Four Winds HOSPITALS
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Estimation of Violence Risk in Adolescents

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A few highly publicized mass murders involving adolescents have made mental health professionals acutely aware of the need to estimate and manage the risk of violence in their adolescent patients. While these events receive intense publicity, they are extremely rare and efforts to predict them have proven ineffective (Mulvey & Cauffman, 2001). While clinicians should be vigilant for signs that an adolescent might be contemplating such behavior, teens are far more likely to become involved in the more mundane but still quite serious forms of violence that take place every day; and scientists tell us that these can be predicted with some degree of accuracy (Otto & Douglas, 2010).

The judgment of violence risk by clinicians is not inherently inaccurate, but clinicians have a tendency to concentrate too little on the factors that have been found to predict violence and too much on those that do not. It is their tendency to focus on the wrong information when forming their judgments that often leads them astray. When their attention is focused on the information that has the most predictive power and they assign appropriate weights to it, their estimation of an adolescent's risk for violence is often quite accurate. Therefore, the challenge is to help clinicians focus on the relevant information and avoid becoming distracted by irrelevant information.

A class of instruments called *Structured Clinical Judgment Tools* has been developed to aid this process. These help the clinician to focus on the key variables, review them systematically and thoroughly and assign each the most appropriate weight before forming their judgment. These are not tests in which items are added up to arrive at a score, but rather guides to help clinicians consider critical information.

One such instrument is the *Structured Assessment of Violence Risk in Youth* (SAVRY) developed by Borum, Bartel and Forth (2002, 2003, 2006). Based on a comprehensive review of the research literature they identified 24 significant predictors, including 10 based on the individual's history, six that concern their current environment and circumstances and seven that involve individual traits or behavior patterns. They provide an explicit definition for each and an explicit definition of low, medium or high. The clinician is asked to read the definition of each variable, reflect on all that they currently know about the patient and decide where they fall. After considering each risk factor, the clinician is asked to consider six factors that have been shown to reduce the risk for violence. Once having considered all of this information, the clinician forms a judgment about the level of risk that this teen currently presents. This judgement may be driven by the total number of risk factors present or it may primarily reflect one or a few variables that seem particularly important. This judgment may change as the adolescent changes or new information comes to light. Working through this structure in this fashion ensures that the clinician has considered all of the relevant evidence and given it the appropriate weight before arriving at their judgment.

Structured clinical judgment tools have been developed for use with adults (e.g., HCR-2) and for predicting specific kinds of violence (e.g., SVR-20). These techniques are not infallible and they are limited by the information available at the time their judgment is formed. Nevertheless, research suggests

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that such tools are a significant improvement on unstructured judgement and they provide a method for ensuring that the clinician has made the best use of the available information when estimating the risk for violence in adolescent patients.

References

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Otto, R.K., & Douglas, K.S. (Eds.) (2010). Handbook of Violence Risk Assessment. New York, NY: Routledge, Taylor, & Francis Group.

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