Violence Risk Assessment in Everyday Psychiatric Practice

Twelve Principles Help Guide Clinicians

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Hy Bloom provided an expert psychiatric report in a multiple murder case in which the accused, who had schizophrenia and depression, had killed his wife and 2 children. Before the murders, the accused had been seeing a psychiatrist and family physician for treatment of the mental disorders.

The extensive media attention that the case received questioned, among other things, the care the accused had received from his family physician and psychiatrist. The press reported that shortly before the murders, the patient’s sister had informed the psychiatrist that her brother’s mental health had deteriorated, that he was psychotically preoccupied, and that he was behaving in a bizarre fashion. The accused’s sister specifically requested that her brother be hospitalized.

The court documents and expert reports, which became a matter of public record, stated that although the patient had been under a psychiatrist’s care for several years, the psychiatrist never spent any appreciable time with him. The evidence strongly suggested that the psychiatrist seemed to have had only a limited understanding (as reflected by his notes) of the seriousness of the patient’s psychotic symptoms and his potential to act out because of them. Whatever understanding he did have was never disclosed to the patient’s primary physician who, as it turned out, shared an office with the psychiatrist. The psychiatrist who assessed the accused after the arrest questioned whether the prescribed dosage of
medication could possibly have been expected to yield a therapeutic effect, especially after extended administration. Finally, there was considerable concern about the adequacy of charting in the patient’s file.

The court ruled that the accused was not criminally responsible (ie, not guilty by reason of insanity) for the murder of his family because of his mental disorders.

This case raises some questions that are important to all psychiatrists and other mental health professionals. Given the paucity of the psychiatrist’s meetings with the patient, it would seem unlikely that he could have probed for peculiarities in his patient’s thinking. However, the psychiatrist should have noted enough red flags to spark a thorough risk assessment. As the late eminent British psychiatrist Peter Scott pointed out, it takes time, persistence, and clinical acumen to gain the sort of information that is so essential to the complexities of a violence risk assessment. Scott believed that clinicians need an “elementary practical guide” to complete evaluations at levels of detail that are acceptable to professional bodies.

As is almost always the case with retrospective analysis of tragic outcomes, this case offers many lessons, which are encapsulated in the following 12 principles about risk and risk appraisal.

**Principle 1. Clinicians must be aware of the possibility of risks at multiple junctures in their patient’s life.**

Clinicians need to have an index of suspicion and, in some areas of psychiatric subspecialization, a high index of suspicion, about potential areas of risk. A critical eye needs to be applied to clinical work.

**Principle 2. Critical appraisal of essential information plays an important role in influencing clinical (and legal) decision making about a patient’s “dangerousness.”**

Assuming that a fuller, timely, “front-end” evaluation had disclosed that the threat was real or credible and that it could be enacted, the psychiatrist in this case failed to take steps to constrain his patient (eg, through voluntary admission to a psychiatric hospital, civil certification, or arranging for intense temporary supervision in the community).

Clinicians need to look carefully for clues to a change in a patient’s psychological or emotional status that could herald a decline potentially associated with danger. A penetrating and informed inquiry in patients deemed to be at risk is needed instead of relying on immediate situational threat appraisals used by police officers, personnel who work in emergency settings, and others. How to deal with such “hands-on” crises is a topic in itself.

**Principle 3. Risk assessments should be carried out under circumstances that are comfortable to both client and assessor (who must ensure the safety and security of all involved in the process).**
Evaluations that are conducted in busy hallways or holding cells are handicapped from the start. There needs to be some realistic chance of establishing rapport. Securing some measure of rapport between the examiner and evaluée and conducting the evaluation in an environment that is conducive to the discussion will greatly enhance the sharpness and overall effectiveness of the inquiry.

**Principle 4.** Assessors should have a working familiarity with the literature on violence risk assessment and management as well as its limitations.

Much of the scientific and professional literature on violence risk assessment and management has been summarized in recent books, and there is an easy-to-find compilation of recent key articles. Although perhaps a little technical, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* describes the largest North American study of released civil patients. It also provides the underpinnings for the Classification of Violence Risk, which was an attempt by the authors to create a computer analysis model for assessing an individual’s risk for violence. It is also useful for clinicians to acquaint themselves with the time-honored work of Hervey Cleckley, especially as formulated by Robert Hare (Psychopathy Checklist–Revised [PCL-R]) and Stephen Hart and colleagues (Psychopathy Checklist: Screening Version [PCL:SV]).

**Principle 5.** A thorough history is essential for the completion of risk assessments. The best predictor of future violence is past violence.

While Principle 5 is true, in recent years the Hare Psychopathy Checklist (which places strong weighting on violence history) has outperformed sheer violence history as a predictor. However, statistically based studies have emphasized repeatedly that active risk factors during childhood and adolescence tend to continue into late adolescence and adulthood. A cue to remember before conducting a thorough risk assessment is depth prevents death.

**Principle 6.** Although actuarial information is not often available to psychiatrists who practice outside mental hospitals and prisons, it should not be ignored if it has been properly consolidated.

One scale with an appreciable correlation between predictions and violent outcomes is the Violence Risk Appraisal Guide. Because of the established correlation, it is unwise to discount such statistically based risk appraisals if they have been or can be compiled—provided that the case corresponds with the essential characteristics of the standardization sample (ie, age, sex, previous violence, psychiatric history, etc). Evaluators will be interested to see whether their own analyses accord with the results of actuarial assessments. More generally, if the results do not match up, clinicians should be at pains to make sense of the discrepancy. Bear in mind that risk assessments are invariably about individuals. Incidents based on the performance of groups can inform the individual assessment, but they also have the capacity to obfuscate a decision when the consequences for the evaluée are or can be dire.

**Principle 7.** Structured professional judgment (SPJ) scales may assist in the assessment task.

In 1995, the Historical/clinical/ Risk Management–20 (HCR-20, V1) scale was published after extensive consultation with psychiatrists, social workers, correctional officers, psychologists, emergency department staff, and other colleagues. The HCR-20 uses a 0 (not present, or “no”), 1 (possibly present, or “maybe”), or 2 (definitely present, or “yes”) scoring scheme. What sets this scale apart from others is the division of items into past (10 items), present (5 items), and future (5 items).
The HCR-20 was reviewed positively for its potential by Borum.\(^\text{20}\) The review excited colleagues abroad who wanted to translate the HCR-20. However, Version 1 had some pretty obvious faults. One such failing was a too-strong reliance on some DSM-diagnostic categories for a few items. Version 2 was developed and the reworked scale was published in 1997.\(^\text{21}\)

The **Table** includes items from the current scheme. Note, however, that this is not a substitute for reading the entire manual carefully before attempting to use the guide. An up-to-date summary of the evidence for HCR-20 and its progeny can be located at [http://kdouglas.wordpress.com/hcr-20](http://kdouglas.wordpress.com/hcr-20). This topic was addressed in detail in 2 recent books and in a review article.\(^\text{7,8,22}\) The HCR-20 outperforms the PCL-R (or the 12-item PCL:SV) in prediction-outcome correlations. Although predictive power is never as high as might be wished, the HCR-20 improves substantially against chance.\(^\text{15}\)

There are other important items about the HCR-20 and similar scales. After the assessment, evaluators are asked to judge whether the potential for future violence risk against others is low, moderate, or high. The HCR-20 manual stresses that occasionally an individual will achieve a very low total numerical score, yet the assessor may still decide that the patient’s case is a high risk. Similarly, a case with a high score may not necessarily warrant a high-risk designation (eg, because the eventual untoward outcome is not expected to be particularly serious or because the risk is easily managed). In other words, unlike strict actuarial approaches, the clinician is left with the final say (presuming that the HCR-20 has been administered as intended).\(^\text{23}\)

Since 1995, roughly a dozen other SPJ scales have been published. There are scales that measure risk for spousal assault, sex offenses, and suicide. There are also scales that measure violence risk in boys and in girls younger than 12 years, in adolescents, and in persons remanded to jails.\(^\text{24-30}\) One scale measures a person’s potential for workplace violence.\(^\text{31}\) In this article, we have emphasized the Hare PCL-R and the HCR-20, but this is mainly for illustration purposes. Other scales are available.

**Principle 8.** Client strengths are important in creating plans for risk management.

There is increasing recognition of the importance of an evalee’s strengths and other protective and promotive factors. First, consideration of these factors provides a more global and fair appraisal of risk. Second, doing so allows for potentially greater liberty and derestriction.\(^\text{32,33}\) The **Structured Assessment of Violence Risk in Youth** departs from tradition by including a small number of “protective factors” (eg, prosocial involvement, strong social support, resilient personality).\(^\text{27}\)

Recently, this recognition was carried a step further in the Short-Term Assessment of Risk and Treatability (START).\(^\text{5}\) All 20 dynamic factors are rated for strength (on a scale of 0, 1, or 2) and risk (again, on a 0, 1, or 2 scale). In one jurisdiction, staff members invite clients to rate themselves on the START items. These opinions help mold a plan that is agreeable to all concerned.

**Principle 9.** Risk of violence against others usually provides a focus for assessment, but there are other interrelated issues that may need to be taken into account.
It might be necessary to assess risk for suicide, self-harm, self-neglect, the taking of unauthorized leave, the tendency to become victims of others, relapse into substance abuse, and so on. The START assesses all of these topics.

**Principle 10. Signature risk signs should be documented.**

Some patients consistently show signs that violence or other violence-related risks may be inevitable. For example, a patient might have his hair cut a certain way, put on particular items of clothing, begin to talk about religion excessively, and so on. These early warning signs, which are unique to each patient, can be crucially important in averting violence if they are understood and documented by staff. Evocative and volatile environments and the presence of a particular potential victim can incite a patient to express injurious behavior that he was managing before the catalytic agents entered the equation.

**Principle 11. All propensity for violence is not entirely inherent within the individual; rather, circumstances and situational effects also exert powerful influences.**

This older idea of violence propensity coming from within revolved around “dangerousness,” as if the person carried around a certain static quantum of this assumed entity. John Monahan’s Predicting Violent Behavior: An Assessment of Clinical Techniques\(^{35}\) helped change our thinking toward the idea that risk can vary with the person and the situation. It is probably true that scales such as the HCR-20 could place greater weight on situational variables than they presently do (item R2, destabilizers, catches some of it).

Scales are now being created around the situational measurement.\(^{36}\) This is a necessary development because it helps us determine whether we could be doing more to eliminate or attenuate violence and other related risks—by paying attention to policy, procedures, building design, organizational issues, staff training, and the like. Specific schemes exist that focus exclusively on systemic risk factors for workplace violence.\(^{37}\)

**Principle 12. It is often vital and reassuring to obtain a second opinion from a trusted and experienced colleague.**

Busy practitioners, even those who are able to spend adequate amounts of time with their patients, may need to avail themselves in some instances of that old, tried-and-true medical practice of seeking a second opinion. Transference issues remain very much alive. In therapeutic relationships, dangers can be overlooked, which later in the harsh lights cast by court hearings and inquests may well be noticed and dealt with.

**Conclusion**

It is not possible to make invariably correct assessments about violence and related risks. Some error is inevitable.\(^{35}\) Certainly, accurate evaluations cannot be completed in a few minutes or, in complex cases, a few hours.\(^{38}\) Yet by paying attention to these 12 principles, evaluators can reduce risks to society without imposing undue restriction on individual patients. Risk assessments require detailed, in-depth analyses of all factors—individual and systemic— relevant to the inquiry by informed, well-read, experienced, and committed evaluators.
Physicians appraise risks of all types in everyday clinical practice. We hope that these 12 principles will help guide and focus evaluations so that the most meaningful considerations concerning risk are brought to bear.

References


