The HCR-20 Version 3: A case study in risk formulation

Article *in* International Journal of Forensic Mental Health · May 2014

DOI: 10.1080/14999013.2014.906516

1 author:

Caroline Logan
National Health Service
54 PUBLICATIONS **1,319** CITATIONS

SEE PROFILE

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH, 13: 1–9, 2014

ISSN: 1499-9013 print / 1932-9903 online
DOI: 10.1080/14999013.2014.906516

Routledge
Taylor & Francis Group

The HCR-20 Version 3: A Case Study in Risk Formulation

Caroline Logan*

Greater Manchester West Mental Health NHS Foundation Trust, Manchester, United Kingdom; Psychology Department, University of Manchester, Manchester, United Kingdom

The third edition of the HCR-20 (HCR-20^{V3}, Douglas, Hart, Webster, et al., 2013) consolidates essential recent thinking about risk assessment and management using the structured professional judgement approach. As with the preceding *Risk for Sexual Violence Protocol* (Hart, Kropp, Laws et al., 2003), risk factors for violence are now assessed for their relevance as well as presence, scenario planning has a central place in anticipating the nature, severity, imminence and likelihood of future harm, and risk management strategies must incorporate a combination of treatment, supervision, monitoring and victim safety planning interventions and recommendations. However, the key process now proposed for linking the assessment and overall management of risk is risk formulation—the act of understanding the underlying mechanism of an individual's harm potential in order to develop sensitive and proportionate hypotheses to facilitate change (embodied within the risk management plan). In this paper, the process of risk formulation is described and illustrated with a case study—Paul. A brief report of the risk assessment, formulation and management recommendations for Paul illustrate the key features of what is recommended in the new version of this internationally renowned violence risk guide. However, empirical research into risk formulation remains outstanding.

Keywords: HCR-20 version 3, violence, risk, risk formulation, case study

What's New From a Practitioner's Perspective?

The long-awaited third edition of the HCR-20 violence risk assessment guide (Douglas, Hart, Webster, & Belfrage, 2013) was officially launched at the Royal Society of Edinburgh in Scotland in the spring of 2013. As with the preceding version, published 16 years earlier (Webster, Douglas, Eaves, & Hart, 1997), version 3 looks set to become the most commonly used and valued set of clinical guidelines for violence risk assessment and management with men and women in community, correctional, and forensic mental health settings throughout the world.

The HCR-20 version 3 (HCR-20^{V3}) represents a considerable improvement on version two; HCR-20^{V3} has more in common with the *Risk for Sexual Violence Protocol* (RSVP; Hart et al., 2003) than it does with its earlier incarnation. Both the HCR-20^{V3} and the RSVP exemplify the structured professional judgement approach to clinical risk assessment and management, which is a very practical and practitioner-focused approach to the task of violence prevention. From the perspective of the practitioner, what is new about HCR-20^{V3} compared to version two? And what is new about the HCR-20^{V3} compared to the RSVP?

First, all 20 HCR risk factors have been updated with new research, and in many cases, new titles also. Several items have been amended substantially such that they are clarified and improved (e.g., H1, *history of problems with violence;* C2, *current problems with violent ideation or intent;* R1, *future problems with professional services and plans*). Several items are so amended or incorporate such a lot of new material that they are effectively new items (e.g., H2, *history of problems with other antisocial behaviour;* H9, *violent attitudes;* R2, *future problems with living situation*). In addition, the key concepts of violence, risk, assessment and management are more elaborately defined compared to previously, and the complete process of risk assessment and management more clearly explicated, organized, and operationalized in a multi-page scenario-planning

Address correspondence to Caroline Logan, Psychology Department, Edenfield Centre, Prestwich Hospital, Bury New Road, Manchester, M25 3BL, United Kingdom. E-mail: caroline.logan@manchester.ac.uk

worksheet. However, while these changes are substantial and positive, the items are not so dissimilar to those of version 2 of the HCR-20 as to make HCR-20^{V3} categorically different risk assessment and management guidance.

Second, each (revised) item in the HCR-20^{V3} now includes a full definition of the risk factor featuring guidance on why it is potentially relevant to future risk for violence and options to specify the nature of the risk factor as it presents in the individual (e.g., the range of ages or types of relationships in which the problem has been present, as in items H1 and H3 respectively). In addition, the revised text for each item now includes indicators or examples that may be used by evaluators to help them to decide whether the characteristic or problem is present and the form of its presentation in the individual being evaluated. Also, the text for each item now includes a set of coding notes to assist the evaluator in qualifying the presence of each risk factor. Therefore, the process of assessing each item enables much greater detail as well as clarity in the mind of the evaluator about exactly how the risk factor manifests itself in the evaluee.

Third, and consistent with the RSVP, evaluators are required to rate both the presence and the relevance of each risk factor to the harm potential of the person being evaluated. Relevance refers to '*the extent to which the factor is critical to the evaluator's formulation of what caused the evaluee to perpetrate violence and how best to prevent future violence*' (Douglas, Blanchard, & Hendry, 2013, p. 50). For example, a young man the author assessed recently had a history of cocaine dependence, yet he had never been violent when he was under the influence of cocaine or when he was withdrawing from it or in the act of its procurement. Therefore, he has a history of problems with substance use—the risk factor is *present*. However, cocaine dependence did not feature in his past violence and is unlikely to be a factor determining his violent conduct in the future—he does not need to be influenced by cocaine in order to be violent, making this risk factor *not relevant* to his future harm potential. This process of determining the relevance of risk factors to the person being assessed ensures individualized assessments based on sound empirical foundations.

Fourth, and also consistent with the RSVP, practitioners are asked to scenario plan the future violence of the clients they are evaluating. That is, they are asked to forecast the nature of the person's possible future violence, its severity, imminence, frequency or duration, and likelihood of occurrence. By characterizing potential harm in this way, evaluators are forced to be specific about those harmful outcomes about which they are most concerned. The essential scenario planning exercise leads directly to risk management arrangements based on the scenarios identified, enabling in turn interventions and recommendations that are more proportionate to the risks identified and against whom and over what time frame. Final opinions are required in respect of case prioritization—and not overall level of risk, which is too blunt a judgment—the specific risk of serious physical harm to others, the imminence of harm, the frequency of review, and the nature of any other risks indicated (for example, harm to self).

However, the final and most important difference between the HCR-20^{V3} and both the HCR-20 version 2 and the RSVP is the explicit requirement to develop a risk formulation. This activity binds—or weaves—together the most important relevant strands of the individual's harm potential into an explanation for *why* that potential exists. This process, in combination with scenario planning, makes for the most potent driver of individualised and meaningful risk management plans.

Focus on Formulation

Individuals who are not well understood—whose actions challenge our understanding—are not risk managed with focus, clarity of objectives, or confidence, and restrictive interventions are more likely to prevail as a consequence (Logan, Nathan, & Brown, 2011; Reid & Thorne, 2007). The process of formulation offers a means by which such an understanding may be acquired. However, until we can set down what are the core or basic features of formulation and how a formulation is developed, this essential step towards managed risk may be skipped, undertaken too briefly or superficially, or overdone such as to limit the usefulness of the resultant product to the task of intervention (Eells, Kandjelic, & Lucas, 1998; Hart, Sturmey, Logan & McMurran, 2011; Nezu & Nezu, 1989; Persons, 1989; Tarrier, 2006). Indeed, until there is such clarity about the task required, formulation may remain more science fiction than science fact (Bieling & Kuyken, 2003).

Formulation has a number of functions (Hart & Logan, 2011). First, it is a process intended to organize information in order to create a platform from which an understanding of violence potential may be generated. Second, it is intended as an opportunity to create an understanding that is agreed between the evaluator and the client. That is, the understanding communicated in the formulation is at least to some degree shared by the evaluator and the evaluee. This mutual understanding is not always possible—the client may refuse to engage in the evaluation, or may wholly disagree with one or more of the key tenets of the explanation proposed. Nonetheless, the process of trying to reach some form of agreement about past and future harm potential allows for continued efforts at dialogue and some agreement, however tender.

Third, formulation is the evaluator's opportunity to make connections between pieces of information relevant to the outcome to be prevented—the process of weaving together different strands of the overall explanation. For example, formulation is the evaluator's opportunity to explain why the client's borderline personality disorder

creates the potential for him or her to be violent towards those who are perceived to be abandoning or rejecting of the client, especially when experiencing unstable emotions and/or substance abuse. Fourth, formulation should be the springboard for intervention—it should be the individual theory of the client's harm potential that creates hypotheses about the generation of change. Thus, if a client's violence is in the main triggered by command hallucinations that the client feels compelled to obey, more so when they have been refusing treatment and engaging in substance misuse, interventions should consist of relationship-building between the client and treatment providers, information about the value of treatment over other destabilizing activities, and treatment itself in the form of a combination of medication and psychological therapy such as CBT for psychosis. Implementing such interventions, and monitoring change allows the testing of the hypotheses and the validation of the formulation. Finally, therefore, the formulation is a means of communicating the most important—risk-relevant—information about the client. To read a risk formulation should be to understand the client's risk (what he or she seeks to achieve by violence) and for that understanding then to be shared by multiple practitioners and by the client him- or herself.

The key task on beginning the formulation process is organizing the most relevant information available about the problem to be prevented. As discussed in Hart and Logan (2011), there are a number of organizational frameworks available to achieve this. Beginning with the most relevant risk factors identified at the start of the HCR-20^{V3} process, this information can be arranged in accordance with the 5Ps model (see Weerasekera, 1996): *p*roblem (that is, risk of what?), *p*redisposing (or vulnerability) factors, *p*recipitating factors (or triggers to harm), *p*erpetuating (or maintenance) factors, and *p*rotective factors. Clarity about the answer to the risk of what? question is the essential first step. Open answers such as 'violence' are to be avoided in favor of more specific statements such as 'physical violence towards intimate partners and/or providers of care.' Clarity, too, about the range of answers to the risk of what? question will be a guide as to how comprehensive risk management will require to be; multiple possibilities for violence will point to the need for a more extensive risk formulation and management plan.

In respect of predisposing factors, the most relevant Historical (H) items will appear here. Relevant Clinical (C) and Risk Management (R) items may also feature here too if problems with insight and instability and personal support and so on are persistent as well as relevant currently and in the future. Once listed, the evaluator is encouraged to look for risk factor clusters, that is, for the most critical risk factors around which other risk factors coalesce (Douglas, Blanchard, & Hendry, 2013). For example, consider a client who has personality disorders consistent with an antisocial and borderline presentation, that is, he has pervasive antisocial attitudes and beliefs in addition to markedly unstable impulse control, emotions, and relationships with others. If this risk factor (H7) is both present and relevant to his future potential for violence, it is to be expected that a number of other risk factors will be present and relevant also because of the nature of the problems generated by such personality dysfunction. That is, it might be expected that he would also demonstrate problems with antisocial behaviour generally (H2), relationships and employment (H3 and H4), and so on; he has problems in these areas *because* he has severe personality problems. These risk factors therefore cluster with personality disorder being the critical or driving one—the root cause of this cluster of problems. This process of clustering allows a long list of relevant risk factors to be reduced down to a more manageable but detailed, even hierarchical list of maybe four or five determining or critical risk factors.

Moving on to precipitating factors or triggers, the HCR-20^{V3} assessment process will have provided a lot of detailed information the evaluator may draw from in order to understand those short-term variables or acute difficulties or problems that trigger a change in risk or 'switch risk on'—C and R items may be especially relevant here. Evaluators are invited to consider all the clients they have assessed who were regarded as high risk, yet they have felt quite safe sitting in the room with the client. What would have to be present—or absent—to make the evaluator fear for their own safety or for the imminent safety of others? An example of a trigger might be an evaluee's disturbed perceptions about the intentions of specific others towards them, which may be so disturbed because the client is acutely psychotic or because he or she is intoxicated. Other examples might include conflict with another person that the evaluee feels unable to resolve, or emotional states or labile emotions that he or she finds intolerable and unrelenting and that lead to impaired decision-making and impulsive behavior. The identity of the triggers most relevant to an individual client will be obtained from understanding the predisposing factors, analyzing the client's past harmful behaviors and identifying triggers on each occasion, asking the client what it would take for them to be harmful again in the future, and thinking through violence scenarios involving the client, which will be considered in more detail shortly.

Perpetuating factors are the subset of predisposing factors that have to be worked around in a risk management plan, the characteristics of the individual or his or her situation that will not change in the short- or even medium-term, or easily. Examples of perpetuating factors may include the client's severe personality disorder (H7) or intellectual disability (H6), both of which would be major considerations in the design of a risk management plan.

Finally, protective factors are those strengths or attributes the individual usually draws on to help them to manage risk factors, which can sometimes fail them resulting in a

change in their risk of harm to others under some circumstances. Protective factors are those variables that usually make the client safe, and might include their good or improving attitudes towards medication or the involvement of treatment or supervising agencies, a supportive family member, stable accommodation or finances, someone they have to care for, a job they like, even the containment of prison or hospital or legal sanction. The *Structured Assessment of Protective Factors* (SAPROF; de Vogel, de Ruiter, Bouman et al., 2012; de Vries Robbé & de Vogel, 2013) could be used to structure thinking about protective factors. However, a good clinical interview with the client, enabling enquiry about what works and the detection of often very delicate circumstances that make the difference between acting harmfully against another person and not, can be just as if not more informative.

The 5Ps model is an attractive way of organizing risk-relevant information for a number of reasons. First, the emphasis on including protective factors in the framework is consistent with the recovery model and with efforts to rehabilitate offenders rather than punish them (e.g., Drennan & Alred, 2012). Emphasizing protective factors encourages practitioners to see the development of more potent and abundant safeguards against harmful activity to be as much their responsibility as the weakening or removal of risk factors. Second, there is a direct way into this system of organising risk relevant information from the findings of the HCR-20^{V3} assessment stage; relevant risk factors may be considered in terms of their role as predisposing factors meaning that subsequent considerations, about precipitating (trigger), perpetuating (maintenance) and protective factors, emerge from this empirical base.

However, this is only one of several possible ways of organising information as the first stem in the production of a risk formulation. A prominent alternative model is the so-called 3Ds model—*d*rivers, *d*estabilizers and *d*isinhibitors (e.g., Johnstone, 2013; Hart & Logan, 2011). This model overlaps somewhat with the 5Ps model in its consideration of disinhibitors (which are not dissimilar to predisposing factors) and destabilizers (similar to precipitating) factors. However, the most attractive component of this organizational framework is its emphasis on motivators or drivers: what does a person expect to achieve by being violent, or *why violence*? Drivers for violence could include its use to gain material goods, influence, or power over others, to enhance or maintain social status, to promote or ensure personal safety, or as a way of bringing about change. By thinking about drivers, the evaluator attempts to access directly the client's psychological needs that he or she has come to believe violence might address.

Organizing risk relevant information using one—or a combination—of these two or any other organisational model (see Hart & Logan, 2011) sets the evaluator up to prepare his or her formulation of their client: with the information so organized, the evaluator is better able to understand the decisions the client has made to be violent in the past and then to appreciate the circumstances under which he or she may again make the decision to be violent in the future, and to prepare this understanding in a narrative form. The focus on past violence is important; the map it provides is invaluable in determining the route or routes the client may take in the future. However, it is the essential process of scenario planning that focuses the evaluator on these *future* possibilities and makes the assessment truly a risk assessment relevant to the prevention of future harm (Hart & Logan, 2011). Scenario planning involves the evaluator plotting the different kinds of harm the person could perpetrate in the future based on the knowledge gathered about the ways in which they have been harmful in the past. The HCR-20^{V3} worksheet supports the evaluator to think through the different scenarios—definitely more than one—in terms of their nature, severity, imminence, frequency/duration, and likelihood. Future scenarios might include the kind of harm they have perpetrated against others before (that is, he or she does again what they have done previously), an adaptation of their harmful behavior because their circumstances are different (for example, how they might be harmful in prison when they were harmful previously in the community), what their harmful behavior would look like if it escalated (worst case scenario), and what their harmful behavior would look like if in fact it was on a harm-reducing trajectory (for example, if they were responding to treatment and their violence became less severe or less frequent, a best—or better—case scenario).

At this point, having collected, organized and considered information relevant to the harm potential of an individual towards others, it is possible for the evaluator to begin writing the risk formulation, the narrative statement that explains the underlying mechanism of the client's violence. This statement needs to be simple, coherent, informative, and to address the likely causes of *this* client's behavior, to be underpinned by the evaluator's knowledge of the violence and other relevant literatures, to link the relevant pieces of the story (for example, the 5Ps or the 3Ds), to offer guidance on the developmental origins and trajectory of the problem, and to be such as to generate testable hypotheses for action to bring about change (Hart et al., 2011). These hypotheses, organized into treatment, supervision, monitoring, and victim safety plans, comprise the risk management plan.

A Note on the Relevance of Interviewing Skills to Formulation

Clinical interviews in forensic settings, especially with clients who have personality pathology, present practitioners with challenges rarely experienced by those working with mentally ill clients or in non-forensic settings (Meloy, 2005). For example, evaluators must gather relevant information relating to subjects that the client is often reluctant

to talk about in detail (e.g., risk-taking behavior, offending behavior, plans, and fantasies) because they know the information they provide will probably be used against them. Also, where the evaluee is the subject of a forensic clinical evaluation, they are not the principle 'customer'—the assessment and treatment of forensic clients is frequently at the request of courts, parole boards, or multi-agency public protection agencies. Therefore, confidentiality is limited or non-existent. Motivating the client to engage in clinical interviews and to provide information or evidence for the presence—or absence—of the experiences highlighted can be a substantial component of the time taken to undertake them.

The diverse demands placed on practitioners interviewing ambivalent, reluctant or even hostile clients require the flexible application of many clinical skills (Meloy, 2005). Yet in spite of this, clinical interviewing skills are a modest component of most professional practitioner training courses. Consequently, the specialist skills required by practitioners working in forensic settings are often only acquired through experience—trial and error—and are dependent on the lottery that is the availability of good quality clinical supervision by a more experienced practitioner. This situation is unfortunate and increases the risk that clinical interviews in forensic settings will not achieve the outcomes envisaged by practitioners, regardless of their skills in more general clinical interviewing techniques and in specific assessment and therapeutic processes.

Attention has been paid in the literature to forensic interviewing skills (Ackley, Mack, Beyer, & Erdberg, 2011) and to clinical interviewing skills (e.g., Shea, 2007). There is less available on the combination of the two, although some publications do exist (e.g., Meloy, 2005), and a smaller number specific to the task of forensic clinical interviewing in relation to risk (e.g., Logan, 2013). It is not the purpose of this article to go into detail on the skills required to interview clients in forensic settings competently, considerately, and successfully. However, the importance of the message—that practitioners must not neglect the specialist techniques required to extract risk-related information from their clients—is made here.

Concluding Comments

In this section, the important changes and innovations of HCR-20^{V3} have been described, and the central role of risk formulation in understanding and managing risk has been emphasized. More will be said at the end of this article about the future of formulation and its evolution from a somewhat mysterious undertaking into an empirically validated and explicit process. However, the application of the HCR-20^{V3} will now be illustrated in the form of a case study in which the findings would be described in a report to the referral source.

A CASE STUDY: PAUL

Paul is a 40-year-old single man with a number of convictions for violence towards others. Currently, he resides in supported accommodation, which has staff available 24 hours a day to assist residents with their everyday mental health needs and activities of daily living. Paul has a mother, two siblings, and an adult son, none of whom he has regular contact with; Paul has alienated all of his family due to serious and repeated but unsubstantiated accusations of abuse and neglect. At the time of assessment, Paul's main social contacts were a small group of men and women who were known and active substance abusers. Paul has formal and current diagnoses of borderline and antisocial personality disorders and a past diagnosis of substance dependence, and he is cared for by a community mental health team because of the difficulties arising from his personality disorder diagnoses—specifically, regular and acute episodes of low mood concurrent with alcohol abuse. Paul has been unemployed and in receipt of government disability benefits for many years.

Paul's first offense of violence took place when he was 23years old and resulted in a conviction for wounding. Here, the victim was a younger male, whom he hit on the head with a brick. Paul received a sentence of 20 months' imprisonment for this offense, which was his third period of detention following two earlier periods in young offenders' establishments following convictions for acquisitive crimes. Paul's second offense of violence took place when he was 34years old, when he assaulted a police constable by punching during the course of an arrest. Paul was given a community order with supervision for this offense. His third offense of violence was when he was 35years old. This offense was a racially aggravated common assault for which he received a suspended sentence and supervision. The victim of this offense was a young male of African origin to whom Paul shouted racial abuse before punching him. His fourth and fifth convictions for violence were when he was 38 years old, when he was convicted first of using threatening or abusive language and, subsequently, of battery when he assaulted a middle-aged female when he was drunk. He was sentenced to three months in prison for this latter offense. Paul's most recent conviction for violence was when he was 39 years old and he was convicted once again of assaulting a police constable during the course of an arrest. This offense was committed when he was on bail and he was given a supervision order in punishment. In addition, Paul has many convictions for offenses of property damage, acquisitive offenses, driving offenses, and failure to surrender to police custody. He also has five convictions for drug-related crimes (possession and supply, last conviction for such a crime when he was 26 years old), as well as many other convictions for offenses of property damage, acquisitive offenses, driving offenses, and failure to surrender.

Paul's most recent conviction was when he was 40 years old, for theft.

Paul was referred to a psychologist for a risk assessment following a physical fight with the other residents of his supported accommodation, during which he threatened a member of staff with a piece of a dinner plate, which he had deliberately broken against a wall.

Risk of What?

Paul is at risk of harming another person physically. He has multiple convictions over a long period of time for violence, which attests to his capacity for harmful conduct. Paul self-reports more violence than he has received convictions for, and he reports urges to be violent when angry or intoxicated, when his control over his behavior is more limited. Paul is specifically at risk of harming those with whom he lives, including staff and his peers, when they highlight to him deficits in his self-care and housekeeping and in his manner of relating to them. However, Paul is also at risk of harming himself. He has overdosed on numerous occasions in the past, mostly with suicidal intent, which on one occasion led to his treatment in intensive care.

Risk Assessment

What appear to be the main predisposing (vulnerability) factors or drivers for Paul's risk of harm to others? Paul's personality presentation suggests a pattern of poor impulse control and instability (which has, however, been better since he significantly reduced his drinking two years ago), negative or antisocial attitudes, very limited personal support from prosocial family and friends, prior supervision failure and poor treatment response, poor planning ability, limited insight, and relationship instability. His problems with anxiety make him vulnerable in the face of challenge—he destabilizes easily due to a limited repertoire of coping strategies—and he has a history of using very poor ways of coping with stress (e.g., alcohol). Paul's history of violence, as much as it is understood presently, is such that it can be anticipated that he is capable of violence again in the future given his reliance on it in the past, both in terms of action, threat, and fantasy.

Table 1 provides a summary of ratings given in relation to the presence and relevance to Paul of each HCR-20^{V3} risk factor.

Does any single instance trigger an actual episode of violence? This is not completely clear, as Paul's recollections were not very coherent. But it appears he is certainly motivated to think about violence towards (1) people whom he thinks act disrespectfully towards him (e.g., treat him like he is not clever, or ignore him when he thinks he should be attended to), (2) people who annoy him, and (3) when his emotions are unstable and/or low (as they are when he experiences conflict in his relationships with others). In the past, Paul has been much more sensitive to these triggers when he has been intoxicated.

Prior to the recent incident during which he challenged a member of staff in his accommodation with a broken piece of dinner plate, Paul had not been harmful towards others for some months. It appears he can go for several weeks at a time not being harmful towards others. What can work protectively to prevent Paul from being harmful? It would appear that what works to protect Paul from harming others is (1) that he says he doesn't want to hurt other people now as he is no longer that kind of person; (2) he appears to be mainly abstinent from alcohol, which is lending his life a great deal more stability than he had previously when drinking; (3) his supported accommodation; (4) medication, to stabilize his mood, and with which he is mainly compliant; and possibly also (5) a lack of easy access to the means by which he would prefer to harm others and himself, namely bladed weapons.

TABLE 1
Summary of Ratings Given in Relation to the Presence and Relevance to Paul of Each HCR-20^{V3} Risk Factor

HISTORICAL FACTORS: History of problems with . . .	*Presence*	*Relevance*
H1. Violence	yes	high
H2. Other antisocial behaviour	yes	high
H3. Relationships	yes	high
H4. Employment	yes	low
H5. Substance use	yes	high
H6. Major mental disorder	no	low
H7. Personality disorder	yes	high
H8. Traumatic experiences	yes	high
H9. Violent attitudes	yes	high
H10. Treatment or supervision response	yes	high
Other historical risk factor(s)	none	
CLINICAL FACTORS: Recent problems with . . .		
	Presence	*Relevance*
C1. Insight	yes	high
C2. Violent ideation or intent	yes	high
C3. Symptoms of major mental disorder	no	low
C4. Instability	yes	high
C5. Treatment or supervision response	yes	high
Other clinical risk factor(s)	none	
RISK MANAGEMENT FACTORS: Future problems with . . .Context = OUT (community)		
	Presence	*Relevance*
R1. Professional services and plans	possibly	possibly
R2. Living situation	possibly	high
R3. Personal support	yes	high
R4. Treatment or supervision response	yes	high
R5. Stress or coping	yes	high
Other risk management factor(s)	None	

Risk Formulation

Paul is at risk of being violent again in the future in situations in which he feels (1) criticized—or disrespected or disbelieved—or (2) powerless and out of control of the events going on around him and his thoughts and feelings. Why? Because such circumstances challenge Paul's limited repertoire or range of coping strategies, increase his level of arousal, fear and anger, and make worse a sense of himself that is fragile and incomplete, creating negative feelings which he cannot tolerate. Violence or the threat of violence seems like an effective way of making him feel powerful and effective in situations in which he feels powerless and ineffective. When intoxicated, or in the context of multiple compounded stressors (such as conflict with others or when also worried about money or the security of his accommodation), when integrated with an antisocial or substance-abusing peer group, and in the absence of consistent risk management, Paul is likely to perceive criticism more frequently, from more sources (people), and in a wider range of circumstances. In addition, Paul is likely to react more extremely, especially if he has the means with which to harm someone seriously (such as a knife).

Paul has a history of violence in the course of a lifetime of a range of antisocial behavior, which commenced in his mid-teens and is on an escalating trajectory in terms of its density. Early difficulties in his upbringing—caregiving problems and inconsistencies, real relationship problems and traumatic experiences—generated over time personality attributes in Paul, such as identity disturbance, unstable mood and cognition and behavior, poor impulse control, that have left him poorly equipped to cope with the challenge of adult life and to be reliant on substances, mainly alcohol now, to help him try to cope. He has little awareness of his problems and of how to avoid them or manage them when they arise. However, it is notable that when Paul has been in receipt of a good supervision regime, this has offered invaluable support and stability. Therein will lie the key to the management of his risk of future violence.

In respect of Paul's risk of harm to himself, the factors that appear to point him towards self- rather than other-directed harm are the same risk factors as above in addition to more prominent low mood paired with shame. That is, Paul appears more likely to want to harm himself when he feels destabilized and powerless, at the same time he is sad for himself and hopeless about making his life better.

Risk Management Plan

The key components of a risk management plan are treatment interventions, supervision, monitoring, and victim safety plans. In terms of risk management, treatment needs are defined as treatment or rehabilitation strategies intended to moderate risk factors or enhance protective factors; that is, interventions intended to repair or restore deficits in adjustment and functioning that have been linked to harmful behavior in the past.

In terms of treatment strategies for Paul, direct interventions should continue to try to address his problem drinking in order to try to encourage total abstinence. Such strategies should utilize very practical cognitive-behavioral therapy (CBT) strategies to support symptom management. Direct interventions to address his mood and its management, or to address his beliefs about himself, are trickier. Paul reacted with fear and alarm at the supportive intervention attempted by a counsellor, and encouraged this counsellor to withdraw the offer of treatment because of a direct threat of violence. This intervention may have triggered feelings of shame or embarrassment in Paul, with which he appeared quite unable to cope. Therefore, interventions in the future should address the consequences of his disorders (e.g., falling out with his peers) and the basic management of these consequences through attention to their presence and the minimization of the distress they cause, and their avoidance if at all possible. And CBT strategies to manage such problems would be best of all as they are practical and superficial, and rely on his cooperation to generate, which may make him feel more in control.

However, the most effective forms of risk management for Paul would appear to be a combination of supervision and monitoring. In terms of risk management, supervision needs are defined as restrictions on activity, movement, association, or communication that are intended to control risk factors—to limit Paul's opportunity to be harmful—as well as enhancements to his lifestyle in the form of structure, boundaries, and role expectations, intended to promote the effectiveness of protective factors. That is, because Paul finds it a challenge to address directly the need for change and to internalize lessons offered about ways of changing, risk management is most effectively delivered by imposing it on him. Therefore, a key supervision strategy is intensive support (such as that offered in his current accommodation and, on occasion, when he is an inpatient in a mental health service), which serves to contain his instability, help normalize his interpretations of the conduct of people around him, and manage his emotions in an adaptive way. Providing Paul with this form of support then offers mental health services excellent opportunities to monitor him, allowing more rapid and effective efforts to adjust his stability when things seem to be starting to go awry.

In terms of risk management, monitoring needs are defined as those early warning signs that are an indication of a relapse to harmful behavior or any other indicator of a change in risk. Monitoring strategies, therefore, attempt to address triggers to violence in order to ensure their early detection and management. Paul's drinking should be monitored most closely as per the routine monitoring arrangements for a periodic problem drinker of his kind. Contact with mental health practitioners will also offer the opportunity to detect changes in his interest in drinking, in his

physical health (for evidence of cuts or bruises suggestive of fights with others), his social network, his interest in hurting people, and his carrying of weapons. Also, if he attempts to commence an intimate relationship with a woman, most likely someone with mental health problems like himself, the potential for his destabilization will increase, as will his need to access sources of support. While the first three items above may be detected by observation and routine questioning, the latter two items—and a relationship—will most likely have to be probed for via direct questioning.

As regards victim safety plans, these could be prepared if and when Paul makes known his associates and indicates the existence of conflict between them. Alternatively, if he makes it known that he is in a relationship, especially if his partner has mental health problems or a history of substance misuse, this too would be an opportunity to monitor risk of harm to her and self-harm in Paul.

Summary Opinions

Paul was referred for a risk assessment because of a recent escalation in his violent conduct, which put at risk his supported accommodation. The findings of the assessment suggest that violence was and remains a way in which Paul protects himself from both perceived threat and confusion about the intentions of others towards him. There is an urgent need, therefore, to work with Paul to assist him to make more clear his wishes and fears, in order for him to utilize alternatives to violence and the threat of violence when distressed. Given his history of violence and his familiarity with the use of weapons, his potential to cause serious physical harm should not be underestimated. Urgent action is required in the form of this negotiation with Paul, which he appears motivated to engage with, as he does not wish to lose his place in his current supported accommodation.

Paul is also at risk of harming himself when he is hopeless about the prospect of positive change and about his control over his life and the direction it takes. Risk of harm to himself is dictated by many of the same risk factors as his risk of harm to others. However, the salience of feelings of hopelessness, guilt, shame, and sadness make it more likely that he will direct his harm towards himself; harm towards others is more likely to follow from feelings of anger and resentment.

CONCLUSIONS AND RECOMMENDATIONS

The HCR-20^{V3} represents an invaluable improvement on its predecessor. The focus on risk formulation—the exploration of the underlying mechanism of a person's potential for violence—is key to this improvement, because of its direct link to more sensitive and proportionate risk management recommendations. However, can this direct link be demonstrated? Is there really an evidential link between the existence of a risk formulation and an effective risk management plan? At the time of writing, the answer to this question is no, but it is thought likely that the answer to this question will be known soon.

Hart et al. (2011) proposed a model for evaluating the quality of risk formulations. Such a model requires that risk formulations be simple, coherent, and informative; that they address the likely causes of a specific client's behavior; are underpinned by the evaluator's knowledge of the violence and other relevant literatures; that it links the relevant pieces of the client's story (for example, the 5Ps or the 3Ds); that it offers guidance on the developmental origins and trajectory of the problem; and that it is such as to generate testable hypotheses for action to bring about change (Hart et al., 2011). This evaluation framework, which appears to work as specified (Minoudis, Craissati, Shaw, et al., 2013), means that it is now possible to identify acceptable as opposed to poor formulations. The stage is therefore set for research to determine whether the existence of acceptable formulations makes a difference to the quality and effectiveness of the risk management plans developed subsequently. And this work is ongoing. Only when it is possible to measure the quality of risk formulations will it be possible to know good from bad formulations, whether it makes a difference to the nature of the risk management plans made subsequently, and even which professional group undertakes the most effective formulations and why (e.g., because of key skills, confidence, or access to the most critical information).

Clinical risk assessment and management practice has turned an important corner with the publication of the HCR-20^{V3}. Risk assessments of known individuals must feature clarity about key risk and protective factors, a statement of understanding about violence potential—or a risk formulation—and a risk management plan tailored to that statement of understanding. Research demonstrating a direct link between high quality risk formulations and risk management plans that are effective in reducing harm remains outstanding. However, the means by which it may be carried out in order to demonstrate the value of formulation is within our grasp.

REFERENCES

Ackley, C. N., Mack, S. M., Beyer, K., & Erdberg, P. (2011). *Investigative and forensic interviewing: A personality-focused approach*. Boca Raton, FL: CRC Press.

Bieling, P. J., & Kuyken, W. (2003). Is cognitive case formulation science or science fiction? *Clinical Psychology: Science and Practice*, *10*, 52–69. doi: 10.1093/clipsy.10.1.52

de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbé, M. (2009). *SAPROF: Guidelines for the assessment of protective factors for violence risk*. Utrecht, The Netherlands: Forum Educatief.

de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbé, M. (2012). *SAPROF, Structured Assessment of PROtective Factors for violence risk*. Utrecht, the Netherlands: Forum Educatief.

de Vries Robbé, M., & de Vogel, V. (2013). Protective factors for violence risk: Bringing balance to risk assessment and management. In C. Logan & L. Johnstone (Eds.), *Managing clinical risk: A guide to effective practice* (pp. 293–310). Oxford, UK: Routledge.

Douglas, K. S., Blanchard, A.J.E., & Hendry, M. C. (2013). Violence risk assessment and management: Putting structured professional judgement into practice. In C. Logan & L. Johnstone (Eds.), *Managing clinical risk: A guide to effective practice* (pp. 29–55). Oxford, UK: Routledge.

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20: Assessing Risk for Violence*, third edition. Vancouver, Canada: Mental Health, Law and Policy Institute, Simon Fraser University.

Drennan, G., & Alred, D. (2012). *Secure recovery: approaches to recovery in forensic mental health settings*. London, UK: Routledge.

Eells, T. D., Kendjelic, E. M., & Lucas, C. P. (1998). What is a case formulation? Development and use of a content coding manual. *Journal of Psychotherapy Practice and Research*, *7*, 144–153.

Hart, S. D., & Logan, C, (2011). Formulation of violence risk using evidence-based assessments: The structured professional judgment approach. In P. Sturmey and M. McMurran (Eds.) *Forensic case formulation* (pp. 83–106). Chichester: Wiley-Blackwell. doi: 10.1002/9781119977018.ch4

Hart, S. D., Kropp, P. K., Laws, D. R. Klaver, J., Logan, C. & Watt, K. A. (2003). *The Risk for Sexual Violence Protocol: Structured professional guidelines for assessing risk of sexual violence*. Mental Health, Law and Policy Institute. Vancouver, Canada: Simon Fraser University.

Hart, S. D., Sturmey, P., Logan, C., & McMurran, M. M. (2011). Forensic case formulation. *International Journal of Forensic Mental Health*, *10*, 118–126. doi: 10.1080/14999013.2011.577137

Johnstone, L. (2013). Working with complex cases: Mental disorder and violence. In C. Logan & L. Johnstone (Eds.), *Managing clinical risk: A guide to effective practice* (pp. 56–88). Oxford, UK: Routledge.

Logan, C. (2013). Risk assessment: Specialist interviewing skills for forensic practitioners. In C. Logan & L. Johnstone (Eds.), *Managing clinical risk: A guide to effective practice* (pp. 259–292). Oxford, UK: Routledge.

Logan, C., Nathan, R., & Brown, A. (2011). Formulation in clinical risk assessment and management. In R.W. Whittington & C. Logan (Eds.), *Self-harm and Violence: Towards best practice in managing risk* (pp. 187–204). Chichester, UK: Wiley-Blackwell. doi: 10.1002/9781119991175.ch10

Meloy, J. R. (2005). The forensic interview. In R. J. Craig (Ed.), *Clinical and diagnostic interviewing* (pp. 422–443). Lanham, MD: Jason Aronson Inc.

Minoudis, P., Craissati, J., Shaw, J., McMurran, M. M., Freestone, M., Chuan, S. J., & Leonard, A. (2013). An evaluation of case formulation training and consultation with probation officers. *Criminal Behaviour and Mental Health*, *23*, 252–262. doi: 10.1002/cbm.1890

Nezu, A. M., & Nezu, C. M. (Eds.) (1989). *Clinical decision-making in behavior therapy: A problem-solving perspective*. Champaign, IL: Research Press.

Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York, NY: W.W. Norton & Company.

Reid, W. H. & Thorne, S. A. (2007). Personality disorders and violence potential. *Journal of Psychiatric Practice*, *13*, 261–268. doi: 10.1097/01.pra.0000281488.19570.f8

Shea, S. C. (2007). Clinical interviewing: Practical tips from master clinicians. *Psychiatric Clinics of North America*, *30*, 145–315. doi: 10.1016/j.psc.2007.03.004

Tarrier, N. (2006). *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases*. London, UK: Routledge.

Webster, C. D., Douglas, K., Eaves, D. & Hart, S. (1997). *HCR-20: Assessing Risk for Violence*, second edition. Vancouver, Canada: Mental Health, Law and Policy Institute, Simon Fraser University and the British Columbia Forensic Psychiatric Services Commission.

Weerasekera, P. (1996). *Multiperspective case formulation: A step toward treatment integration*. Malabar, FL: Krieger.