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Historical-Clinical-Risk Management-20, Version 3 (HCR-20^{V3}): Development and Overview

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The HCR-20 Version 3 (HCR-20^{V3}) was published in 2013, after several years of development and revision work. It replaces Version 2, published in 1997, on which there have been more than 200 disseminations based on more than 33,000 cases across 25 countries. This article explains (1) why a revision was necessary, (2) the steps we took in the revision process, (3) key changes between Version 2 and Version 3, and (4) an overview of HCR-20^{V3}'s risk factors and administration steps. Recommendations for evaluating Version 3 are provided.

Keywords: violence risk assessment, HCR-20^{V3}

The opening words of both HCR-20 Version 1 (Webster, Eaves, Douglas, & Wintrup, 1995, p. v) and Version 2 (Webster, Douglas, Eaves, & Hart, 1997, p. 1) were that "[t]he challenge in what remains of the 1990s is to integrate the almost separate words of research on the prediction of violence and the clinical practice of assessment." And, Version 1, penned nearly two decades ago, closed by warning that "[g]iven the present rate of publication in this area, it can be argued, this system will date quite rapidly. . . . At the same time, it is thought that the scheme should serve as an

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important starting point for new research" (Webster et al., 1995, p. 50). Indeed, we published a revised HCR-20 a mere two years after Version 1 was released in 1995.

In our view, important strides have been made over the past two decades toward fulfilling our early hopes that the HCR-20 could both stimulate research and facilitate the integration of this research with clinical practice. The HCR-20 (primarily Version 2) has been subjected to more than 200 empirical evaluations (see Douglas, Shaffer, et al., 2014, for an annotated bibliography). It has been translated into 20 languages, and adopted or evaluated in agencies within 35 countries. A recent large-scale survey by Singh (2013) of 2,135 clinicians across 44 countries indicated that the HCR-20 was the most commonly used violence risk assessment instrument both in terms of assessing risk and creating risk management plans. We have little doubt that this widespread adoption of the HCR-20 is attributable both to its extensive evaluation by independent researchers, and to its clinical utility.

We will not review here the ever-growing research base on the HCR-20 and the Structured Professional Judgment (SPJ) model of violence risk assessment and management more broadly. That task has been done before (for reviews, see Douglas, in press; Douglas, Hart, Groscup, & Litwack, 2014; Guy, Hart, & Douglas, in press; Heilbrun, Yasuhara, & Shah, 2010; Webster, Haque, & Hucker, 2014). In our view, the research base and meta-analytic reviews indicate that the HCR-20 performs as well as or better than – in terms of predictive validity – other approaches (for meta-analytic reviews, see Campbell, French, & Gendreau, 2009; Fazel, Singh, Doll, & Grann, 2012; Guy, 2008; Guy, Douglas, & Hendry, 2010; Singh, Grann, & Fazel, 2011; Yang, Wong, & Coid, 2010). However, we realize that others might have different views, and we will leave that discussion for other outlets.

The question arises, then, why revise the HCR-20? This article answers that question, and then provides an overview of Version 3 of the HCR-20 (Douglas, Hart, Webster, & Belfrage, 2013), along with how it was developed. First, we will give a brief overview of the SPJ model. Second, we will delineate the rationale for revising the HCR-20, along with our goals for the revision. Third, we will describe the revision process itself. Next, we will outline the key features of HCR-20^{V3} and primary changes from Version 2. Then, we will discuss the administration procedures of HCR-20^{V3}. Finally, we will conclude with recommendations for evaluating HCR-20^{V3}.

THE STRUCTURED PROFESSIONAL JUDGMENT MODEL OF VIOLENCE RISK ASSESSMENT AND MANAGEMENT

There are many published descriptions of the SPJ model and how it differs from other approaches (Douglas, in press; Douglas, Hart, et al., 2014; Douglas & Reeves, 2010; Guy et al., in press; Hart, 1998; Heilbrun et al., 2010; Pritchard, Blanchard, & Douglas, 2014; Webster et al., 2014), including in the Version 3 manual itself (Douglas et al., 2013). As such, we will provide only a brief description of the main elements and goals of the SPJ approach, which the HCR-20 Version 3 exemplifies and embodies.

SPJ measures typically include 20-30 risk factors chosen on the basis of a thorough review of the scientific literature, rather than based on the results of a single or small number of samples. This is done to enhance comprehensiveness of coverage in terms of risk factors, and to promote generalizability across settings and samples. The approach helps evaluators and decision-makers identify risk factors that are present and relevant to the individual being evaluated; risk reduction and management strategies; and relative risk level.

SPJ measures adopt non-algorithmic, non-numeric decision processes and risk estimates. They do so to avoid the pitfalls inherent in actuarial approaches, such as sample dependence, exclusion of potentially important risk factors, instability of precise probability estimates across samples, and the inherent difficulty in applying group-based probability estimates to individuals. The SPJ model, rather, uses a simple, narrative approach to risk estimation, requiring evaluators to come to a decision of low, moderate, or high risk. This estimate derives from the number and relevance of risk factors, the corresponding concern that a person will be violent in the future, and the anticipated nature and intensity of intervention or management strategies necessary to mitigate risk (see Douglas, Hart, et al., 2014, for a review). As described by Douglas (in press),

> [a]lthough specific cut-points are not provided, generally, the more risk factors that are present, the higher the risk typically will be. The greater the intervention efforts that would be required to stem risk, the higher the risk. The SPJ approach allows for exceptions to this general rule. If, for instance, a person has a small number of highly compelling risk factors (i.e., threats of homicide and a history of acting on said threats) a decision of high risk could be justifiable.

This non-algorithmic, professional approach to risk estimation has been shown in many studies to be as or more accurate vis-à-vis future violence compared to numerically-based estimates (for reviews, see Guy, 2008; Guy et al., in press; Heilbrun et al., 2010; Singh et al., 2011).

The SPJ approach is ultimately geared toward informing risk management plans so as to facilitate risk reduction. All SPJ instruments contain dynamic, or changeable, risk factors. A large part of using SPJ approaches involves determining which dynamic risk factors are present and relevant, and using those to shape, monitor, and revise management plans over time. Most recently, the SPJ approach has expounded upon the benefit of case formulation and scenario planning to achieve the goals of optimal risk management and risk reduction (Douglas, Blanchard, & Hendry, 2013; Hart & Logan, 2011; Hart, Sturmey, Logan, &

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McMurran, 2011; Lewis & Doyle, 2009). We next turn to the goals for revising the HCR-20.

RATIONALE FOR AND GOALS OF THE REVISION

Rationale

In 1995, we identified the risk that the HCR-20 could become dated without periodic revisions. Since the publication of Version 2 in 1997, there have been literally thousands of research studies on violence generally. As such, one of the main reasons for revision was to ensure that the HCR-20 continues to reflect contemporary scholarship on violence, in terms of the risk factors that it contains. The HCR-20 – as with all SPJ instruments – is intended to be a comprehensive set of professional guidelines. As such, it must reflect contemporary knowledge on violence. Although we did not expect to come across completely new risk factors, we did think it possible that revisions to some HCR-20 risk factors might be warranted given new developments in research. Further, it was possible that certain new risk factors should be included in the HCR-20, and perhaps some modified or dropped. For instance, research indicates that being victimized by violence as an adult can elevate one's risk for violence (Desmarais et al., 2014; Swanson et al., 2002). This was not directly reflected in Version 2. In Version 3, it is.

Second, SPJ scholarship has evolved considerably since 1997. At that point, much of the concern in the field was to identify the most important risk factors to include on risk assessment instruments. Less attention was paid to the decision-making process, and the link to risk management. The field now benefits from abundant conceptual and practice-oriented contributions devoted to concepts such as dynamic risk (Douglas & Skeem, 2005), the link between assessment and management (Webster et al., 2014), the interplay between the nomothetic and idiographic levels of functioning (Douglas, Blanchard, & Hendry, 2013), and scenario planning and formulation (Hart & Logan, 2011; Hart et al., 2011). It was critical to integrate these developments into HCR-20^{V3}.

Third, based on feedback from hundreds if not thousands of users of the HCR-20 Version 2, and using it ourselves in research, clinical-forensic assessments, and release decision making (i.e., Canadian *Criminal Code* Review Board Hearings for persons found Not Criminal Responsible on Account of Mental Disorder), there were certain aspects of it that we were confident we could improve. Much of this included enhanced attention to the decision-making process itself. In Versions 1 and 2, we provided little guidance to evaluators concerning the making of summary risk ratings, what these mean, and how they are an important part of constructing useful management plans. We were silent on issues such as formulation and scenario planning, two concepts that have received considerable attention in the SPJ literature in the past several years (Hart & Logan, 2011; Lewis & Doyle, 2009). And, although we had produced a companion guide to the HCR-20 Version 2 focused on risk management (Douglas, Webster, Hart, Eaves, & Ogloff, 2001), the manual itself did not include extensive information on risk management. We also thought that we could provide greater guidance to users of the HCR-20 in terms of identifying the manifestation and relevance of single risk factors at the individual level – that is, to specify how risk factors might operate uniquely for any given person being evaluated with the HCR-20. We revised the HCR-20 with these areas in mind.

Goals and Guiding Principles for the Revision

We set out a number of guiding principles and goals for the revision process, including (1) continuity of concept; (2) exemplification and embodiment of the SPJ model; (3) practical utility; (4) enhanced clarity; (5) legal and ethical acceptability; and (6) empirical defensibility. We review these below.

Continuity of Concept

Although we needed to make any revisions that we felt were important, we also aimed to preserve core aspects of the HCR-20 so that Version 3 did not differ so greatly from Version 2 that it represented a completely different approach to risk assessment. Indeed, we believe that Version 3 can be used in much the same way that Version 2 has come to be used, particularly for those users who have kept up to date on conceptual developments in the SPJ model. We wanted HCR-20^{V3} to be conceptually similar to its predecessor. As such, it retains its focus on past, present, and future through the inclusion of three scales (Historical; Clinical; Risk Management). There is the same number of risk factors on each scale (10, 5, and 5, respectively) as there was on previous versions, although some of the broader or more complex risk factors now contain subitems. Risk factors are still rated using a three-level system. We still encourage users to come to summary risk ratings of low, moderate, or high risk. Users who are familiar with Version 2 should be able to learn Version 3 quite quickly because of these similarities. Moreover, agencies that have adopted Version 2 ought to be able to shift to Version 3 without changing their philosophy about risk assessment.

Exemplification and Embodiment of the SPJ Approach

The HCR-20 was one of the original SPJ approaches, and it was important to us that V3 exemplified and embodied contemporary thought within the SPJ model. Some of these features have existed from the early days of the SPJ approach (i.e., key role of professional judgment; link to risk management), although other features have developed

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since Versions 1 and 2 were published (i.e., formulation). As a set of professional guidelines, it was necessary that the HCR-20 not only reflected current scholarship on violence, but also exemplified the applied use of risk assessment technology. The SPJ approach is thoroughly described in numerous recent publications, including the HCR-20^{V3} manual (Douglas et al., 2013) and other disseminations (Douglas, Hart, et al., 2014; Webster et al., 2014), and will not be repeated here.

Clinical and Practical Utility

Many of the changes to the HCR-20 were made with an eye toward enhancing its usefulness for the individual evaluators and systems that rely upon it. We did so by providing more guidance about individual decision-making, the relevance and manifestation of risk factors for understanding a given person's violence, and creating risk management plans that target key risk factors and anticipate possible future scenarios of violence. We have retained flexibility in the use of HCR-20 Version 3. For instance, we have provided three sets of rating sheets – single page (ratings of the presence and relevance of risk factors; summary risk ratings); double page (includes sub-items for applicable risk factors); and a multi-page extended worksheet that facilitates case formulation, scenario-planning, and risk management. None of these are required, but are provided as examples of mechanisms that might be useful in terms of recording and communicating risk-relevant case information. Ultimately, our goal was to produce a comprehensive set of professional guidelines that are optimally helpful to individuals and agencies alike. We engaged in extensive beta-testing as part of our development of Version 3 to evaluate and refine its clinical and practical utility (outlined below and described in detail in some of the articles in this special issue).

Enhanced Clarity

Going into the revision process, we had been alerted to aspects of Version 2 that could be clarified. We had collated feedback provided by experienced users of the HCR-20 Version 2 and tried to find themes and commonalities. For instance, we now provide more guidance on the mental disorders that do and do not count for ratings under H6 (Major Mental Disorder) and C3 (Recent Problems with Symptoms of Major Mental Disorder). We address the selection of rating windows for the Clinical Scale and Risk Management Scales (that is, how far back or into the future should one look when making these ratings?). We also provide more guidance for establishing re-evaluation schedules (that is, how frequently should the risk factors be re-rated?). Definitions of key concepts (i.e., violence; intentionality; high risk) have been elaborated and enhanced, where required.

Legal and Ethical Acceptability

Some risk factors, despite showing statistical associations with violence in the population, may be considered *prima facie* objectionable to include in an assessment for the purpose of estimating violence risk. Examples include race, gender, and minority ethnic status. Typically, any associations between these factors and crime or violence at the population level can be better explained by important social factors. In addition, the HCR-20, as a set of SPJ professional guidelines, should be able to withstand clinical and legal review in terms of how decisions are made about people. Any approach to risk assessment should permit a transparent review of how decisions were made, with respect to sources of information, risk factors identified, evidentiary basis for ratings of risk factors, and the specification of reasoning behind final judgments.

Empirical Defensibility

Finally, we wanted to ensure that Version 3 performed at least comparably to Version 2 in terms of reliability and validity. To that end, we organized and engaged in substantial empirical testing of Version 3 prior to publishing it. Some of this research was conducted by us, but most of it was conducted by experienced researchers with past HCR-20 research and clinical experience. These efforts are described in various articles in this special issue. We were satisfied that ratings could be made with acceptable reliability, and that HCR-20^{V3} risk factors and summary risk ratings were satisfactorily related to subsequent violence. We also wanted to establish concurrent validity with Version 2, as evidence of "continuity of concept" described above. Clearly, we could not produce the volume of research in our testing stages that has accumulated on Version 2. However, results of initial studies on Version 3 are highly consistent with results from Version 2, and very much in line with meta-analytic findings. In the next section, we will discuss the revision process – how we tried to realize the goals and principles described in the current section.

THE REVISION PROCESS

The revision process for the HCR-20 Version 3 was extensive, and involved (1) conceptual and logical analysis of the empirical and professional literatures on violence, risk assessment, and the HCR-20 specifically; (2) beta-testing by experienced HCR-20 users; (3) empirical testing of the reliability and validity of Version 3; and (4) subsequent modifications to the initial draft manual in response to beta-testing and empirical testing.

Conceptual and Logical Analysis

In addition to extensive informal consultations with colleagues and discussions amongst the HCR-20^{V3} authors in

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terms of how to improve the instrument, we engaged in several systematic activities to help define our aims for the revision process. To facilitate our review of the violence literature, Guy and Wilson (2007) produced a 300-page literature review and bibliography that summarized key developments in violence research. The violence domains covered by this review were organized according to the HCR-20 Version 2 risk factors so that we could assess the support for these risk factors more broadly in the literature. This process also allowed us to identify whether our definitions of existing HCR-20 Version 2 risk factors should be modified for Version 3, and whether we needed to add new risk factors or new content to existing risk factors.

We also carried out various statistical analyses using large-scale HCR-20 data sets ($N = 5000+$). These analyses were primarily internal working procedures aimed at understanding issues such as frequency of item missingness and distribution. We also conducted experimental factor analytic and item response theory analyses aimed at understanding whether any latent constructs underlie the HCR-20 risk factors, and whether the risk factors tapped these along the range of the latent constructs. We used these procedures, in part and along with our other activities, to help ensure adequate content coverage by risk factors.

Based on these early activities, we produced a Draft Manual in late 2008. Our first formal presentation of the Draft Manual to the professional community was in December 2008 at a conference hosted by Professors Michael Doyle and Jenny Shaw at the University of Manchester, UK. Day 1 was an open conference, during which we provided brief presentations on the ideas behind Version 3. Day 2 was an invitation-only workshop-format presentation to roughly 40 experienced HCR-20 Version 2 users. After a detailed presentation of the Draft Manual, delegates broke into working focus groups to discuss the revision, and provide written opinion to us. We had asked delegates to focus on a number of evaluative grounds, such as administration ease or difficulty; facilitation of clinical practice; relevance to risk management; coherence and clarity of risk factor definitions; ability to guide risk communication about the presence and relevance of risk factors; whether any risk factors seemed to be missing; and any other feedback. Generally, responses were positive, although delegates did not have a chance to use the Draft Manual on actual cases. As such, we asked several groups to engage in beta-testing of the Draft Manual on actual cases. The work of these groups is summarized in several articles in this special issue (see Kötter et al. and de Vogel et al.), as well as in the HCR-20^{V3} manual.

Beta-testing

Across the beta-testing groups, roughly 30 clinicians evaluated approximately 50 actual cases using the Draft Manual. We were provided with detailed feedback on all aspects of the Draft Manual, including commentary on all risk factors, clinical utility, and usefulness for formulation and risk management planning. Testers also addressed any potentially unclear language, as well as any other issues that arose.

The authors of Version 3 met for several days to address this feedback, paying particular attention to themes that arose across several of the beta-testing groups. The revised Draft Manual was improved in terms of the clarity of its instructions and definitions. We dropped some "experimental" features, such as a four-point rating system for risk factors. Even when we did not make substantive changes based on feedback, we were able to better describe some of the features of Version 3 as a function of the feedback.

Empirical Testing

The results of empirical tests of Version 3 are included amongst the articles in this special issue, and as such we will not review the studies and their findings in detail. Essentially, we were interested in having Version 3 tested in different countries and different settings, by researchers and users who were familiar with the use of Version 2. We were interested in whether we would observe similar findings across different researchers, settings, systems, and countries. Studies, ranging from small to large, were conducted with participants from several countries (Canada; Germany; the Netherlands; Norway; Sweden; Wales; UK; United States), and are represented in this special issue. Settings included forensic psychiatric, civil psychiatric, and correctional. In total, Version 3 was evaluated on more than 800 research participants. Topics covered included interrater reliability, concurrent validity (with HCR-20 Version 2 and the Psychopathy Checklist, Screening Version; Hart, Cox & Hare, 1995), predictive validity of risk factors and summary risk ratings, and the interplay of relevance and presence ratings vis-à-vis summary risk ratings. Generally, we were of the view that the results from these various studies supported the performance of Version 3, and therefore that publishing the manual was appropriate. We are aware of a number of other studies that are in progress at the time of writing, and look forward to their findings.

OVERVIEW OF PRIMARY CHANGES

Changes to Risk Factors

The HCR-20^{V3} risk factors are presented in Table 1. Readers who are familiar with Version 2 will recognize that the general domains of risk covered by the Version 3 risk factors is similar to Version 2. However, we did drop some items, and added a couple of others. We also reduced redundancy, and tried to sharpen the distinctions between the Risk Management risk factors. Minor changes were

TABLE 1
Violence Risk Factors Contained within the HCR-20^{V3}

Historical Scale (History of Problems with…)
H1. Violence
a. As a Child (12 and Under)
b. As an Adolescent (13–17)
c. As an Adult (18 and Over)
H2. Other Antisocial Behavior
a. As a Child (12 and Under)
b. As an Adolescent (13–17)
c. As an Adult (18 and Over)
H3. Relationships
a. Intimate
b. Non-Intimate
H4. Employment
H5. Substance Use
H6. Major Mental Disorder
a. Psychotic Disorder
b. Major Mood Disorder
c. Other Major Mental Disorders
H7. Personality Disorder
a. Antisocial, Psychopathic, and Dissocial
b. Other Personality Disorders
H8. Traumatic Experiences
a. Victimization/Trauma
b. Adverse Childrearing Experiences
H9. Violent Attitudes
H10. Treatment or Supervision Response
Clinical Scale (Recent Problems with…)
C1. Insight
a. Mental Disorder
b. Violence Risk
c. Need for Treatment
C2. Violent Ideation or Intent
C3. Symptoms of Major Mental Disorder
a. Psychotic Disorder
b. Major Mood Disorder
c. Other Major Mental Disorders
C4. Instability
a. Affective
b. Behavioral
c. Cognitive
C5. Treatment or Supervision Response
a. Compliance
b. Responsiveness
Risk Management Scale (Future Problems with…)
R1. Professional Services and Plans
R2. Living Situation
R3. Personal Support
R4. Treatment or Supervision Response
a. Compliance
b. Responsiveness
R5. Stress or Coping

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made to the definitions of most risk factors; substantive changes are summarized in Table 2.

Sub-Items

One of the new features of Version 3—and any SPJ instrument—is the addition of sub-items. Generally, we simplified and clarified risk factor definitions in Version 3. For some risk factors, the constructs they represent are complex or nebulous. Hence, the best way for us to promote clear consideration of these risk factors by evaluators was to ensure proper attention was paid to them through sub-division. We had noticed that with some of these risk factors on Version 2, evaluators sometimes considered certain aspects of the risk factor but not others. For instance, with C1 (Lack of Insight) on Version 2, it could be easy to consider insight into mental disorder and need for treatment, as called for by the definition, but sometimes insight into proneness for violence was missed. With the addition of sub-items, this should not occur.

Another reason for adding sub-items was to bring in new content to the existing risk factors. For instance, H1 (History of Problems with Violence) now includes three sub-items (as a child, as an adolescent, and as an adult). Not only does this prompt evaluators to consider violence across the lifespan, but it also reflects literature showing that chronicity of violence across developmental periods is itself risk enhancing.

For these risk factors, we provide an over-arching definition that can be used to rate the main risk factor. We also provide definitions (and indicators, discussed below) of the sub-items. Evaluators should in all cases rate the overall item, but may also choose to rate the sub-items. This may be of particular interest in research, as well as in clinical applications where evaluators want to describe and understand the nuances of how risk factors manifest for a given individual. If an evaluator rates any of the sub-items as being Present, the overall item should be rated as Present as well.

Indicators

Version 2 defined risk factors in an intensional manner, by reference to their underlying general properties or features. We continue to do so in Version 3, but we also added an ostensional aspect to the definitions, as was done in the Stalking Assessment and Management (SAM) manual (Kropp, Hart, & Lyon, 2008). This approach provides examples of specific ways in which a given risk factor might manifest at the individual level. We provide sets of *indicators* for each item and sub-item. Clearly, the same risk factor does not "look" the same across different people. The indicators are intended help clinicians develop a more complete and individualized understanding of how risk factors manifest for their evaluees.

The indicators are included for guidance and reference. Evaluators should not consider them to be an exhaustive or comprehensive accounting of how risk factors are expressed. Further, the indicators are not directly related to the rating of the over-arching risk factors or sub-items. That is, there are no rules about how many indicators must

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TABLE 2
Changes to Risk Factors between HCR-20 Versions 2 and 3

HCR-20 Version 3 Item	Substantive Change from Version 2
H1.	This risk factor was broadened to reflect not only the nature and severity of the history of violence, but also its developmental trajectory.
H2.	This is a new risk factor that reflects the nature, severity, and developmental trajectory of a history of non-violent antisocial behavior. Such content was included in Version 2 under H8 (Early Maladjustment) for children and adolescents only, and to some extent under H10 (Supervision Failure). The information that was considered as part of H2 in Version 2 (Young Age at First Violent Incident) is now considered as part of H1 in Version 3.
H3.	This risk factor was broadened to reflect not only problems with intimate or romantic relationships, but also problems in other relationships (e.g., family, friends, colleagues).
H4.	No substantive changes.
H5.	No substantive changes.
H6.	No substantive changes.
H7.	This risk factor was broadened to include not only psychopathic personality disorder, but also other personality disorders that previously were considered as part of H9 (Personality Disorder) in Version 2. Version 3 no longer requires use of the PCL-R or PCL:SV when coding H7.
H8.	This risk factor was broadened to include experiences in adulthood as well as in childhood and adolescence. It was also broadened to include experiences that are not traumatic per se, but can disrupt development or attachment (i.e., parental criminality; upbringing in chaotic environment). It was narrowed in that conduct problems that were considered as part of H8 in Version 2 are now considered as part of H1 and H2 in Version 3.
H9.	This is a new risk factor. It was added to include information about entrenched, long-standing attitudes that support or condone violence. Personality disorder is now considered as part of H7 in Version 3.
H10.	This risk factor now includes problems with treatment response in addition to institutional or community supervision.
C1.	No substantive changes.
C2.	This risk factor was narrowed to focus on ideation, thoughts, plans and intentions concerning perpetration of violence. Longer-standing, entrenched violent attitudes that were considered as part of C2 in Version 2 are now considered under H9 in Version 3.
C3.	No substantive changes.
C4.	No substantive changes.
C5.	This risk factor was broadened to include problems with response to institutional or community supervision in addition to treatment response.
R1.	This risk factor was revised to minimize redundancy with other items on the R scale. It was narrowed to focus on difficulties making adequate plans or implementing adequate professional services for the evaluee.
R2.	This risk factor was narrowed to focus on difficulties securing a living situation in the institution or in the community that will minimize destabilizing influences on the evaluee.
R3.	No substantive changes.
R4.	This risk factor was broadened to include problems with future treatment response stemming not only from compliance problems but also from treatment refractoriness.
R5.	No substantive changes.

be present in order to rate the risk factor as present. Rather, evaluators should first rate whether the risk factor is present, according to the principled (intensional) definition. Then, if seeking to understand the subtleties of the manifestation of the risk factor for an evaluee, consideration of the indicators may be helpful.

Elaboration of Administration Procedure

As described above, after the publication of Version 2 in 1997, substantial conceptual developments occurred in the risk assessment field. These are now reflected in Version 3, particularly through its administration procedure. Version 2 of the HCR-20 focused on rating risk factors and coming to final risk estimates. Risk assessment instruments published after Version 2 sought to structure the entire process of violence risk assessment and management. For example, the Risk for Sexual Violence Protocol (RSVP; Hart et al., 2003) included a six-step administration procedure and

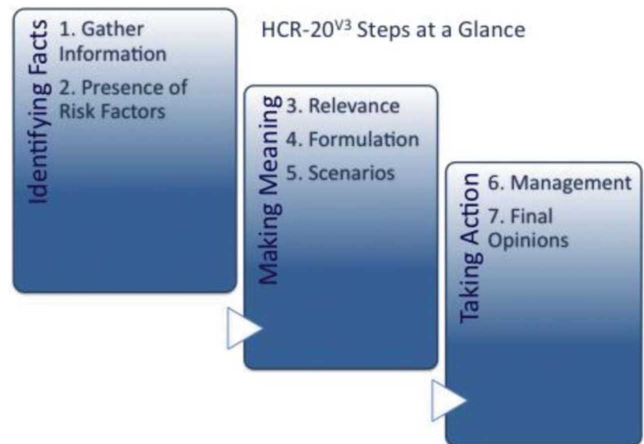

FIGURE 1 Steps in the HCR-20 Version 3 Administration Procedure. *Note*. Modified, with permission, from the Mental Health, Law and Policy Institute, Simon Fraser University. (Color figure available online)

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corresponding worksheets to help guide and document the administration; relevance ratings for risk factors, to determine potential causal links between risk factors and violence; scenario planning methods, to facilitate individualized management plans; and a more extensive set of summary risk ratings, to facilitate risk communication. In addition, as mentioned above, commentators have highlighted the importance of case conceptualization or formulation of violence risk. We attempted to build upon these past developments in Version 3. Version 3 includes a seven-step administration procedure (see Figure 1) that includes and expands the six steps from the RSVP. It also includes a new step in which the evaluator develops an explicit formulation of violence risk. We also developed a worksheet that includes space for documentation of these steps. However, we realize that not all steps will be done by all evaluators or in all cases. Hence, we also developed abbreviated worksheets that focus only on presence, relevance, and summary risk ratings.

ADMINISTRATION AND USE

Contexts and Populations

As with its predecessor, Version 3 is intended to be used with adult men and women (age 18 and over). There is some small degree of flexibility here, depending on a potential evaluee's developmental level and living context. For instance, it may be acceptable to use Version 3 with a 16- or 17-year-old if he or she has been living independently. Likewise, in some instances it may make sense to use an instrument such as the *Structured Assessment of Violence Risk in Youth* (SAVRY; Borum, Bartel, & Forth, 2006) with a 19- or 20-year-old who has been living at home with parents and is relatively immature. These issues are discussed further in Borum, Lodewijks, Bartel, and Forth (2010) and Douglas and Reeves (2010).

The HCR-20 Version 3 can be used whenever there is a clinical or legal requirement to evaluate risk for general violence. Common settings include correctional, civil (general) psychiatric, and forensic psychiatric settings, both within institutions and in the community. Although in such settings the vast majority of evaluees have mental, personality, or substance-related disorders, use of the HCR-20 Version 3 does not require the presence of such disorders in order to be used. Indeed, evaluators will determine as part of their evaluation whether these disorders are present, and, if so, whether they are of relevance to a person's risk. Similarly, the HCR-20 can be used whether or not a person has a history of violence, as determining the extent of an evaluee's violence history is part of the evaluation process. Typical applications of Version 3 include release decision-making, admission to institutions, transitions from higher to lower security levels, and continuing risk management. There are circumstances in which it may not be feasible to use the HCR-20^{V3}, such as when a decision about risk must be made immediately.

Key Definitions and Concepts

Violence

The criterion being evaluated is general interpersonal violence. We consider violence to have occurred if (1) a person engaged in an act or omission (2) with some degree of willfulness that (3) caused or had the potential to cause (4) physical or serious psychological harm to (5) another person or persons (see Douglas et al., 2013, Table 3.1, p. 37). More generally, violence is "*actual, attempted, or threatened infliction of bodily harm on another person*" Douglas et al., 2013, p. 36). This definition applies also to the rating of H1. We include serious psychological harm as part of the definition of physical or bodily harm in part because psychological harm can often be as or more hurtful to an individual who experiences it, and in part because to do so is consistent with law. The Supreme Court of Canada, for instance, has equated serious psychological harm (that substantially interferes with health or well-being) with bodily or physical harm (see *R. v. McCraw*, 1991; *Mustapha v. Culligan of Canada, Ltd.*, 2008). For the purposes of Version 3, psychological harm also includes fear of physical injury. Threats of harm must be explicit expressions of intent to harm, rather than vague statements of discontent or anger. Attempts at violence are included in the definition of violence because the only difference between an attempt and an act violence of violence is that the perpetrator failed. We exclude from the definition acts in genuine self-defense, acts sanctioned by law (i.e., in military, sports, or law enforcement), and acts against animals.

Willfulness

Acts or omissions must be accompanied by some degree of willfulness or deliberation. We do not require the same level of intent necessary for criminal prosecution, but only that the person had at least some limited awareness that the act, attempt, or threat may result in bodily harm. In considering the acts of children when making ratings of past violence under H1, they must have been developmentally mature enough to have had at least basic appreciation that their behavior could lead to harm (i.e., in the range of 4 to 6 years of age). If an act is accidental or reflexive, it is not considered willful, and hence would not be considered violent.

Risk

Risk is defined in the HCR-20^{V3} manual as a threat or hazard that is incompletely understood by its very nature (that is, pertaining to the future). It is multi-faceted, including notions of not only likelihood, but also frequency, seriousness, imminence, nature, and duration. Risk is presumed

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to be dynamic, that is, to change, and contextual, that is, to be susceptible to particular external or situational influences. Risk is a state of potential that need not materialize. That is, a person can be high risk and yet not act violently. This may reflect successful management. This is contrasted with the concept of prediction, which is a definitive statement about that future that is incorrect if it does not materialize. Given the conceptual and pragmatic complexities of risk, use of a comprehensive, structured decision model is necessary.

Administration Steps

Prior to using the HCR-20 Version 3, evaluators should ensure that they are prepared and qualified to do so. Although we do not require that persons have doctoral level training, proper use of HCR-20^{V3} (and all SPJ measures) requires "considerable professional skill and judgment" (Douglas, Hart, et al., 2013, p. 38). Generally, evaluators should have extensive knowledge of the literatures on violence, individual assessment, and mental disorder, together with training and experience in interviewing and evaluating persons. Users should also have training and experience in the diagnosis of mental, personality and substance-related disorders. Otherwise they should conduct assessments of these constructs under supervision or with consultation. We do not require that individuals attend training sessions on the HCR-20^{V3}, although this may be useful. Evaluators can engage in other training activities. These might include self-study, supervised practice, working through sample cases, and consultation with experienced colleagues.

Step 1: Case Information

This first basic step simply requires that the evaluator assemble a sufficient information base upon which to make ratings of risk factors, their change over time, and how and why they have led a person to be violent. At a minimum, we would require an interview with the evaluee plus a review of relevant files (i.e., health, justice, law enforcement, employment, social). Other useful sources of information include observation of the evaluee, interviews with collaterals (i.e., professionals, friends, family), interviews with victims, and psychological or psychodiagnostic testing.

We realize that it will be neither feasible nor possible to include all sources in all assessments. Evaluators should gather the information that is reasonably necessary to complete the HCR-20^{V3} and hence be able to offer an opinion regarding risk. The focus should be on information that is specific and contributory (non-redundant); trustworthy (from reliable sources); and useful (directly relevant to risk assessment). As Monahan (1993) reminded us some time ago, information should be documented clearly and concisely, including not only the nature of the information, but also the sources. Special attention should be paid to past violent behavior and ideation; that is, evaluators should include a reasonably detailed summary of past violent acts and thoughts, including their nature, frequency, severity, as well as descriptions of the victims, context, and whether weapons were used. Identifying the social, interpersonal, affective, and cognitive precipitants of past violence is critical in terms of understanding (i.e., formulating) a person's risk for violence and planning to prevent future occurrences.

Step 2: Presence of Risk Factors

The next step is to start the simplification process of organizing all of the information obtained in Step 1 by using it to rate whether risk factors are present. This is also a basic step with which readers will be familiar if they have familiarity with any of the SPJ instruments. In addition to rating the standard 20 HCR-20^{V3} risk factors, evaluators can also rate any case-specific risk factors. Unlike Version 2, which used a 0, 1, 2 rating process for risk factors, Version 3 uses a *No*, *Possibly or Partially*, and *Yes* rating structure. The two methods for rating risk factors mean exactly the same thing so that raters familiar with the Version 2 rating system can easily make the transition to Version 3. Evaluators should document evidence both for and against the presence of risk factors. This can help ensure that ratings are balanced. It also can assist with being able to justify ratings in written or oral communications.

Evaluators can omit risk factors if there is simply no information upon which to make a rating. Note that if the absence of information is deemed to be reliable (i.e., the file information consistently indicates no known history of substance use, and the evaluee denies substance use in the interview), then an item should be rated as *No* rather than *Omit* because the evaluator can conclude based on reliable information that a risk factor is not present. Generally, we encourage evaluators to omit ratings sparingly, as omitting risk factors can greatly complicate and reduce the effectiveness of the evaluation process.

Historical factors refer to areas of past functioning, behaviors, and experiences. Although there is no formal structure to this domain of factors, it may be helpful to think of them as comprising several themes: (1) problems in adjustment or living (H3, H4, H8); (2) problems with mental health (H5, H6, H7); and (3) past antisociality (H1, H2, H9, H10). The coding timeframe for these risk factors is lifetime. Evaluators should rate these as present if they existed at any point in a person's life, even if those factors are no longer active. At later stages of the evaluation, a determination will be made as to the relevance of the risk factors.

Even though these are historical factors, we do not consider them necessarily to be static. Indeed, the very nature of some of the factors (i.e., major mental disorder) is inherently dynamic. These factors are static only to the extent

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that once they have existed, they always will have existed. However, we strongly encourage evaluators to consider the relevance of Historical factors and changes in their ratings when formulating risk, devising scenarios, and constructing management plans.

Clinical factors focus on recent or current psychosocial, mental health, and behavioral functioning. These items should be rated as present if they have existed at any point in the coding timeframe. We have added considerable material in the manual, relative to Version 2, about how to determine an appropriate timeframe (that is, how far back the evaluator should look when making these ratings). No one single timeframe fits all. Context influences what is feasible and appropriate. Generally, from several weeks to several months is a good general starting point, as these items are intended to capture relatively short-term change. Some recent research indicates that changes in Clinical factors over one to two months (Blanchard, 2013; Blanchard & Douglas, 2014) and six months (Douglas, Strand, & Belfrage, 2011; Michel et al., 2013) are predictive of subsequent violence.

Although we offer more detail in the manual, evaluators can use the following general principles to determine a coding timeframe within the past one to six months: (1) select an important milestone, such as most recent arrest, hospitalization, or review board hearing, and make ratings since that point; (2) choose the past six months – or as much of that time period for which information exists – if evaluating someone for the first time; (3) extend the rating period longer than six months (say, 12 months) only if an individual has been under observation, treatment or supervision for that time period, and has been relatively stable throughout that duration.

Clinical factors should be re-evaluated periodically. We do realize that some evaluators will be doing a one-time evaluation. However, in such instances, we would still advise that evaluators recommend that the Clinical factors be re-evaluated after a certain specified time period, if possible given an evaluee's future situation. Often, after a one-time assessment (say, a parole hearing), other professionals will be assuming responsibility for an individual and hence will benefit from the former opinion about re-evaluation.

Consider the following general principles when deciding on the re-evaluation interval: (1) higher risk individuals should be re-evaluated more frequently (say, monthly) than lower risk individuals, where biannual re-evaluations may be appropriate; (2) if a supervised individual has not been violent for 12 months, extending the re-evaluation window to 12 months may be appropriate; (3) regardless of the initial re-evaluation interval, the Clinical factors should be rated again if there have been notable changes in a person's functioning, if violence has occurred recently, or if a transition is being contemplated (i.e., discharge, change of security levels).

Risk Management factors refer to areas of future functioning, psychosocial adjustment, living situation, and use of professional plans. As with the Clinical factors, research has indicated that changes in Risk Management factors are associated with violence (Blanchard, 2013; Blanchard & Douglas, 2014; Michel et al., 2013). The same considerations that apply to the Clinical factors concerning coding timeframes and evaluation intervals also apply to the Risk Management factors and will not be repeated here, except to make the perhaps obvious point that the coding timeframe is in the future rather than the past. As in Version 2, the Risk Management factors for Version 3 can be rated based on either continued living within an institution, or based on community living. Following a practice encouraged with Version 2, colleagues in some agencies rate Risk Management factors for both contexts for those who currently reside within an institution, but for whom discharge into the community is a possibility at some point in the future.

The first two steps (gathering information and coding risk factors) are common to most kinds of risk assessment. What primarily differentiates the SPJ approach from most other approaches, in addition to its non-algorithmic decision making, is what follows in the remaining steps. These steps are primarily devoted to facilitating an understanding of the specific individual being evaluated in terms of why he or she has been violent, what the evaluator is concerned he or she might do in the future, and how to mitigate risk through risk management plans that address the specific characteristics of the evaluee. We turn to these remaining steps now.

Step 3: Relevance of Risk Factors

Including relevance ratings is our attempt to bridge the nomothetic and idiographic levels of analysis within the risk assessment and management task. That is, the risk factors on the HCR-20—or any risk assessment instrument—have support in the larger scientific literature at the sample and ostensibly the population (nomothetic) level. As others have pointed out (Monahan et al., 2001), risk factors are not equally relevant to all persons. In other words, "every man is in certain respects (a) like all other men, (b) like some other men, (c) like no other man" (Kluckhohn & Murray, 1953, p. 53). The applied task, then, is to determine whether those nomothetically derived and supported risk factors are relevant at the individual (idiographic) level, on a case-by-case basis (Douglas, Blanchard, & Hendry, 2013). Risk factors may have differential relevance to individuals within samples, although on average they elevate risk within the sample. They do not necessarily affect risk in the same way for all people. We recommend that evaluators consider the presence of a risk factor (under Step 2) a potential problem area or as an hypothesis that the factor may elevate risk in the case at hand. To determine whether

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it actually has done so for the individual, evaluators need to investigate the role that it has played in past violence, or may play in future violence. Determining which risk factors are most relevant is also instrumental to subsequent decision steps, such as formulation (Hart & Logan, 2011). Preliminary research suggests that relevance ratings may add incrementally to the validity of presence ratings (Blanchard & Douglas, 2011), and play an important role along with presence ratings in determining evaluators summary risk ratings (see Smith, Kelley, Rulseh, Sormen & Edens, this issue).

We recommend that evaluators consider a risk factor that is present or partially present to also be relevant as follows: (1) it was a material contribution to an individual's past violence; (2), it is likely to influence a person's decision to act violently in the future (say, violent attitudes); (3) it may influence or impair a person's ability to use non-violent problem solving in the future (say, substance use problems; major mental disorder); (4) it is otherwise crucial to manage to reduce risk (say, treatment noncompliance; problems with professional plans).

Essentially, we recommend that evaluators try to determine which of the risk factors that were rated as present or partially present may play a causal role in violence, at the individual level. To do so, it may be advisable, vis-à-vis a person's violence, to consider the extent to which risk factors have acted as motivators (i.e., increase the perceived benefit of violence), disinhibitors (i.e., decrease the perceived cost of violence), or destabilizers (i.e., impair decision making).

Relevance is rated on a three-point scale similar to ratings of the presence of risk factors. We suggest that evaluators make a determination that a risk factor is of *Low*, *Moderate*, or *High* relevance to understanding a person's violence. These judgments are probably best made after all of the presence ratings are completed in Step 2. The process of making presence ratings requires careful consideration of all aspects of a case, and hence the differential relevance of risk factors starts to emerge naturally at this step. Indeed from our experience it may be most natural, when making relevance ratings, to first select those risk factors that stand out as being most highly relevant, and then complete the relevance ratings for the remaining risk factors. It should be stressed that initial judgments of relevance made at this step may be revised in light of risk formulations and scenarios constructed in Steps 4 and 5. That is, evaluators can iterate between relevance, formulation and scenario planning, a process that probably best captures clinical or professional decision-making about a person's risk.

Step 4: Risk Formulation

The concept of formulation, or case conceptualization, has a long history in general mental health and therapy disciplines. Its basic purpose is the integration of case material into an explanatory framework for a given individual under evaluation. It further condenses material from previous steps, and serves as the link to subsequent steps that are focused on risk reduction. Essentially, in order to prevent violence, it is necessary to understand violence.

Hart and Logan (2011) provided an extensive discussion of desirable elements of formulation. Some important components of their discussion worth highlighting include the idea that formulation focuses on the causes of behavior, explains the behavior of a single individual, guides risk reduction efforts, and is based on a principled theoretical or conceptual framework. In Version 3 of the HCR-20, we provide numerous examples of formulation frameworks that evaluators might consider. These include, *inter alia*, reliance on theoretical models such as Andrews et al.'s (2010) general personality and cognitive social learning (GPCSL) theoretical perspective; Ward's (2002; Ward & Laws, 2010) Good Lives Model; criminological models such as bond, strain or social disorganization theories; frameworks such as deriving conceptually meaningful clusters of risk factors, or specifying gateway or portal risk factors or signature threats; use of a decision theory framework that highlights the perceived costs and benefits of violence (recall motivators, disinhibitors, and destabilizers); use of Weerasekera's (1996) Four P model (predisposing factors, precipitating factors, perpetuating factors, protective factors); and root cause analysis. We do not require the use of all such approaches, or indeed any of those described in the manual. The various approaches are presented as examples. Evaluators can choose other defensible formulation frameworks.

The most important task to complete during Step 4 is to have a solid understanding of why a person has acted violently in the past, and why they may do so in the future. Such an understanding is necessary to manage violence, a process that benefits from considering what a person might reasonably be expected to do in the future, concerning violence, and hence how best to reduce the risk thereof.

Step 5: Risk Scenarios

After an understanding of which risk factors are most important for a person, and how these cohere into a cogent explanatory framework, evaluators can turn their thinking to concerns about the person's functioning in the future. The process of scenario planning is helpful in this regard, and relies heavily on previous steps. As stated in the Version 3 manual, "[b]efore taking preventive action the evaluator must first answer the question, what am I trying to prevent? Or, put another way, what exactly is it that I am worried this person might do?" (p. 56).

As Hart (2003; Hart et al., 2003; Hart & Logan, 2011) has described, scenario planning has a long history within numerous fields, such as business, health care, and the military (Ringland, 1998; Schwartz, 1990; van der Heijden,

1997). Its purpose is to develop informed, reasoned projections (i.e., linked to and derived from case facts) about future behaviors and the contexts that may lead to a certain violent outcome. It is not mere speculation, but rather thoughtful specification about future possibilities that are logically possible based on what is known about an individual. The scenario is based on what is known about an individual, yet must recognize that the future can ever be but relatively unknown. Scenarios are projections about what *could* reasonably happen, rather than statements about what *will* happen, in the future. Typically, only a few scenarios are reasonable and therefore needed in any given case – these are those that are credible and internally consistent to evaluators, given case facts (e.g., Chermack & van der Merwe, 2003).

Consistent with others' recommendations (e.g., van Notten, Rotmans, van Asselt, & Rothman, 2003), we recommend that evaluators consider several types of scenarios: repeat; twist; escalation; optimistic. A repeat scenario is one in which the person engages in the same type of violence, for similar reasons, as past violence. An escalation or worst-case scenario is one in which the severity of violence becomes worse over time. The twist scenario involves a change in the nature of violence (say, victim selection or use of weapons to accomplish goals). Finally, there is the optimistic or best-case scenario, in which the severity of violence decreases. Evaluators, relying on case facts and formulation, can attempt to discern the conditions under which any of these scenarios is likely to occur. In doing so, they can consider the following issues: (1) what kind of violence will a person engage in, for what reasons, and against whom? (2) What might be the physical and psychological harm to victims? (3) How soon and how often might violence happen? (4) What are the warning signs that the scenario might be unfolding? Working through these considerations, in conjunction with a solid formulation based on relevant risk factors, promotes informed consideration of the risk management strategies that might best mitigate risk and prevent scenarios from unfolding.

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Step 6: Management Planning

Management strategies are intended to address any important or relevant risk factor, and take into account reasons why a person may be violent (i.e., formulation) and what they might do in the future (i.e., scenarios). As a general principle, we are in agreement with the Risk-Need-Responsivity (RNR) model of risk management used most commonly in correctional settings to address risk for general recidivism (Andrews, 2012; Andrews et al., 2010). Management resources should be devoted primarily to high and next to moderate risk cases. Services should be proportional to risk level. Management strategies should focus on dynamic risk factors, or criminogenic needs. They should be delivered in a manner that is responsive to an individual's learning abilities and particular needs.

For Version 3 purposes, management includes the full breadth and range of risk reduction strategies at the disposal of agencies or persons responsible for the supervision of an individual. Four basic areas of management from which evaluators can select, or recommend, interventions include: (1) monitoring, (2) supervision, (3) treatment, and (d) victim safety planning (following Hart, Webster, & Douglas, 2001). The HCR-20^{V3} manual describes these areas in some detail. *Monitoring* is simply observation of and contact with evaluees and others (i.e., professionals, family members) who can shed light on the person's functioning. Frequency and intensity of monitoring should coincide with risk level, and can be used to keep track of changes in risk-relevant functioning, and any troubling warning signs that could prompt action. By *supervision* we mean the extent to which the freedoms of evaluees are restricted so as to make it difficult for a person to engage in violence. At the most basic level is the distinction between community versus institutional placement. Within either of these general settings, additional decisions can be made about necessary restrictions, such as security level, drug and alcohol testing, no-go areas, no-contact orders, prohibition of weapons, electronic monitoring, curfews, supervised community leaves, and so forth. *Treatment* spans multiple areas of intervention, including but not limited to psychiatric, psychosocial, educational, and vocational. Specific therapies could include anger management, skills training, and relapse prevention. As mentioned earlier, treatment should only target risk-relevant areas. Meta-analyses indicate that the more criminogenic needs or dynamic risk factors targeted, the greater the odds of reducing crime and violence (for reviews, see Andrews et al., 2010; Andrews, 2012; Douglas, Nicholls, & Brink, 2009). Finally, *victim safety planning* is of relevance in some cases where the potential victim is known. Steps can be taken to address the behavior of potential victims (i.e., promote consistency of behavior; offer therapy to address stress) or their context (i.e., physical security of residence) that might elevate risk.

In general, as described in the Version 3 manual (p. 61), evaluators might consider the following basic questions when devising risk management plans: "What are the most appropriate ways to monitor changes in risk? What restrictions on activity, movement, association, or communication are most appropriate? What assessment, treatment, or rehabilitation strategies are most likely to be effective? What steps could enhance the physical security or self-protective skills of the victim or complainant?"

Step 7: Conclusory Opinions

The final step in the HCR-20^{V3} administration procedure is to summarize concerns about risk level and prioritization of services. As described earlier, the SPJ model uses a

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narrative categorical approach to risk communication – *Low*, *Moderate*, or *High* risk. In Version 3, we recommend that these summary risk ratings be made for (1) risk of future violence generally, or case prioritization, (2) risk for serious physical violence, and (3) risk for imminent violence.

As described in the Version 3 manual (p. 62), the general definition of low, moderate, and high risk are as follows:

> "Low" or "Routine" means the person is not considered in need of any special intervention or supervision strategies designed to manage violence risk, and that there is no need to monitor the person closely for changes in risk.

> "Moderate" or "Elevated" means that the person requires some special management strategies, including at the very least, an increased frequency of monitoring.

> "High" or "Urgent" suggests that there is a pressing need to develop a risk management plan for the person, which typically would involve (at a minimum) advising staff, increasing supervision levels, placing the person on a high priority list for available treatment resources, and scheduling regular re-assessments. Some high risk cases will require an emergency response (e.g., hospitalization, suspension of conditional release).

As we described above, generally, the more relevant risk factors that are present, the higher will be the risk, and the more urgent will be the necessity of intensive management. However, in some instances, evaluators will conclude that risk is high, and hence priority for management resources must be high, based on a small number of risk factors (i.e., homicidal threats and a history of having acted on them). We encourage evaluators who make decisions of high risk in cases with few risk factors, or the converse, to explain *why* their decision does not follow the general rule of "more risk factors, higher risk." This follows the basic principle that these summary risk ratings always require justification based on case facts. Persons rated as *High* risk should be first in line priority-wise for services such as intensive supervision and correctional or mental health programming.

As mentioned, new additions to Version 3 include summary risk ratings for serious physical harm and imminent harm (harm over the coming hours to days, or days to weeks). The general principles that define "risk for violence, generally, or case prioritization," as described above, apply to these ratings as well, but with type (severity) or timing (imminent) as modifiers. That is, rather than asking "what is the risk of violence" generally, the evaluator would ask "what is the risk of serious physical harm" or "imminent violence" specifically? These judgments are independent of the general violence risk rating, such that whereas a person may be judged to pose a high risk for violence generally, the evaluator can conclude that she or he poses a low or moderate risk for serious physical harm or for imminent violence, as the case may be.

For ratings of serious physical harm, evaluators should consider whether evaluees have engaged in violence in the past that did, or reasonably could have, led to serious physical harm. Have weapons been used, or does the evaluee have access to weapons? Has the evaluee made any statements that indicate planning of serious violence? For ratings of imminent harm, evaluators should consider whether the evaluee is particularly unstable. Has he or she made any statements indicating that violence is planned for the near future? Is there a lack of services or supports in the near term future? Is the individual about to face any particularly destabilizing factors? Are there any warning signs present? Is there a large number of risk factors that are not addressed by existing management plans?

Finally, HCR-20^{V3} includes prompts for evaluators to specify when a case review should occur, and whether there are any other risks indicated. For the former, the general principle is that the higher the risk posed by a person, the sooner the case should be reviewed. For the latter, evaluators can specify whether there are any specialized types of violence for which a person shows risk factors (i.e., sexual violence; stalking; intimate partner violence). If so, the evaluator may wish to evaluate specifically for risk for those types of violence. Other potential risks indicated include suicide or self-harm.

Using these seven steps, Version 3 of the HCR-20 is intended to provide a comprehensive structuring of the entire risk assessment process, from the initial gathering of case information to the final summary conclusory opinions. In our view, Version 3 still exemplifies and embodies the SPJ model. It is based on a more all-embracing view of SPJ than was apparent in Version 2. People who are familiar with Version 2, and who are also familiar with contemporary SPJ scholarship, will, to an extent, be familair with the concepts and step-by-step procedures embodied in HCR-20^{V3}. Of course, the ultimate test of the utility and value of Version 3 will come through its professional and scientific evaluation by independent parties.

RECOMMENDATIONS FOR EVALUATION

We hope that the HCR-20^{V3} spurs research not only on the basic—but critical—topics of reliability and validity, but also on as-yet nascent areas of the risk assessment field. More needs to be found out about formulation and scenario planning, and their links to risk management and risk reduction. Evaluating the interrater reliability and predictive validity of the presence, relevance, and summary risk ratings will be important. In addition to evaluating the over-arching risk factors, evaluating the sub-items will be important as well.

For all such analyses, the ideal methodological approach would include both interviews and file reviews, in a prospective design. We recognize, however, that file-only

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research is a legitimate methodology, especially during the early days of evaluation. Testing the incremental validity of relevance ratings and summary risk ratings relative to presence ratings will shed light on their interplay vis-à-vis violence. We expect that all such ratings should be related to violence, but that relevance ratings and summary risk ratings might add incrementally to presence ratings. Research on Version 2 and other SPJ instruments has shown that summary risk ratings tend to add incrementally to the sum of presence ratings, although this has not been observed in all studies (for reviews, see Douglas, Hart, et al., 2014; Guy et al., in press; Heilbrun et al., 2010). It will also be important to operationalize violence in a manner that is consistent with the definition of violence in Version 3. Further, we recommend using multiple sources to measure violence.

Evaluating the risk factor indicators will be interesting. They are not intended to reflect manifest indicators of latent traits, and as such indices such as coefficient alpha, or use of factor analytic or item response theory analyses may not be appropriate. However, such approaches may find some utility for research purposes for investigators to further explore these indicators.

What will be particularly compelling, for its novelty, is evaluating formulation and scenario planning. Currently there is little research on these topics, and they are included in the HCR-20^{V3} for their clinical and heuristic value. Evaluations of formulation could focus on the extent to which they improve risk management plans (i.e., Are risk management plans more closely tailored to key risk factors? Are a greater proportion of relevant risk factors addressed compared to when explicit, HCR-20^{V3}-based formulation is not used? Do key stakeholders consider them useful?). Further, it is possible that formulation increases evaluators' understanding of individual cases, which could enhance predictive validity. This could be evaluated in a research design that compares decision-making with and without the use of formulation. Similarly, to the extent that formulation might produce more informed risk management plans, researchers could test whether the use of formulation leads to lower rates of violence in the future.

Many of the topics that can be evaluated vis-à-vis formulation could also be evaluated with respect to scenario planning (i.e., improved quality of risk management; increased validity). Studies could also address whether posited scenarios actually are more likely to come to fruition compared to non-posited scenarios. This, of course, is very complicated if people are specifically acting to prevent scenarios from unfolding. Hence, unobtrusive measurement would be key. For instance, scenarios would have to be constructed without influencing actual practice. Subsequent acts of violence would be compared to the scenarios that were constructed.

Clearly, guidelines for the ethical conduct of research would have to be followed (i.e., duty to protect). One approach might involve archival research where scenarios are constructed, and any subsequent violent acts are measured, based on past file information. If research teams were allowed to shadow actual cases in a prospective design, the duty to protect, where applicable, could still lead to researchers intervening to prevent violence. In such cases, the actual dependent variable would not be completed acts of violence, but any warning signs and early evidence of the unfolding of scenarios. In essence, these dependent variables would serve as proxy markers — an ethical step removed — from completed violence.

Of course, one of the key purposes of the SPJ approach is to prevent subsequent violence through risk management. Evaluating risk management should focus on whether using Version 3 increases the quality of risk management plans. The ultimate test is whether the use of HCR-20^{V3} to construct management plans actually reduces violence compared to assessment/management approaches that do not use HCR-20^{V3}.

Finally, the role of ethnicity, gender, setting or country could also be addressed within any of the above research areas, and we hope that they are. We also look forward to $N = 1$ descriptions not only of cases, but of successful implementations of HCR-20^{V3} into practice at the agency level. We are aware of many such examples from Version 2, and a few that are starting with Version 3. Publishing examples of these activities might help the field more broadly when it comes to using the HCR-20^{V3} in practice.

CONCLUSION

The purpose of this article was to introduce Version 3 of the HCR-20 to the field. Our work on the development of Version 3 benefitted from and was influenced by many colleagues, some of whose work is included in this special issue. We started this article by looking back at our aspirations when we published Version 1 of the HCR-20 two decades ago. We wanted the practice of risk assessment to be better informed by science. It was our thought that Version 1 might contribute to that goal, and might itself stimulate some research. Our goals have remained similar over 20 years, though are now more refined. We still aim for practice to be informed by science, and hope now that HCR-20^{V3} may stimulate further research. Many of the basic assumptions of the SPJ approach have been supported by research conducted by many people across numerous SPJ instruments, across many countries. We know that its risk factors are associated with violence, and that professional judgments based on these risk factors are associated with violence. We know, too, that changes in dynamic risk factors on SPJ instruments such as HCR-20 Version 2 are related to changes in subsequent violence. We look forward to new programs of research that address some of the more novel aspects of the SPJ model incorporated by HCR-20^{V3}, such as relevance ratings, formulation, and scenario

planning. And, as always, we look forward to research that evaluates the effect of risk assessment and management on risk reduction.

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