treatment for his mental illness in a high-security setting. Several months later, the charges were dismissed. Because Mr. S was deemed to require continued treatment for his mental illness but not within a high-security setting, he was transferred as a civilly committed patient to the Psychiatric State Hospital (PSH).

At the time of the violence risk assessment, Mr. S had been hospitalized at PSH for 1 year. His hospital privileges consisted of supervised access to unsecured parts of the PSH and its grounds. The purpose of the violence risk assessment was to help Mr. S's PSH treatment team determine whether he should be granted unsupervised access within the hospital and its grounds and supervised access to the community. The treatment team also requested consultation regarding risk factors relevant to Mr. S's discharge from the hospital. The violence risk assessment was based on two interviews with Mr. S (total time of 4 hours), consultation with his treatment team, review of treatment records, review of two competence to stand trial reports conducted in relation to the index charges, and various records (mental health, school, and criminal history).

Past Functioning

Mr. S was born outside the United States but moved to the United States with his family at the age of 6. He began to have problems at school by age 11; he was involved in fights frequently with peers and was suspended several times. Mr. S was placed in a juvenile detention facility twice as a teenager (ages 13–15, 17–18), once related to a charge of assault and battery (see criminal history, below). Mr. S was placed in special education classes at age 15, but it is unclear whether this was related to learning or behavioral difficulties. He dropped out of high school in tenth grade and had no interest in obtaining a GED. He had worked in fast food settings and had held short-term jobs in the construction industry. During periods of unemployment, he had relied on support from family and friends.

Mr. S. had used marijuana daily since the age of 12 when in the community. He had used cocaine approximately once every 3 months between the ages of 13 and 25 but reportedly had used marijuana only during the

[1] Identifying information and other case specific information were altered to protect confidentiality.

past few years. He had drunk beer socially but typically not to the point of intoxication.

Mr. S was diagnosed with attention-deficit hyperactivity disorder at age 11. During his years in juvenile detention, he was on the mental health caseload and treated with a mood stabilizer. His first psychiatric hospitalization was at age 18, at which time he was diagnosed with bipolar disorder. He had received community support services since. Mr. S had four subsequent hospitalizations and received consistent diagnoses of bipolar disorder. He had a long history of stabilizing as an inpatient, decompensating quickly upon discharge to the community as a result of medication noncompliance and drug use, and eventually being readmitted when his psychotic and mood symptoms worsened. Mr. S exhibited paranoid delusions (e.g., that the police were following him; that the city was going to be invaded, which compelled him to contact the CIA to forewarn them); symptoms of mania (e.g., not sleeping for days, loud/pressured speech, hyper-religiosity as exhibited by wrapping himself in a bedspread and professing to be a religious figure); symptoms of depression (e.g., poor hygiene, isolating); and odd or dangerous behaviors (e.g., attempting to stop cars in the street). These symptoms generally had been controlled via pharmacological management. Mr. S had never attempted suicide and emphatically denied that he ever would ("I love myself too much").

Apart from being in a car accident at age 20 (no injuries sustained), Mr. S had never experienced any acute traumatic incidents. He had no history of physical or sexual victimization. Mr. S had no physical medical problems and no history of neurological damage. Testing completed at PSH indicated Mr. S was at an average level of cognitive functioning.

Mr. S said that he had dated women but had never been in a long-term relationship. He had no children. He claimed that being in a relationship was not a priority for him but that he might consider it in the future. His hobbies included karate, martial arts, and weight lifting. He reported that he had strong religious beliefs and that he read the Bible.

Mr. S's juvenile record listed seven charges, two of which were for assault and battery. His adult criminal record listed 22 charges, 11 of which were for assault charges (e.g., assault and battery with a dangerous weapon-knife; assault to kill). Mr. S indicated such charges stemmed from fights with people he knew and that he always had acted in self-defense. Other charges he had incurred related to drug possession, trespassing, theft, and weapons possession (carrying a knife).

The index offense that led to the admission occurred when Mr. S entered a local restaurant, approached a police officer who was eating, and stated that he was the "viceroy" and wished to kill the officer. Mr. S was escorted outside, refused to leave, and continued to yell at the officer. Mr. S was then placed under arrest and punched both the arresting officer and another officer present in their stomachs. Throughout his hospitalizations at

HSFH and PSH, Mr. S had maintained emphatically that he was innocent and that the police set him up. When asked about possible effects related to substance use or mental illness, Mr. S reported that he was not drunk, not using drugs, and not experiencing active symptoms of mental illness when he was arrested.

Adjustment to Hospitalization and Recent Functioning (Past Six Months)

Mr. S's treatment team diagnosed him with bipolar disorder 1, mixed, in remission; polysubstance abuse, in a controlled environment; and cannabis abuse, in a controlled environment. According to his treating psychiatrist, Mr. S also displayed antisocial traits. Mr. S had been prescribed mood stabilizing and anti-psychotic medications throughout his hospitalization. Apart from one instance at PSH when he was caught spitting out pills, he had remained medication-compliant. Mr. S admitted that he typically stops taking his medication in the community and then becomes psychotic. He said that he would be agreeable to taking an injectable form of antipsychotic medication.

Mr. S's adjustment after admission to HSFH was poor. He was in two physical fights with peers during the first 3 months (it was clear that he instigated the assault on one occasion). He was caught trying to sneak off his HSFH unit using another patient's name; when confronted, he made aggressive threats to staff. He had no behavioral problems at HSFH during his last several months there and did not assault anyone at PSH. However, a consistent theme in PSH clinical notes was Mr. S's persistence in testing staff limits regarding ward routine/rules and hospital policies (e.g., smoking despite having his smoking privileges suspended). His treatment team often described him as being entitled, argumentative, irritable, intrusive, and demanding. He also was observed to become agitated easily, often yelling/swearing at staff and patients (particularly when his needs were not immediately attended to). Mr. S's community provider reported that he made repeated phone calls to her during the past few months and that he became angry and threatening when his demands (e.g., for cigarettes, money, take-out food) were not met. Although he had been in several arguments and verbal confrontations with peers at PSH, he remained in behavioral control with staff intervention.

Mr. S temporarily lost privileges because he delayed in providing a urine sample after being suspected of using drugs (the drug screen was negative). He denied using drugs at PSH but said that he planned to use marijuana when discharged. When asked whether doing so might impact him adversely insofar as it might increase the likelihood that he would go to jail, he responded, "Smoking pot is only a misdemeanor."

Consistent with Mr. S's self-report, his treatment team had not observed any symptoms of psychosis during the past 6 months. Mr. S admitted that

he had felt paranoid in the past but not for several years. When questioned directly regarding the statement he made to the police officer (i.e., that Mr. S was the "viceroy"), he clarified that he meant to say that he knew the "vice" of the "vice squad," which Mr. S described as being a local police drug unit. He said that the "vice squad" did not like him because "of all that [he had] done." With the possible exception of his references to the vice squad, Mr. S's recent and current thinking appeared to be reality-based. He denied having any recent or current thoughts or fantasies about violence in general, about hurting or killing another person, or about hurting or killing himself.

Although Mr. S attended physical fitness group regularly, he rarely, if at all, attended other groups included in his treatment plan. He was offered and declined the opportunity for vocational activity in the hospital (he reported his "bad back" prevented him from working). He did not attend substance abuse treatment and explained that he did not have a problem with drugs. When asked about his failure to attend intervention groups at PSH aimed at helping him manage his anger, he said he attended group once, but found it "boring . . . because there [were] lots of retardation people there." Mr. S added, "My anger is always going to be the same."

In discussing his behaviors that led to contacts with the police over the years, Mr. S presented an image of having led a life in which physical violence was a necessary and inevitable component of survival, including using violence for the purpose of maintaining one's reputation in certain circles. His violent behaviors have occurred both in the presence and in the absence of symptoms of mental illness and substance abuse. He admitted that he has peers in the community who engage in illegal behavior, such as selling drugs (although he denied having done so himself). Apart from three visits from his brother who lived in the area, Mr. S had no other visits or contact with his family or friends.

Plans for the Future

When asked what he planned to do if granted an increase in privileges, Mr. S reported that he would like to go to his brother's house (who uses marijuana regularly). He had no specific plans for obtaining a job when discharged to the community. At the time of the assessment, he received $200 per month in Social Security Disability Insurance. He did not know where he would live but was not agreeable to his treatment team's recommendation that he live in a halfway house type of setting. He reported that he plans to continue to use marijuana and to carry a knife as a matter of routine course when released to his "old neighborhood." He stated that he plans to continue to take his medication but admitted that he "might quit the meds." He did not want to attend any treatment programming, including substance abuse or anger management programs, because he did not believe that he had problems in those areas.

Psychological Testing

As part of the violence risk assessment, the *Psychopathy Checklist: Revised* (PCL-R; Hare, 1991, 2003) was administered. Mr. S's true total PCL-R score likely fell within the range of scores between 26 and 32, which indicated a clinically significant level of psychopathic characteristics. Mr. S's treating psychologist administered the *Personality Assessment Inventory* (PAI; Morey, 1991). Validity scales indicated that the PAI could be interpreted. Mr. S's highest scale score was on the scale that assesses drug use and the presence or history of problems that arise as a result of drug use. His second highest scale score was on a scale that assesses dominance. Overall, his pattern of responses was consistent with an impulsive individual who has negative attitudes toward authority. Persons with similar profiles are impatient, hostile, easily provoked, narcissistic, and grandiose. Notably, his responses indicated that he was not experiencing active symptoms of psychosis at the time of the testing.

Analysis of Risk of Violence Using the HCR-20

In the original violence risk assessment report, the HCR-20 was used to facilitate an evidence-based, structured professional case formulation regarding the presence of specific risk factors in Mr. S's case; how the risk factors were manifested for Mr. S; how relevant each factor was for Mr. S's previous violence and future potential violence; which risk factors were most salient or concerning for Mr. S at the time of the evaluation; and the type and intensity of intervention strategies (treatment, supervision, management, monitoring) judged most likely to reduce or manage Mr. S's risk factors. Because of space constraints, an abridged analysis is presented here.

All of the risk factors from the Historical scale (i.e., largely static, nonchangeable factors) were partially or fully present for Mr. S. These factors included the seriousness of his violence history, the early age at which he first engaged in violence, the absence of any long-term intimate relationships, problems with employment, substance use, having been diagnosed with a major mental illness, clinically significant psychopathic personality traits, factors related to his adjustment during childhood, maladaptive personality traits, and prior supervision failure.

With regard to current Clinical (i.e., dynamic, potentially changeable) risk factors, Mr. S evidenced some limited insight regarding his mental illness, displayed markedly negative attitudes related to law enforcement and criminality, and had a recent history of and potential for behavioral and affective impulsivity. Although Mr. S had responded to psychopharmacological interventions while hospitalized with significantly decreased symptoms, he had not been responsive to or cooperative with other attempts to provide risk-reducing interventions.

Ratings on the Risk Management scale should be made on either an "in" or "out" basis, reflecting whether a person will be in an institutional setting or out in the community during the time frame of relevance. Because Mr. S was being evaluated simultaneously for hospital privileges and discharge to the community, the future Risk Management factors were rated on both an "in" and "out" basis (full details not presented given space limitations). Mr. S did not have feasible plans to receive treatment or remedial programming in the hospital or community. Mr. S planned to place himself in situations in which he would be exposed to hazardous conditions to which he previously had proven vulnerable (e.g., spending time with his brother, a regular marijuana user). Mr. S, in the course of experiencing increased levels of liberty, likely would have been exposed to destabilizers in addition to drugs and alcohol that may have made adequate supervision more difficult (e.g., being in the community with likely exposure to criminal peer associates and his previous neighborhood where crime was more prevalent). He planned to carry a knife in the community, which was the type of weapon he used in past assaults. Furthermore, notwithstanding that he was in contact with his family, he lacked a substantial and well-developed basis of personal support. Mr. S indicated that he would comply with his medication in the community, but his commitment to this goal was questionable. He did not see a need to attend substance abuse or anger management groups.

As an example of how to consider the individual manifestation and relevance of an HCR-20 item, consider the risk factor item H5, Substance Use Problems. In terms of how the item is *manifested for Mr. S*, his drug of choice was marijuana, although he had used other drugs as well. Problems he had experienced as a result of substance use included working while intoxicated, being arrested for drug possession, and impairment in mental health functioning. In the past, his drug use tended to coincide with his medication noncompliance, which led to mood and psychotic symptoms. Substance use was *relevant to Mr. S's violence risk* because, as noted, it tended to coincide with psychiatric decompensation, and Mr. S previously had been violent under such conditions. His efforts to acquire and use drugs could be expected to lead to placing himself in potentially risky situations with antisocial peers where violence could occur. Substance use problems also were relevant to his risk of antisocial behavior more generally in that Mr. S planned to use marijuana, which indicated his intention to violate important aspects of his recommended treatment plan (or of a conditional release plan in states where such legal status is available).

A risk factor that Mr. S did not exhibit at the time of the violence risk assessment was active symptoms of mental illness. Since his admission to PSH, he had been compliant with psychopharmacological medications, and reported that he had been free of symptoms of psychosis and major fluctuations in mood. However, were Mr. S to stop taking his medications and

were his symptoms to become active again, his level of risk would increase accordingly.

There did not seem to be a primary explanatory factor associated with Mr. S's use of physical aggression. Although some of Mr. S's acts of violence appeared related to mental illness/medication noncompliance and/or substance use, other violent incidents were more properly attributable to his antisocial traits. He had been violent under a range of circumstances, including when compliant with medications, noncompliant with medications, sober, and intoxicated by drugs and/or alcohol. Mr. S had engaged in violence numerous times since he was an adolescent, and his use of violence had proven to be impulsive and life-threatening (stabbing). He had been violent both when incarcerated (at HSFH) and in the community; he planned to continue to carry a knife when discharged.

Based on the available information and given the overall pattern of risk factors, both in terms of lifetime presence and recent functioning, Mr. S's level of risk for violence in the community was judged to be high. It seemed apparent that he required services of a high intensity to address his cluster of primary risk factors. Although he presented with multiple areas of risk as outlined earlier based on his HCR-20 ratings, his risk was elevated primarily as a result of: psychopathic traits and antisocial attitudes; substance use and lack of motivation or intention to accept treatment; and the strong potential for noncompliance with psychotropic medication that was expected to lead to mood and psychotic symptoms. Importantly, most of these were dynamic risk factors that could be targeted by his treatment team for remediation and management during the balance of his admission to PSH (see Belfrage, Fransson, & Strand, 2004).

Recommendations to the PSH Treatment Team

The following recommendations regarding risk management, privilege level, and discharge were made to the treatment team contingent on Mr. S's mental status remaining as it was during the evaluation. Mr. S should be encouraged to attend his recommended programs, especially ones that addressed anger management and substance use issues. Because he appeared to be at a pre-contemplative stage of change, motivational interviewing may have been clinically indicated. Privilege increases were recommended to occur incrementally. At the time of the violence risk assessment, it was recommended that Mr. S be given unsupervised access to some locked areas of the hospital. If Mr. S continued to be psychiatrically stable, medication-compliant, and safe within these environments, his treatment team was encouraged to increase the length of time of his privileges gradually. Mr. S was recommended to have unsupervised access to all hospital grounds only after an extended period of accessing the locked areas without incident. Thereafter it was recommended that he be allowed supervised contact with

the community. Community privileges were recommended to begin with conditions of group supervision (e.g., staff-escorted trips to the bookstore or community treatment day programs). Once he had several incident-free supervised contacts with the community, it would be appropriate to grant unsupervised access to the community. Prior to doing so, it was thought that inviting his brother and sister-in-law to participate in a family meeting might prove useful.

We recommended that, once given any unsupervised privileges (within the grounds of the hospital or on a pass to the community), Mr. S be monitored closely and routinely, particularly for substance use and weapon possession. Examples of relevance to Mr. S included urine screens given randomly and close in time to periods of unsupervised access within the hospital/grounds and in the community. It was suggested that Mr. S could be asked in advance of a pass to consent to physical searches of his body and/or room upon return to the unit to look for weapons such as knives and shanks.

It was recommended that a reevaluation of violence risk should be conducted if any changes were noted in Mr. S's mental status, if he engaged in any major rule violations or violence, or if he experienced any major life changes. It also was recommended that a review be done prior to discharge to assess his status and any progress made as a result of treatment participation in the intervening period and progress with discharge planning (e.g., setting up a place to live). Finally, it was recommended that Mr. S be evaluated to determine whether he was an appropriate candidate for treatment with depot antipsychotic medication in the community.

DISCUSSION AND RECOMMENDATION FOR CLINICAL PRACTICE

The purpose of an SPJ tool such as the HCR-20 is to structure clinical decision making regarding the likelihood of violent behavior and the conditions under which violence might be expected to occur and to inform the identification of risk-reducing treatment and management strategies. The recommended steps for conducting a violence risk assessment using an SPJ tool (see Douglas, 2009) were followed in the case of Mr. S. Information was gathered about Mr. S using multiple sources and different methods (file review, collateral interviews, and direct observation). The adequacy of the information was evaluated (opinions presented in reports should be qualified in light of any critical missing information). Evidence for and against each HCR-20 item was written down and considered prior to making a rating. The presence of each factor and any changes in the factor over time were appraised. Importantly, the manifestation and relevance (or potential causal role) of each risk factor for Mr. S were considered. Each item also

was evaluated as to whether it was a "critical" item (an item that, on its own, compels a conclusion of high risk). The item description and scoring guidelines presented in the manual were reviewed for each item prior to assigning the rating.

Next, patterns among, clusters of, and associations between risk factors were considered. Then, items were weighted in the sense that some were considered relatively more salient or relevant for Mr. S than others (e.g., psychopathic traits, intention to carry a weapon). HCR-20 total scores were not presented (numeric estimates are not intended to be part of the SPJ approach; see Douglas, 2009). An overall risk level ("high") was assigned to reflect the judgment that Mr. S had a high level of need for intervention to manage his risk and that his case should be "prioritized" in terms of receipt of intervention strategies. Context-specific considerations were made that could affect the validity of the overall risk estimate (e.g., medication compliance or noncompliance).

In addition to offering an opinion about the likelihood of future violence (in terms of low, moderate, or high), educated estimates also could be offered regarding imminence (how soon will violence occur?); severity (what is the potential or anticipated degree of harm to a victim?); density (how much violence could occur?); nature (impulsive/reactive or instrumental violence?); likely targets (spouse, friends, strangers?); and weapon use (none, type, etc.). Next, flowing logically from the identification of the risk factors most relevant to Mr. S's risk at present, specific treatment, supervision, monitoring, and management strategies were identified and communicated in the report. Finally, recommendations regarding when a reevaluation was needed or what would trigger an immediate review were discussed.

It bears repeating that a final risk judgment of low, moderate, or high should never be presented in the absence of an explanation or justification, specified risk management plans, and time parameters regarding reevaluation. In Mr. S's violence risk assessment report, the rationale for the final risk judgment of high was explained based on the available evidence, including the number and individual relevance of risk factors. Persons at low risk have few risk factors present or few salient risk factors. Such individuals are not in need of any special intervention or supervision; there is no need to monitor the individual closely for changes in risk, and either no or low-intensity management/supervision is sufficient. For individuals judged to be at moderate risk, a risk management plan should be developed, and a method of ensuring reevaluation within a specified time should be implemented. For individuals at high risk, many risk factors or some critical risk factors are present. There is an urgent need for a management plan that incorporates high-intensity management/supervision, and regular reassessments are needed. Indeed, because the HCR-20 assesses risk factors for violence that are potentially amenable to change, it offers a systematic way to reassess risk whenever the decision-making context changes (e.g., inpatient versus

community residence) or if there are fluctuations in risk management issues (e.g., changes in social support, stress, noncompliance) or the severity of clinical factors (e.g., psychiatric symptoms, insight, impulsivity).

Because of its apparent simplicity and avoidance of quantifying behavior in the form of scores that can be interpreted with respect to norms, some commentators have assumed that the final risk judgment is subjective, unreliable, or invalid. Quite the contrary, a strong and growing body of research provides evidence that final risk judgments can be made by trained raters reliably. Moreover, in almost every study in which the predictive validity of the numeric total score has been compared directly to the final risk judgment, the categorical judgment performed as well as or better than (including incrementally better than) the total score (see Douglas & Reeves, 2010). The SPJ approach thus represents a scientifically grounded and empirically validated approach to assessing risk of violence. Moreover, its inclusion of dynamic risk factors that can be targeted for intervention to reduce or manage risk makes it a clinically useful paradigm in contexts such as that in which Mr. S was evaluated.

REFERENCES

Belfrage, H., & Douglas, K. S. (2002). Treatment effects on forensic psychiatric patients measured with the HCR-20 violence risk assessment scheme. *International Journal of Forensic Mental Health*, *1*, 25–36.

Belfrage, H., Fransson, G., & Strand, S. (2004). Management of violent behaviour in the correctional system using qualified risk assessments. *Legal and Criminological Psychology*, *9*, 11–22.

Douglas, K. S. (2008). The HCR-20 violence risk assessment scheme. In B. Cutler (Ed.), *Encyclopedia of psychology and law* (pp. 354–360). Thousand Oaks, CA: Sage.

Douglas, K. S. (2009, Winter). Assessing risk for violence using structured professional judgment. *American Psychology-Law Society Newsletter, 29*(1), 12–15.

Douglas, K. S., Blanchard, A., Guy, L. S., Reeves, K., & Weir, J. (2010). HCR-20 violence risk assessment scheme: Overview and annotated bibliography. Retrieved from http://kdouglas.wordpress.com/hcr-20/hcr-20

Douglas, K. S., Cox, D. N., & Webster, C. D. (1999). Violence risk assessment: Science and practice. *Legal and Criminological Psychology*, *4*, 149–184.

Douglas, K. S., Hart, S. D., Webster, C. D., Belfrage, H., & Eaves, D. (2008). *HCR-20: Assessing risk for violence* (*version 3, draft 1.0 Nov. 14, 2008*). Burnaby, BC, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Douglas, K. S., & Kropp, P. R. (2002). A prevention-based paradigm for violence risk assessment: Clinical and research applications. *Criminal Justice and Behavior*, *29*, 617–658.

Douglas, K. S., & Reeves, K. A. (2010). The HCR-20 violence risk assessment scheme: Overview and review of the research In R. K. Otto & K. S. Douglas

(Eds.), *Handbook of violence risk assessment* (pp. 147–186). New York, NY: Routledge/Taylor & Francis Group.

Guy, L. S. (2008). *Performance indicators of the Structured Professional Judgment approach to assessing risk for violence to others: A meta-analytic survey*. Unpublished doctoral dissertation, Simon Fraser University, Vancouver, BC.

Guy, L. S., & Wilson, C. M. (2007). *Empirical support for the HCR-20: A critical analysis of the violence literature*. Burnaby: Mental Health, Law, and Policy Institute, Simon Fraser University. Retrieved from http://kdouglas.files.wordpress.com/2007/09/hcr-20-report-2007.pdf

Hare, R. D. (1991). *Manual for the Hare Psychopathy Checklist–revised*. Toronto: Multi-Health Systems.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist–revised* (2nd ed.). Toronto: Multi-Health Systems.

Hart, S. D. (2008). *The structured professional judgment approach to violence risk assessment: Core principles of SPJ*. Paper presented at the annual meeting of the International Association of Forensic Mental Health Services, July 14–16, Vienna, Austria.

Hart, S. D., & Kropp, R. (2010). Structured professional judgment guidelines for sexual violence risk assessment: The Sexual Violence Risk-20 (SVR-20) and Risk for Sexual Violence Protocol (RSVP). In R. K. Otto & K. D. Douglas (Eds.), *Handbook of violence risk assessment* (pp. 269–294). New York, NY: Taylor & Francis Group.

Monahan, J., Steadman, H. J., Silver, E., Applebaum, P. S., Robbins, P. C., Mulvey, E. P, et al. 2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. New York, NY: Oxford University Press.

Morey, L. C. (1991). *Personality Assessment Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.

Webster, C. D., Douglas, K., Eaves, D., & Hart, S. (1997). *HCR-20: Assessing risk for violence, Version 2*. Burnaby, BC, Canada: Simon Fraser University.

Webster, C. D., Eaves, D., Douglas, K. S., & Wintrup, A. (1995). *The HCR-20 scheme: The assessment of dangerousness and risk*. Burnaby, BC, Canada: Simon Fraser University and British Columbia Forensic Psychiatric Services Commission.

Yang, M., Wong, S. C. P., & Coid, J. (2010). The efficacy of violence prediction: A meta-analytic comparison of nine risk assessment tools. *Psychological Bulletin*, *136*, 740–767.