

In search of a model procedure for assessing the risk of violence in polish conditions – summary of authors' research results

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Abstract:

The aim of the article is to analyse the possibilities available to Polish specialists in the process of assessing the risk of violence and accompanying difficulties. In the study, three categories of problems related to the assessment of the violence risk are taken into account: systemic, personal and methodological. In accordance with the conclusions formulated based on the results of the authors' research, an analysis of the literature and on the recommendations of the creators of internationally recognised tools for assessing the risk of violence, a model procedure for diagnosing and monitoring risk was proposed, aimed at improving the accuracy and effectiveness of assessment in Polish conditions. The authors also formulate recommendations for improving activities at systemic, personal and methodological levels, facilitating the effective and efficient implementation of the model procedure in psychiatric and penitentiary areas.

offenders; risk assessment; violence; structured professional judgement

INTRODUCTION

Risk assessment related to violence has been successfully implemented in the context of legal decision-making around the world for at least thirty years in the fields of forensic and general psychiatry, as well as in the penitentiary area. The use of professional tools based on solid empirical knowledge in this process seems to be its essential element due to the high costs of making a wrong decision, both for the assessed offender – whose freedom may be seriously restricted, and for public safety – if the risk is not

assessed correctly, consequently, aggressive recidivism is not prevented [1]. Along with the widespread use of this method, the development of empirical knowledge on risk assessment was rapid. On this basis, the use of professional, structured tools for assessing the risk of violence by professionals associated with the justice system can be considered the best practice [2]. It is also worth noting that in various contexts and in different jurisdictions, criminal regulations or policies even require the use of violence risk assessment tools [3], [4]. In previous studies, it was also shown that courts widely accept expert opinions on risk assessments [1]. Unfortunately, similar research is not conducted in Poland, and analyses on the psychometric properties or usability of risk assessment tools are rare.

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Initially, structured violence risk assessment tools were mainly developed for the purpose of prediction, or in other words, to provide a scientific basis for determining the level of risk of violence. They were later refined to facilitate the process of risk conceptualisation [5] and their functionality was expanded to include the possibility of risk management and reduction [2].

One of the most widely used tools for assessing and managing the risk of violence in clinical and forensic practice is the Historical Clinical Risk (HCR-20V3) scale, developed in accordance with the assumptions of the Structured Professional Judgement (SPJ) trend. It allows for determining and monitoring the individual risk of violence over time, by simultaneously taking static and dynamic risk factors into account. The scale is intended for short-term prediction, over a period of six to 12 months, or whenever a significant change in context occurs, e.g. acquiring the right to unsupervised leave, a change in security level, etc. Singh, Desmarais, Hurducas, Arbach-Lucioni and Condemarin et al. [6] empirically confirmed the universal use of the HCR-20 v3, based on data collected from 2,135 respondents from 44 countries (located on six continents). The surveyed professionals reported using the HCR-20 v3 in more than half of the risk assessments they had completed in the previous 12 months. The scale was used more frequently by psychologists than psychiatrists or nurses.

Increasingly, in accordance with the recommendations of the scale's authors, the HCR-20 v3 is used in conjunction with the Structured Assessment of Protective Factors (SAPROF) tool, which allows for expanding the researcher's perspective to include assessment of protective factors. Due to this, an integrated risk assessment as well as a resource-focused treatment/remedial action plan can be developed. The psychometric properties of the HCR-20V3 and SAPROF have been studied within various populations and contexts [1]. At least 'good' agreement has been demonstrated between judges' assessments made using them in penitentiary, forensic-psychiatric and mixed populations. The majority of the published ICC agreement indices ranged from 0.70 to 0.80, which indicates 'high/very high' agreement [1]. In unique analyses conducted in Poland, Banasik, Welento-Nowacka, Wojtowicz and Gierowski [7] confirmed simi-

lar, 'high' agreement between evaluators in the final assessment of risk intensity (measured via HCR 20 v3) and the evaluation of protection level (measured using SAPROF) in a group of prisoners ($n=200$, three judges, $\alpha = 0.77$) as well as in the group of forensic psychiatric patients ($n=201$, three judges, $\alpha = 0.86$). These data should be considered significant in the context of increasing the trust of Polish specialists in assessments made using SPJ tools, and thus, the possibility of increasing their dissemination in psychological, forensic psychiatric opinions and periodic assessments at institutions dealing with therapy, the implementation of therapeutic and protective measures towards perpetrators or their resocialisation.

The aim of this article is to present the contexts and specifics of the process regarding violence risk assessment in Polish conditions, taking the applicable legislation into account. The relevant legal regulations were analysed, which do not precisely define the framework of the procedure for assessing the risk of violence in the area of forensic psychopathology. An attempt was also made to systematise the challenges and problems related to assessing the risk of violence in Poland, resulting from both methodological limitations as well as the aforementioned legislative and organisational barriers. Based on the results of the authors' research, analysing studies conducted by the creators of internationally recognised tools for assessing the risk of violence and practical solutions developed by national specialists, a proposal is formulated and presented for a model procedure used to estimate the risk of violence, taking implementation possibilities into account. An important basis for the developed procedure was noted in the conclusions drawn from the analyses conducted by the authors as part of the research project entitled *The Role of Risk and Protective Factors in Assessing and Monitoring the Probability of Committing a Prohibited Act Among Perpetrators Covered by the Isolation System of Therapeutic and Protective Measures and Serving a Prison Sentence*, implemented in the years 2019-2025. The presented model aims to improve the accuracy and reliability of violence risk assessment and increase the effectiveness of preventive actions as well as those aimed at monitoring the level of risk among perpetrators in Polish con-

ditions. The authors also indicate directions for further research and legislative changes that will facilitate the process of violence risk assessment in Poland, increasing the trust of Polish specialists in the methods, which may facilitate their wider use in psychological and forensic psychiatric opinions and periodic assessments at penitentiary institutions. All considerations will be placed within the context of empirical analyses and best practices developed in other countries.

Possible contexts for assessing the risk of violence in Polish conditions

Assessment regarding the likelihood of repeating acts of significant social harm mainly concerns the application of security measures and the Act of 22 November 2013 on proceedings towards persons with mental disorders posing a threat to the life, health or sexual freedom of others (hereinafter referred to as the Act). Experts are obliged to state whether there is high probability that, due to mental illness, retardation or other disturbances in mental functions, the perpetrator will commit the prohibited act again. The necessity of applying security measures may also be ruled in connection with the existence of sexual preference, personality disorders or addiction of the perpetrator of the prohibited act. This means that experts must not only make a diagnosis, assess whether in a given case the perpetrator was insane, but also determine whether and what the risk is that, due to the above premises, the perpetrator will commit a similar act again. Assessment in the event of lifting a security measure against the perpetrator is equally important. Article 202 of the Code of Criminal Procedure obliges medical personnel to achieve such a state of remission in the patient that this risk becomes 'not high'.

Another example of a situation in which the probability of recidivism is assessed concerns acquiring the right to early conditional release from serving a prison sentence. In this case, it is necessary to conduct a criminological and social forecast, the scope of which is precisely defined by the Regulation of the Minister of Justice on the methods of conducting penitentiary actions at prisons and detention centres (Journal of Laws 2003, No. 151, Item 1469, consolidated

ed text Journal of Laws 2024, Item 1344, hereinafter referred to as the Regulation of the Minister of Justice). Despite the similar purpose of the actions undertaken by experts, which is to determine the level of risk, in the context of security measures, the assessment carried out is not identical to the criminological and social prediction. In this case, the legislator treats the assessment of probability quite narrowly, limiting the premises only to the evaluation of the degree of improvement in health and progress in treatment. The situation is similar in the situation of the using security measures against perpetrators manifesting sexual preference disorders, diagnosed with addiction and personality disorders. Based on the data from literature and the practice of foreign specialists presented in the 'Introduction' section, information on the diagnosis, degree of remission or progress in treatment do not constitute a sufficient basis for an accurate decision to terminate preventive measures. In the literature on evidence-based methods of assessing the risk of violence, attention has long been drawn to the mere fact that the presence of a mental illness is not the only factor, but also not the most significant one determining the increased risk of committing acts of violence [5].

The aforementioned methods, such as HCR-20 V3, SAPROF, as well as Sexual Violence Risk (SVR-20) tool and similar ones, take a number of risk factors (and protective factors) into account that should be considered in the assessment process. In addition, they allow to emphasize the importance of the assessment context for its results (institutional or non-institutional), which suggests the need to repeat the assessments each time a change occurs in context. In addition to analysis of the past and current situation of the perpetrator, they also require making a prognosis regarding the future, including the availability of risk management methods. To confirm the validity of such a procedure, data may additionally be cited from analyses concerning the probability of aggressive behaviour among people diagnosed with schizophrenia. They provide two types of explanations. On the one hand, it is believed that patients who regularly take medications do not pose a greater risk to society than the rest of the population [8]. On the other, it is insinuated that those who are in an acute phase of the disease and do not take medications

may pose such a risk [9]. This means that the achieved improvement in mental state cannot be treated as the only factor justifying the decision to terminate the use of a preventive measure. Additional consideration should be given regarding future response to treatment and supervision (included as a risk management factor in the HCR-20 v3), which includes adherence to pharmacotherapeutic recommendations established by a psychiatrist. Many factors of a diverse nature, i.e. motivational, self-regulation and adverse effects, can underlie effective pharmacotherapy.

As attempted to demonstrate, both in the group of people diagnosed with schizophrenia and in the case of perpetrators who commit prohibited acts due to addiction, personality or sexual preference disorders, an accurate risk assessment requires taking a much broader context into account, encompassing not only psychological or psychiatric factors, but also criminological and social ones. The determinants of evaluations regarding the probability of committing prohibited acts in the context of security and post-penal measures specified by the legislator seem insufficient in view of the literature. In practice, this leads to significant differences between assessors in the applied methodology and the assessment results. This means that some experts, when estimating the risk, refer only to the current mental state of the perpetrator, while others extend the assessment to include elements of criminological and social prognosis. Regardless of the assessment context, the repertoire of determinants should be elaborated and unified in accordance with scientific evidence. Based on the guidelines of the Regulation of the Minister of Justice, a wide range of factors should be taken into account in the social and criminological prediction, such as: a) family environment; b) personality traits, including the degree of self-discipline and tendency to use violence; c) problems with alcohol or those related to the use of psychoactive substances other than alcohol; d) completed addiction treatment, as well as motivation to maintain abstinence; e) path of social derailment, including the degree of demoralisation; f) type of crime for which the convicted person is serving a sentence; g) conduct during previously served sentences, with particular emphasis on the manner of using permits to leave

the institution; and h) environment in which the convicted person will stay while on leave.

In the context of adjudicating or revoking security measures, similar guidelines have not been formulated by the legislator. The need to specify them is increasingly noted in specialist literature in order to improve the consistency of assessments made by specialists and to reduce their bias as well as intuitive nature. Some more experienced experts already indicate in their opinions such factors as: lack of social support, co-existing addiction, lack of a safe place of residence or employment, previous problems of the perpetrator with supervision or compliance with medical recommendations, justifying the assessment of violence risk. However, this is not a widespread practice. Providing specialists with a standardised model or more precise assessment guidelines, created on the basis of scientific knowledge, would improve the quality of opinions, especially in the case of less experienced experts, but it would also provide experienced ones with a defence against routine, biased actions.

Article 202 of the Executive Penal Code requires the personnel treating patients, as part of security measures, to undertake such medical, rehabilitation, resocialisation and therapeutic actions so that the person leaving the psychiatric hospital does not pose a threat to the legal order, and their further treatment also becomes possible outside the facility (Journal of Laws 2024.706 Executive Penal Code, Art. 202 [Purposes of Executing Security Measures]). Therefore, such action should be taken not only to improve mental state, but also to prepare the patient for life in society, so that s/he does not commit another prohibited act. This expresses the expectation that thanks to the applied actions, not only will the patient not present psychotic symptoms, but will also regularly take medication after leaving the hospital, will not have a lapse in abstinence and will use specialist advice to monitor the effectiveness and management of the further treatment process. Such formulated expectations should direct specialists' attention towards tools for assessing the risk of violence, following the practices used in developed, modern psychiatric systems, e.g. Dutch or Norwegian, where their use is controlled by regulations at a national level. These systems emphasize the fact that the ul-

timate goal of specialists is not to assess the risk, but to effectively manage its level [10]. Planning appropriate therapeutic activities, developing an accurate prognosis of future risk and methods for its management undoubtedly require reference to knowledge about the risk factors of violence as well as the constant updating of this knowledge. Currently, in Polish conditions, the described procedural method is used extremely rarely. Possible reasons for this situation will be detailedly analysed in the next section.

Challenges and problems in process of assessing risk of violence in Polish conditions

The attempt to develop a model procedure for assessing the risk of violence required a prior anal-

ysis of the challenges and problems faced by specialists evaluating risk in various contexts and in Polish conditions. Based on the authors’ research and the guidelines available in foreign literature, it becomes possible to indicate proposals for their solution in the further part of the article. Some of the difficulties have already been signalled in the earlier parts of this publication, for example, during the analysis of the applicable legal solutions in the field of assessing the risk of violence. The observed challenges and problems have been provisionally assigned to three categories: systemic, personal and apparatus/methodological (see Table 1). In the further part of the article, due to the limited volume of this study, selected ones are discussed. First, the authors analyse examples of difficulties that are systemic in nature.

Table 1. Categories of challenges and difficulties related to assessing the risk of violence in Polish conditions (authors’ research)

Systemic
1. Low precision of statutory provisions regarding the scope and basis of risk assessment.
2. “Unrealistic” expectations of the legislator regarding the differentiation of risk categories.
3. Low availability of psychological and psychiatric staff in units/overcrowding of psychiatric and penitentiary wards.
4. Lack of standards in the implementation of the goals set by the Executive Penal Code in the areas of therapeutic and protective measures.
5. Low availability of non-institutional solutions enabling supervision/monitoring the risk level of violence.
Personal
1. Perceived effort required to assess risk using SPJ tools.
2. Concerns about the need for extensive experience/high level of competence among SPJ users.
3. Attachment to unstructured clinical diagnosis.
Apparatus/Methodological
1. Low availability of data on the psychometric properties of tools/low confidence in risk assessment methods.
2. Lack of tools in full Polish adaptations.

Systemic challenges and difficulties

Low precision of statutory provisions regarding scope and basis of risk assessment

As suggested in the previous part of this publication, based on the analysis of current legislation, the determinants of the assessment regarding the probability of committing prohibited acts have not been sufficiently standardised in the various contexts of the analysed assessment. They have not been formulated with the same precision in the context of adjudicating

therapeutic as well as security measures and in the penitentiary area. A wide range of determinants is required to be taken into account only in the process of making a criminological and social prognosis. This approach is, in principle, consistent with the recommendations of risk researchers presented in the literature. Regardless of the context of assessment, the repertoire of determinants should be elaborated and standardised in accordance with scientific evidence. Modern risk assessment tools, such as the HCR-20 V3 and SAPROF, undoubtedly provide guid-

ance on the scope and type of violence risk factors that should be considered. Beisert, Bartoszak, Szumski, Izdebska and Zielona-Jenek [11] also emphasize that it is necessary to ensure not only that risk factors are measured using empirically-based tools designed for this purpose, but also that dynamic factors are measured cyclically for as long as the punishment/measure is carried out or the perpetrators are later supervised. Unrealistic” expectations of legislator regarding differentiation of risk categories

In the opinion of Szumski et al. [12], one of the most problematic provisions of the Act of 22 November 2013 is the one indicating the necessity to distinguish perpetrators from groups of ‘high’ and ‘very high’ probability of committing a prohibited act, as well as to make a precise distinction between these two groups of perpetrators. This issue was also subjected to detailed criticism by Gierowski and Paprzycki [13] and Bocheński [14]. In case law and doctrine, there is a well-established view that the decision in a specific case belongs exclusively to the court, and the expert opinion is only evidence subject to assessment. The expert is to provide the court with specialist knowledge and not to decide whether the statutory requirements have been met. In the context of the Act of 22 November 2013, questions posed for experts should therefore concern, among others, the occurrence of mental disorders, their nature and intensity as well as the risk level of recidivism. However, specific statutory regulations seem to contradict this principle. According to Art. 11, experts, and not the court, must determine the existence of two of the three grounds for considering the participant as a person posing a risk. They must also assess whether there is a high probability of committing a serious crime. Thus, the court, although formally making a decision, is largely dependent on the expert opinion [15] [16].

The discussed provisions of the act are also described as controversial by experts themselves. Available risk assessment tools, especially those developed in the SPJ approach, do not contain separate standards for the ‘very high risk’ category, but they allow for observing a high level of risk of violence [12].

Low availability of psychological and psychiatric staff at units and overcrowding of psychiatric and penitentiary wards

In 2016, as part of Order No. 19/16 of the Director General of the Prison Service on detailed principles for conducting and organising penitentiary work as well as the scope of activities of officers and employees of penitentiary and therapeutic departments and penitentiary wards, in Paragraph 93.3.2, standards were introduced regarding the size of educational groups entrusted to the care of penitentiary psychologists¹. In accordance with these regulations, one psychologist employed in a prison covers a group of no more than 200 inmates. According to information published on the website of the Office of the Commissioner for Human Rights (BRPO), on a national scale, there were 458.75 penitentiary psychologists for every 73,000 inmates at the end of December 2018. More recent statistics on this subject are not publicly available. Nevertheless, the cited data provide a certain image regarding the realities of the work of penitentiary psychologists. Excessive workload in this group appears to be a significant systemic problem with serious consequences, such as, reduced effectiveness of interventions undertaken by psychologists and efficacy of the resocialisation process.

The accounts of people working at forensic psychiatry departments indicate that a similar problem also concerns the psychiatric context. Many departments provide medical services significantly above the number of “beds” contracted under the National Health Fund (NFZ). The problem is compounded by the low availability of specialists in psychiatry and psychology within the departments. Sometimes, in a forensic psychiatry department, 68 patients are treated by two psychologists, one addiction therapist and two doctors. There is a persistent trend – more people are admitted to forensic psychiatry departments than are discharged from them. Due to the low availability of solutions enabling supervision or monitoring the risk level of violence among patients after leaving the department, detention in Poland lasts a long time. In the absence of unified principles regarding the

¹ <https://bip.brpo.gov.pl/sites/default/files/Odpowied%C5%BA%20%20Zast%C4%99pcy%20Dyrektora%20Generalnego%20SW%20%2011.03.2019.pdf>

basis of risk assessment, staff confidence in the conducted assessments is low, and decisions to lift therapeutic and protective measures are sometimes made with a delay.

According to Beisert et al. [11], specialists working directly with perpetrators should be treated as key resources enabling the construction of an effective system with nationwide impact. Consequently, one of the initial stages in the process of creating the aforementioned system should be attempts to stop the wave of resignations from working in this group and to strengthen (the high, after all) competences of its members through systematic training. This training should concern basic specific competences related to diagnosis and therapy.

Lack of standards in implementation of objectives set by Penal Code in area of therapeutic and protective measures

Another problem is, to some extent, related to the discussed staff shortages. Treatment, therapeutic, rehabilitative and resocialising measures should be taken in relation to patients covered by a security measure. While the therapeutic measures taken by psychiatrists seem to be consistent and result from the recommendations concerning pharmacotherapy of mental disorders, in the case of therapeutic or rehabilitative measures for perpetrators there are no consistent guidelines or unified programmes. The authors' experience shows that each forensic psychiatry department creates its own therapeutic programmes based on experience and staff capabilities. Some departments offer, for example, therapeutic groups aimed at reducing aggression, psychoeducation and metacognitive training, while others offer only individual conversations with a psychologist. Similar difficulties are encountered by the staff of penitentiary departments, especially those with a "general" profile – not a therapeutic one. A penitentiary psychologist carries out his/her tasks by conducting individual psychological consultations with persons deprived of their liberty, undertaking crisis interventions, preventing self-aggression and suicide, giving opinions and psychological diagnosis (also in the field of addictions). Apart from individual meetings, the penitentiary psy-

chologist conducts group psycho-corrective and educational workshops on various topics. The therapy is supposed to take place in therapeutic wards. The functioning of such wards is regarded positively within the Polish penitentiary system. However, they undoubtedly require further expansion in order to increase their availability, also within the system of therapeutic and protective measures.

Rehabilitative activities for forensic psychiatric patients also pose a specific challenge in the Polish psychiatric system. They usually include encouraging everyday activity, teaching sensible money management or everyday chores, such as doing laundry, cooking or cleaning and even taking care of personal hygiene. They should also aim at professional activation. In the case of patients of forensic psychiatry departments, the above-mentioned activities should, it seems, be extended to include certain activities of a resocialising nature. The Executive Penal Code (KKW) defines them, in relation to persons serving a prison sentence, as a set of methods and principles of conduct, the implementation of which is to cause changes in the area of the prisoner's personality, as a result of which s/he should make efforts towards readaptation and social reintegration [17]. Among the resocialisation techniques, those based on personal influence, cultural technology, eco-technology and the system of punishments and rewards are mentioned [18]. The first three methods do not raise ethical doubts when applied to patients of psychiatric hospitals. After all, the system of punishments and rewards based on recognised and widely used cognitive-behavioural therapy does raise such doubts. Although its effectiveness is broadly discussed and its aim is to develop correct attitudes according to the principle of responsibility [19], in psychiatric hospitals, the technique is considered unacceptable and contrary to the Mental Health Protection Act. This probably results from concerns about the abuse of patients. However, this could be avoided by using, following the example of the penitentiary system, an officially created system of penalties and rewards, taking the specificity of a psychiatric hospital into account. The authors consider steps to be highly desirable that are focused on unification of the rules applicable at various centres in Poland in a way that reflects the spec-

ificity of departments with different levels of security.

Beisert et al. [11] have a similar opinion regarding the impact on perpetrators of crimes against sexual freedom and decency. They postulate increasing the care taken to apply empirically proven effectiveness to perpetrators, which would mean the dominance of the behavioural-cognitive approach (in some conditions, also systemic) in this area. The context of the impact is also important. In this situation, outpatient conditions are preferred, or possibly psychiatric hospitals, which would replace therapy conducted in prisons. At the same time, Beisert et al. [11] emphasize, alike the authors of this article, the need to unify practices in the area of applying specific measures throughout the country to perpetrators of crimes against sexual freedom and decency. The unification process could be facilitated by an entity established to coordinate impacts on a nationwide scale and to ensure the appropriate competences of specialists from all over the country.

Low availability of non-institutional solutions enabling supervision/monitoring risk level of violence

To put it simply, it may be assumed that the forensic psychiatry system in Poland operates in a binary manner. It does not offer non-institutional solutions that would allow monitoring the risk of violence in a patient and supervision over him/her. The penitentiary system, of course, struggles with a similar problem. A certain group of prisoners have the opportunity to use passes or conditional early release, but in the case of people ending their prison sentence on time, the prison staff have practically no means of supervision over the perpetrator leaving the institution. They do not have to offer them systematically designed non-institutional solutions that would guarantee specialist support in social reintegration and the possibility of monitoring the level of risk of violence in conditions of freedom. In both systems, we are therefore dealing with a transition – from full or almost total isolation to a complete lack of supervision after release from the institution. Analysis of foreign solutions, e.g. the Dutch one, allows us to indi-

cate many benefits resulting from expanding the scope of so-called transmural solutions, offering various degrees of supervision over the perpetrator [1]. Meanwhile, in the Polish system of forensic psychiatry, the patient usually starts hospitalisation within the Regional Forensic Psychiatry Department or at a ward with an enhanced level of security, and ends up in a basic ward. The role of the wards with a maximum and enhanced level of security is primarily to stabilise the patient's mental state and to undertake initial therapeutic actions, mainly focused on psychoeducation regarding the disease. The next stage of action takes place within the forensic psychiatry ward having a basic level of security. In Polish conditions, this is the final stage, immediately preceding the patient's return to society, which is to prepare him/her appropriately for this moment. This task should be considered extremely difficult, knowing that it is carried out in a closed ward, without the possibility of freely leaving the hospital premises, e.g. to take professional courses, practice how to make purchases, meet with family in intimate conditions, etc. In such a context, the ward staff does not have a solid basis for assessing whether a specific patient is ready to leave the hospital. S/he may only grant him/her permission for a temporary stay outside the hospital (for three days, and in special cases, for seven days) under the care of family or a trustworthy person. The provisions of the KKW include, admittedly, the possibility of granting leave under the care of a reliable individual. A therapist from the ward could be included in this category of people, but with a small number of staff and a large number of patients, this solution should be considered unavailable in practice. The indicated problem is also not solved by the existing provision expressed in Art. 93a, Point 2 of the Penal Code, which allows for supervision in the form of a non-custodial security measure, such as therapy or addiction therapy. In this case, the procedural bodies do not present a uniform understanding of therapy – from a broad approach, encompassing pharmacotherapy, psychotherapy or psychological therapy [20] to a narrow one, treating the impacts described in Art. 93f of the Penal Code, as reserved for perpetrators requiring a reduction in sexual drive. Adopting a narrow approach takes away the possibility of us-

ing therapy as a non-custodial protective measure for insane perpetrators.

The lack of systemic solutions, non-institutional in nature, significantly limits the possibilities of providing patients and prisoners with a safe and pro-social place of residence and support when returning to the community. Based on extensive empirical data obtained using risk assessment tools created in the SPJ trend, one can be sure that future problems with the life situation and support are significant risk factors for violence outside the institution [21], [22], [23]. Banasik et al. [24], in their study with the participation of Polish forensic psychiatric patients, listed a group of six factors significantly influencing the assessment of violence risk intensity in the future. In the absence of other solutions, the decision on the possibility of the patient leaving the psychiatric hospital is often based on the family's commitment to care for the patient. Such supervision of relatives, however, is usually only focused on monitoring the intake of medication and monitoring medical visits. Quite often, relatives do not have the knowledge on how to help the patient fully return to society or do not show any particular willingness in this regard. Many patients, especially those hospitalised for a long time or hospitalised as a result of violence against loved ones, do not necessarily have families who are ready to provide them with help. In such a situation, it is often necessary to place the patient in a Social Welfare Home. This is associated with many problems, such as: long waiting times for admission to this type of institution, the inability to apply for placement in a Social Welfare Home during hospitalisation, the lack of indications for placement in a Social Welfare Home in the case of a large group of patients without a place to live, etc.

The need to provide systemic solutions guaranteeing supervision of perpetrators of crimes against sexual freedom and decency in non-institutional conditions is also emphasized by Beisert et al. [11]. In their opinion, optimally designed supervision should consist of two elements: assistance and control of perpetrators. The first is to provide them with the necessary support in building a new, "non-criminal" lifestyle, expanding resources and coping with deficits. The second gives specialists the opportuni-

ty to monitor the current risk of violence/recidivism, so that they can observe a potential increase in this risk and implement appropriate measures to minimise it in time.

Personal challenges and difficulties

The second group of problems facing specialists involved in risk assessment for the needs of the justice system has been provisionally called personal. They concern the beliefs and customs observed among Polish specialists performing violence risk assessments for the needs of the court.

Concerns about need for extensive experience/ high level of competence of SPJ users and perceived effort required to assess risk using SPJ tools

Risk assessment, in accordance with the procedure proposed within the SPJ tools, due to its multi-stage and partially qualitative nature, seems to require a lot of clinical experience and is also time-consuming. Their creators, however, expect users to meet three basic criteria: knowledge of the literature on violence, experience in individual diagnosis and knowledge of mental disorders. Users whose clinical knowledge is insufficient should consult a more experienced specialist during the assessment process. The creators also recommend undergoing training supervised by a qualified trainer before starting to use the tools. As indicated in the 'Introduction' to this study, assessments using the HCR-20 v3 and similar tools can be performed by specialists of various specialties, not only psychologists and psychiatrists. The authors of the scales also agree that the user's proficiency is crucial for the assessment of results, especially in forensic psychiatric opinions [1]. Tully [25] shares a similar opinion and, at the same time, points out the need to provide institutional/organisational support to assessors, regardless of how many resources this process will consume. When writing about support, this researcher means institutional conditions that provide the possibility of continuously improving competences and broadening knowledge concerning the assessment of the risk of violence by users,

e.g. through supervision, participation in conferences, literature analysis. Specialist training offered by employers is also important. In order to improve the quality of assessments, high awareness of users in terms of the possibilities offered by the applied methodology and in the area of the risk of bias is also important. They should actively strive to minimise the probability of cognitive errors when making decisions and transparently present both the strengths and limitations of the conclusions given in the opinion in order to facilitate their proper assessment by the court [1].

The perceived laboriousness of the risk assessment procedure assumes particular significance in the context of the problem regarding the shortage of specialists employed at psychiatric and penitentiary wards, described in one of the earlier sections of the article. The use of an unstructured clinical method in assessing the risk of violence seems to be the only and necessary "shortcut" in such a situation. The effect of such an approach is an increase in the percentage of low-quality opinions at risk of bias and, consequently, not very reliable or prognostically accurate.

Methodological challenges and difficulties

The final, third group of problems facing specialists dealing with risk assessment for the needs of the justice system are those of an apparatus-related or methodological nature. They concern availability of diagnostic scales in Polish adaptations and the trust of users in their implementation.

Low confidence in risk assessment methods/low availability of data on psychometric properties of tools

Polish experts associated with the justice system often emphasize concerns about the subjectivity of assessments made using SPJ tools, especially for final risk assessment, which is not a simple reflection of the sum of observed risk factors, but requires assessment of their weight and interrelationships. As mentioned in the 'Introduction' to this study, such concerns seem unjustified.

Literature provides solid data on the reliability and validity of risk assessments in the SPJ approach. In many studies, at least 'good' agreement has been proven between judges' assessments made using the HCR-20 v3 in penitentiary, forensic-psychiatric and mixed populations. 'High' agreement between raters (three judges) in the final assessment of risk intensity (measured by HCR-20 v3) and the assessment of the level of protection (measured by SAPROF) was also confirmed in a group of Polish forensic-psychiatric patients and prisoners in the only analysis of this type conducted in our country to date. The highest agreement concerned the assessment of historical factors, which are stable and usually well-recorded in medical records/documents [7]. Importantly, according to the recommendations of the Association for the Treatment of Sexual Abusers, in the case of making decisions on the use of long-term isolation measures (such as placement in the National Centre for the Prevention of Dissocial Behaviour), static factors are considered the most important for the assessment, followed by stable dynamic factors, and the least important comprise dynamic acute factors [12]. In the group of Polish prisoners, 'low' agreement was observed between judges in assessment regarding the intensity of problems with managing the risk of violence, while in the group of forensic psychiatric patients, 'low' agreement was also noted for the evaluation of external protection [7]. The above observations should be explained by referring not so much to the properties of the applied SPJ tools, but to the lack of systemic solutions in the area of supervision and non-institutional support in both of the studied groups described in the previous fragment. Differences in the assessments of individual judges could have resulted from difficulties in predicting the availability of specific forms of supervision and therapy after the completion of hospitalisation/penalisation.

One of the most important areas of verifying the psychometric properties of violence risk assessment tools is the measurement of predictive validity. Evidence concerning the predictive validity of the HCR-20v3 has been collected in different cultures and in various offender populations (forensic psychiatric, general psychiatric and penitentiary), as well as in different contexts (non-institutional settings and dur-

ing institutional stays). The results of the studies allow to confirm the high predictive power of the severity scores related to individual risk factors and the final HCR-20 v3 risk scores (also known as summary risk scores, SRR) [26] [27] [28]. Dynamic factors (clinical and related to violence risk management) seem to be more strongly associated with violence revealed in institutional settings and in the short-term compared to violence after release from an institution and occurring in the long-term.

Lack of tools in full Polish adaptations

Polish specialists have very limited access to tools for assessing the risk of violence, for which the full adaptation process has been completed. This process involves the following stages: a) translation of the manual (assessment/coding principles) with possible adjustment of the assessment principles to the national criminal justice system; b) testing the reliability of the tool; c) testing the validity of the tool; d) standardisation of the tool (this stage does not apply to tools created in the SPJ stream) [12].

The tools recommended by the authors of the article – HCR-20 v3 and SAPROF – can be described as almost fully adapted. Polish versions of the user manuals for both of the above-mentioned scales have been published. Users are offered professional, certified training within their scope, in accordance with the recommendations of the tools' authors. Banasik et al. [7] also provided promising data on their reliability. The authors of this article also plan to conduct analyses on the prognostic accuracy of HCR-20 v3 and SAPROF in the population of Polish perpetrators. Nevertheless, already at the current stage of adaptation, based on data collected by researchers around the world, their use can be confidently indicated as an element of good practice in the assessment of the risk of violence in Polish conditions.

Proposal of model procedure for assessing risk of violence based on results of authors' research

Based on the presented analysis of the difficulties faced by Polish specialists in the risk as-

essment process, as well as on proven foreign solutions described in the literature, a model assessment procedure was developed. The authors' research results on the reliability of modern methods for assessing the risk of violence and risk determinants in the population of Polish perpetrators were an important source of knowledge [7], [24], [29], [30]. In this model, it is assumed that the assessment regarding the risk of violence in Polish conditions should:

- 1) be based on uniform regulations or recommendations on a national scale, adapted to the context of the assessment, but above all, consistent with current scientific knowledge;
- 2) be based on modern structured methods of assessing the risk of violence with established psychometric properties, adapted to Polish conditions;
- 3) be carried out by an interdisciplinary team (at least three members) based on a consensus model (the team members are trained in the use of structured methods of risk assessment and have the possibility of supervision);
- 4) be based on methods of assessing the risk of violence adapted to the diagnosis of specific groups of perpetrators;
- 5) be carried out taking the presence and intensity of protective factors into account, otherwise referred to as the perpetrator's resources of an individual and systemic nature;
- 6) be carried out in relation to a specific context of assessment (inside/outside the institution);
- 7) be carried out cyclically, taking dynamic factors into account, both during the sentence/application of therapeutic and protective measures, and during the period of supervision of the perpetrator in non-institutional conditions;
- 8) consequently assume the obligation to monitor and manage the risk of violence in the perpetrator on an institutional and non-institutional basis (e.g. within the system of non-custodial therapeutic and protective measures).

The procedure described in this way assumes the need to introduce improvement actions at

systemic, personal and methodological levels. Recommendations for improvement in each of the above-mentioned areas are presented in Tables 1-3. Due to the complexity of the issue

and the volume of this study, the authors limited themselves here only to defining the general directions of changes, which will be further analysed and presented in a separate publication.

Table 2. Recommendations for systemic improvement actions (authors' research)

Recommendations for systemic improvement actions
Introducing a requirement (ideally: in the relevant legal provisions and, prior to their introduction, in guidelines addressed to procedural bodies and specialists) to base decisions on all measures applied to perpetrators on risk assessment methods well-established in research (following the Dutch model). Alternatively: Introducing standards for estimating the risk of violence through a regulation specifying the principles for conducting a criminological and social prognosis based on recognised tools, both in the context of penitentiary and forensic psychiatry.
Extension of the code criteria for assessing the risk of offenders, especially those with mental illness.
Adapting concepts and requirements of the Code in terms of defining risk categories to the possibilities offered by modern tools for assessing the risk of violence.
Introducing systemic solutions that, based on identified risk and protective factors, would enable supervision of persons leaving prison or psychiatric wards in order to monitor the risk level of violence and prevent recidivism (a system of non-custodial therapeutic and protective measures implemented in a uniform manner on a national scale by therapeutic and rehabilitation institutions established for this purpose, integrated with the system of isolating measures).
Introducing systemic support in the adaptation and dissemination of modern tools for assessing the risk of violence (through financial involvement in the process of their implementation and facilitating access to/offering training for specialists using them).
Introduction of recommendations with regard to a risk measurement schedule: 1. Beginning from the moment of commencing the execution of imprisonment/undergoing therapeutic sentence and security measures. 2. Periodically during the sentence/therapy and security measures (ideally every dix months) or each time the context changes (e.g. ward, security level). 3. Periodically during supervision after serving the sentence/therapy and security measures (ideally every six months).
Increasing the coherence and coordination of actions taken against perpetrators (matching different types of measures to them and unifying the practice of using measures throughout the country); perhaps, through a newly established coordinating entity (see: Beisert et al., 2024).
Developing a training and consultation/supervision system for specialists working with perpetrators and assessing risk for the court in the scope of assessment procedures and the use of at least some of the available tools.
Gradually increasing the number of specialists at forensic psychiatric departments: psychologists, psychiatrists, psychotherapists, sexologists, addiction therapists, and penitentiary departments: psychologists.
Gradually decreasing the excessive number of patients in the wards by increasing the repertoire and availability of extra-institutional (outpatient) actions against perpetrators.
Organising therapy for perpetrators, taking the results of previous research on its effectiveness into account.

Table 3. Recommendations for personal improvement actions (authors' research)

Recommendations for personal improvement actions
A systematic shift from making decisions based on clinical assessment of the risk of violence to using modern, structured methods of assessing its risk.
Initiating interdisciplinary cooperation in the process of assessing the risk of violence at institutions (interdisciplinary assessment teams).

Introducing a consensus model for decision-making with regard to individual risk of violence, according to the following order: 1. At least three specialists (e.g. psychiatrist, psychologist, educator, diagnostician, etc.) independently code the HCR-20 sheet (or another tool tailored to the specificity of the perpetrator) for a given perpetrator. 2. During a joint conference regarding a given perpetrator, three assessors agree on the coding of all components of the tool, decide on the final risk assessment, discuss the possibility of additional risk or protective factors and establish a risk management strategy (in relation to the intra – or extra-institutional context). 3. The evaluation report is submitted to: a) the unit staff as a basis for developing a risk management plan (e.g. making a decision to start a new phase of treatment or other actions, such as professional activation, resocialisation programme), as well as making decisions regarding release; b) to the court in the form of recommendations supporting the decision to apply/extend/discontinue the use of therapeutic and protective measures; c) (any) specialists responsible for supervising the perpetrator in non-institutional conditions after release from the institution.
Introducing the “institution” of a researcher/diagnostician (following the Dutch model, see: de Vogel, van den Broek & de Vries Robbé, 2014) supporting the assessment team comprising specialists employed at the unit in the process of professional structured risk assessment (in response to the insufficient number of specialists with regard to the number of patients undergoing assessment and concerns about the insufficient level of expertise in the use of risk assessment methods by the existing specialist staff members).

Table 4. Recommendations for methodological improvement actions (authors’ research)

Recommendations for methodological improvement actions
Translation and adaptation of further tools for assessing the risk of violence developed for the purposes of examining specific groups of perpetrators (e.g. females, sex offenders, perpetrators of intimate partner violence, etc.) to Polish conditions.
Extending cooperation between the scientific community and that of specialist practitioners in order to improve the process of adapting subsequent risk assessment tools developed for the purposes of examining specific groups of perpetrators and their evaluation (for example, through: mutual consultations covering the needs of both communities in the process of adapting/developing tools, enabling scientists access to data enabling the assessment of the psychometric properties of tools by practitioners, expanding access for practitioners to the results of analyses of the psychometric properties of tools obtained by scientists).
Expanding knowledge about modern risk assessment tools and access to them through systematic training of staff working with perpetrators and dealing with risk assessment for court purposes (ideally: coordinated at the system level) and interdisciplinary conferences addressed to the psychological, psychiatric, legal and pedagogical community.

In accordance with the stated aim of the article, a review and preliminary categorisation of the possibilities and difficulties related to risk assessment in Polish conditions were made. Based on the conclusions formulated by the authors according to their research and data from the literature, a proposal for a model procedure was given to assess the risk of violence is presented. It is aimed at improving the accuracy and reliability of diagnoses regarding the threat of violence formulated on the basis of psychological and forensic-psychiatric opinions, as well as increasing the effectiveness of violence prevention. Its full implementation will be possible thanks to parallelly undertaking of improvement actions at systemic, personal and methodological levels.

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