

ARTICLE

Risk assessment and management: forensic methods, human results[†]

John Baird & Ruth Stocks

John Baird is accredited by the Risk Management Authority (RMA) as a risk assessor and is a member of the Mental Health Tribunal for Scotland and of the Parole Board for England and Wales. He is also an honorary consultant forensic psychiatrist with NHS Greater Glasgow and Clyde (NHSGGC).

Ruth Stocks is a chartered clinical and forensic psychologist who specialises in the assessment and treatment of mentally disordered offenders. She is Professional Lead for Psychology in Forensic Mental Health in the Directorate of Forensic Mental Health, NHSGGC, and a part-time Mental Welfare Commission for Scotland visitor.

Correspondence Ruth Stocks, Douglas Inch Centre, 2 Woodside Terrace, Glasgow G3 7UY, UK. Email: Ruth.Stocks@ggc.scot.nhs.uk

SUMMARY

Risk assessment and management is an integral part of modern clinical practice. In this article we discuss best practice in the assessment and management of risk of harm to others. Unstructured clinical judgement methods have been used for many years, but it is only more recently that actuarial and structured clinical judgement methods have been introduced. These methods are discussed and compared. We describe a process that could be followed by a clinical team and give an illustrative case example. Last, we reflect on aspects of current practice and consider the possible direction of developments in the field.

DECLARATION OF INTEREST

None.

a history of violent behaviour – a task variously referred to as violence risk assessment, threat assessment, assessment of risk of harm or, in the field of forensic clinical practice, risk assessment and management.

In this article we discuss this process of assessing and managing risk of harm to others in more detail and particularly as it is applied in forensic mental health settings. On the basis of our own experiences of working in this field, we highlight areas of potential weakness and propose future developments which might improve the practice of risk assessment and management.

Clinical practice

We will now describe what is generally considered to be best practice in the assessment of risk and the preparation of a risk management plan. Although immediate steps may be taken to manage presenting concerns – prescription of medication, admission to hospital, close observation and so on – the compilation of a comprehensive risk management plan is based on a full assessment of the risks and may take several months. This is a task best done by the clinical team as a whole and includes investigations by individual members and meetings as a group. It should be seen for what it is, a complex clinical procedure which informs the overall care and management of the patient.

There are three main methods for assessing risk: actuarial, unstructured clinical judgement and structured clinical judgement.

Actuarial risk assessment

Actuarial procedures are concerned with prediction. In developing them, the histories and outcomes of samples of violent offenders are studied to find characteristics that predict recidivism. A statistical equation is then derived, allowing other individuals to be compared with the sample, and producing a numerical probability of repeat violent behaviour. Actuarial measures are ‘non-discretionary’ in that they require the person using them to make forced choice responses based on facts, usually ‘yes’ or ‘no’ to whether each of a list of risk factors is present. Box 1 lists the most well-known actuarial instruments.

Risk assessment and management is a fundamental part of the lives of all of us, although we probably do not think of the task in these terms. When taking decisions, even everyday decisions, we think ahead to what may happen and reflect on problems that may arise. Next, we estimate how likely the problems are to occur and decide on any action we should take to deal with these potential difficulties. A practical example helps to clarify this.

As children grow up, parents have to decide what freedoms to allow them. Their decision-making is likely to take account of characteristics of the child, such as age and ability, temperament and previous behaviour, how the child is today, what the neighbourhood is like, what is going on in the child’s life. A degree of risk may be accepted in the interests of allowing the child to develop independence, but precautions will be taken to reduce the chances of something going wrong.

There are many other examples from everyday life – planning an overseas trip, buying a car or a house. The process which we go through in all these situations is the same: we look ahead, we form a view on the main potential problems, we consider priorities and we then take specific action to mitigate the risks. This same sequence is at the core of assessing and managing the future risk of violence presented by someone who has

[†]For a related article, discussing involvement of service users in forensic risk assessment, see pp. 351–357, this issue.

BOX 1 Widely used risk assessment tools**Actuarial instruments**

- Risk Matrix 2000 (RM2000; Thornton 2007)
- Static-2002 (Hanson 2003)
- Violence Risk Appraisal Guide (VRAG; Quinsey 1998)

Structured clinical judgement tools

- Historical-Clinical-Risk Management-20 (HCR-20; Webster 1997) for general violence
- Risk of Sexual Violence Protocol (RSVP; Hart 2003)
- Spousal Assault Risk Assessment Guide (SARA; Kropp 1999)
- Stalking Assessment and Management (SAM; Kropp 2008)

Limitations of actuarial tools

The actuarial approach is very useful for professionals who must deal with a large number of individuals or who do not have the time or skills to undertake a comprehensive assessment. It is used for screening and to assist in identifying at an early stage individuals within a group about whom there should be particular concern. However, the individual must be similar enough to the sample population from which the tool was generated, as the characteristics and recidivism rates of different offender groups may vary greatly. Moreover, meaningful predictions about individuals cannot be made from group data (Hart 2007; Cooke 2010; Hanson 2010), on which actuarial tools are founded. Neither can these tools be used to measure change in risk, as they are usually based on fixed or 'static' information, and so are of no use in determining whether progress has been made in response to rehabilitation. To overcome this last problem, some more recently published actuarial tools, such as the Stable and Acute Dynamic Risk Assessment Tool (SA07; Hanson 2007) do include dynamic risk factors. However, even with this revision, the result from an actuarial measure is of no help in describing what exactly might go wrong, when and how to prevent it.

Take the example we used earlier: parents may be mildly interested to know that the chance of a 7-year-old being abducted in Canada is, say, one in a million or that the chance of a child being knocked down by a car in Glasgow is, say, 1 in 250 but they are unlikely to find this knowledge hugely helpful in deciding whether to let their child walk alone to a friend's house.

Long-range predictions in the low to mid range, such as a 20–30% chance of reoffending in 10 years, are particularly unhelpful for risk management. However, if an appropriate tool is available and

its limitations acknowledged, clinicians may still wish to apply an actuarial tool for guidance on the recidivism outcomes for particular types of offenders and offences.

Unstructured clinical judgement

The traditional method of assessing and managing risk is clinical opinion. Consider how decisions are commonly made on whether or not to admit a person to hospital, to reduce or increase a patient's freedoms, or to move someone on. Clinicians relying on unstructured clinical judgement are forming opinions based on their professional training and experience. In doing so they may draw on a wide range of information about a person, from a variety of sources. This can allow flexibility, can weight and take account of individual factors of a particular case and can highlight change. Some clinicians are highly skilled in this regard, but the method relies too heavily on the skills and partiality of the assessor and, consequently, studies show unacceptable reliability and validity (Monahan 1981). There can be a tendency to focus on current clinical presentation, overlooking important historical factors known to be closely associated with future violence. Moreover, this decision-making lacks transparency and may be difficult to scrutinise.

Structured clinical judgement

Structured clinical judgement involves the combination of clinical experience and research-based evidence. The purpose is planning and prevention rather than prediction, identifying the presence and relevance of risk factors and producing a detailed description of what could reasonably be expected to happen in certain situations. The approach is dynamic and can be repeated, allowing progress in response to risk management strategies or changes in circumstances to be taken into account. Risk assessment instruments such as those listed in Box 1 provide a list of the various factors to be taken into account for the particular form of violence – the factors having been identified from research and specialist expertise. Other instruments are available for different forms of violence, but the process for conducting the assessment is the same regardless of the nature of the violence.

Although a numerical coding system is provided in some of the risk assessment manuals, for example the HCR-20 (Webster 1997), this does not indicate that the risk factors are of equal weighting and the manuals note that the numbers are only to be summed for research purposes. Raters using the tools in clinical practice are instructed not to

do this. Training courses are available for those wishing to use the tools. However, anyone with appropriate professional qualifications and the necessary competencies should be able to use them. It should be noted, though, that those items relating to specific aspects of mental disorder require formal training in appropriate assessment techniques, e.g. the Psychopathy Checklist – Revised (PCL-R; Hare 2003). Without this, raters must omit items or request a specialist assessment.

Strengths of structured clinical judgement

In summary, the most important aspect of structured clinical judgement is that the reviewer is provided with information on the risk factors known to be linked to particular forms of violence recidivism, but is also required to gather comprehensive information about the case, to evaluate that information and to assess the individual within the framework of these risk factors. Other strengths of structured over actuarial methods are that they help in risk management planning and can provide evidence of progress, or the lack of it, in response to treatment as they are repeated over time.

In our opinion, it is for these reasons that structured risk tools are superior to actuarial instruments with their rigidity and their inability to capture potentially key aspects of an individual case. Compared with ‘unstructured’ opinion, the structured approach reduces rater bias and provides greater transparency to decision-making.

The process of risk assessment and management

There are seven stages to the structured clinical judgement approach (Box 2).

Stage I – Gathering information

Multiple sources are necessary, and judgement and common sense should be used to decide what is of particular importance. One person with the appropriate expertise (Box 3) must take lead responsibility for the process, but individual team members can be assigned to explore different aspects of the patient’s history in the files.

For example, a psychiatrist might chart the progress of the patient’s illness and response to medication, and a social worker might look into the family background. The patient should be interviewed on a number of occasions, together with relatives and other informants. Official information, such as from prosecuting authorities or the police, has to be evaluated alongside interview and file information. Contradictions need to be identified and appraised.

BOX 2 The seven stages of structured clinical judgement

Stage I	Gathering information
Stage II	Identifying present and relevant risk and protective factors
Stage III	Offence analysis and risk formulation
Stage IV	Scenario planning
Stage V	Preparation of risk management plan and relapse plan
Stage VI	Presentation of findings and feedback to the patient
Stage VII	Updating the risk assessment

The extent of exploration required to investigate a person’s background and circumstances will vary. In our view, the decision should rest not on the apparent seriousness of the risk presented but on how well a person’s offending can be understood and on how easily an effective risk management plan can be devised.

Stage II – Identifying present and relevant risk and protective factors

Risk factors

Applying the appropriate risk tool, the information gathered should be used to identify risk factors. Definitions of the risk factors are provided in the manuals, but the judgement approach implies that these need not be used prescriptively unless for research. However, the presence of historical risk factors, as defined, anchors the summary risk judgement. The relevance of each factor should then be considered, in terms of whether it helps in understanding previous offending, or

BOX 3 Lead assessor competencies

- Expertise in the assessment and diagnosis of mental disorder, as recognised by a professional regulatory body
- Expertise in the assessment of violent offenders
- Understanding and knowledge of violence and violent offender outcomes
- Skills in the analysis, presentation and communication (verbal and written) of risk information
- An understanding of how clinical teams should function and the ability to work collaboratively and productively with colleagues

(Based on the recommendations of the Directorate of Forensic Mental Health and Learning Disabilities, NHS Greater Glasgow and Clyde. Reproduced with permission)

informs the description of future risk scenarios or the design of risk management strategies. The detail of how a particular risk factor contributes to these hypotheses can be described in the risk formulation. However, unless the relevance to risk management of each identified risk factor is clearly specified, there may be a failure to properly translate risk assessment findings into effective risk management plans.

Protective factors

There is little empirical evidence to inform how protective factors affect future risk. Given that the purpose of rehabilitation is to build and enhance protective factors they must be taken into account, but a straightforward counterbalancing of risk and protective factors cannot be assumed. The Structured Assessment of Protective Factors for violence risk (SAPROF; de Vogel 2009) and the Short-Term Assessment of Risk and Treatability (START; Webster 2004) are useful tools to consult about protective factors.

Stage III – Offence analysis and risk formulation

Offence analysis and risk formulation are crucial but commonly neglected components of risk assessment.

Offence analysis

Offence analysis entails an examination of the circumstances of previous offences to identify patterns. In risk formulation, relationships between risk factors and circumstances are appraised, with speculation as to the how and why of the person's previous violence. Case-specific factors are taken into account along with established risk factors. The way in which these risk factors are relevant is also described. Both tasks inform scenario and risk management planning.

Let us illustrate this using the risk factor 'substance misuse'. A history of drug or alcohol misuse has repeatedly been linked to recidivism, such that those who have misused substances are generally at higher risk of reoffending than those who have not. Knowledge of a person's substance use can, however, be more revealing – intoxication might have been a disinhibiting factor at the time of offending or it might indicate that the person deals poorly with stress or lacks confidence in social situations – and help to inform the formulation, future risk scenarios or risk management plan. Likewise, the presence of intellectual disability might explain why someone was coerced into committing an offence and might be again. It would also indicate a need to adapt psychological treatments for that particular offender.

The contribution of protective factors should also be explored in this way. As an example, consider positive life goals – one of the protective factors listed in the SAPROF. Included within this category are religious beliefs and the sense of meaning to life which they can provide. For some offenders, religious conviction can be a protective factor, but for others it can appear to be linked with an attempt to avoid taking personal responsibility for their offending. Professional judgement is applied to ascertain the significance of religious belief in a particular case.

Risk formulation

Essentially, the risk formulation is a story which describes an individual's life and provides a theory about the reasons underlying the offending. It can be presented in narrative form, or broken down into five elements (Box 4):

- predisposing factors
- motivating factors
- precipitating factors
- perpetuating factors
- protective factors.

Risk formulation therefore requires knowledge of the literature on offenders and offending and goes beyond the guidance that any instrument provides.

Stage IV – Scenario planning

Arising from the offence analysis and risk formulation is a description of the various circumstances that might give rise to violence in the future. These 'risk scenarios' should be plausible rather than possible. In designing them,

BOX 4 The five key elements of a risk formulation

Predisposing factors These are social or environmental experiences or biological aspects of a person's history that are associated with problems in later life; examples include poor attachments, early emotional trauma or head injury.

Motivating factors In terms of motivation, it is important to consider the relative roles of intrinsic influences and circumstances. Generally, the former give rise to greater concern than the latter. For example, consider the difference between a violent offender who deliberately harms people he believes to have wronged him and another violent offender who once lost his temper in a particularly heated situation.

Precipitating factors These can be immediate triggers to an event, such as an argument, or more general circumstances in a person's life, such as stress. They also include destabilising experiences, such as a deterioration in mental health, and disinhibiting factors, such as intoxication.

Perpetuating factors These are characteristics of offenders or their circumstances that mean they continue to be risky. Examples are unhealthy relationships or poor engagement with treatment.

Protective factors These are strengths within the person or external factors that reduce risk. Examples are effective coping skills or a supportive family.

BOX 5 A risk formulation and future scenario for Mr Burns**Case vignette**

Fourteen years ago, when he was 19 years old, Mr Burns was convicted of culpable homicide and was subsequently detained in a high secure hospital, suffering from paranoid schizophrenia. In early childhood, Mr Burns was severely neglected and physically abused by his parents and sexually abused by an elder brother. From the age of 7 he was brought up in local authority care. He also lived in a community where violence was rife and he was the victim of random attacks on several occasions. He has a long history of violence, including assaults on teachers and family members, and apparently unprovoked attacks on strangers and acquaintances, some involving the use of weapons and several resulting in serious physical injury to the victims. During his first few years in hospital he was violent on several occasions towards fellow patients, but there have been no incidents of physical aggression in the past 6 years. He is currently living in a low secure unit and there are plans for him to move to the community soon.

Risk formulation

Limited opportunity to develop secure attachments may help to explain Mr Burns's failure to form lasting, healthy relationships and his poor emotional regulation. His abusive experiences are likely to have exacerbated the problem by making it difficult for him to trust people. Added to this, frequent exposure to violence in his neighbourhood perhaps accounts for the development of his suspiciousness, i.e. as a protective characteristic which, with the compounding effects of mental illness, has become a significant pathological feature of his personality. Aspects of his cognitive functioning identified at neuropsychological testing, namely, his concrete thinking style and limited ability to see things from another person's point of view, also help to explain his tendency to misinterpret other people's intentions and to believe that he has been wronged. This suspicious or paranoid nature, combined with attitudes condoning violence as a means of solving conflict, may help to make sense of his assaults. Thus, it seems that he has assaulted people he has found threatening, in

order to protect himself. Alcohol and illegal drugs also appear to have played a role by reducing even further his behavioural control and by exacerbating his general anxieties and suspicions.

Future scenario

Mr Burns is most likely to be violent if he takes alcohol or drugs again, as this might lead to non-adherence to treatment and consequent deterioration in his mental state. Given his propensity for paranoid thinking about family members when unwell, his violence is most likely to be directed at his parents or siblings and perhaps any future partners. The outcome could be serious physical harm if he were to be concerned enough to be carrying a weapon again. However, while his mental state and lifestyle remain stable, the likelihood of this happening is very low, with no imminent risk. Only a period of prolonged stress is likely to trigger a return to drugs or alcohol, but Mr Burns usually withdraws when he is upset, and this would be an early warning sign to those around him.

it can be as helpful to pose the question 'What are we not worried about?' as to ask 'What are we worried this person might do?'. They should provide detail on the likelihood, with respect to relevant reoffending statistics if possible, as well as the likely nature, circumstances, triggers, imminence, duration and frequency of the violence. The potential severity of harm and characteristics of victims should also be described. Finally, the impact of risk management should be considered.

Box 5 gives an example risk formulation and scenario planning for the fictitious Mr Burns.

Stage V – Preparation of risk management plan and relapse plan

The risk assessment concludes with a management plan, the purpose of which should be twofold: to manage the presenting risks in the least restrictive manner and to identify rehabilitation or treatment targets. Risk management plans should specify clear goals, detailing each team member's contribution and allowing patients to see what progress they need to make to gain more freedom.

Each risk factor identified as being relevant to risk management should be linked to a risk management strategy aimed at reducing or preventing that risk. Critical factors are most effectively managed with several strategies. Mental illness, for example, might be managed by medication as well as a psychological treatment

and symptom monitoring. Together, the strategies should be sufficient to manage the risk without being overly restrictive. Responsibilities related to them should be assigned to members of the clinical team and reviewed regularly by the team.

A relapse plan should also be drawn up, outlining contingency plans in the event of any failures in the risk management plan or the emergence of any warning signs.

Risk management strategies fall into four categories (Box 6):

- monitoring
- supervision
- treatment and interventions
- victim safety plans.

BOX 6 The four categories of risk management strategies

- Monitoring – e.g. random drug testing, observations, mental health checks or home visits
- Supervision – e.g. tagging, prohibiting alcohol consumption or restriction of freedom
- Treatment and interventions – e.g. medication, psychological and occupational interventions, vocational rehabilitation
- Victim safety plans – e.g. disclosure to victims, community safety plans

It can be helpful to think about and plan management strategies under these different headings as this might prevent aspects being overlooked. Also, more recently there has been an understanding that interventions which improve offenders' general well-being – the sense of worth and the level of fulfilment that they feel their life is providing – can be important in reducing the risk of further offending (Ward 2004; Laws 2011).[‡]

Stage VI – Presentation of findings and feedback to the patient

The detail of a person's history can be contained in a separate evidence document or included as an appendix, but all of the important information should be put together in a comprehensive, chronological narrative, a 'biography'. As well as a useful description of the risk, this is an opportunity to tell the person's story – not to excuse behaviour but to present a balanced account of what has happened in the person's life to lead him or her to the point of harming others. The risk management and contingency plans may be included in the risk report or issued separately. However, the plans should be presented in such a way that the links between the assessment findings and the management strategies are obvious. In our experience this is an area where services often fall short.

Feedback should also be given to the subject of the assessment in a form that helps the person and carers understand the findings and the management plan.

Finally, the limitations of risk assessment should always be acknowledged and an indication of the perceived adequacy of the available information should be reported.

Stage VII – Updating the risk assessment

As risk assessments are to a great extent concerned with a person's recent functioning, they should be regularly updated. The frequency for carrying this out may be determined by local policy, but it is good practice to do it at least every year, or sooner if there has been or is expected to be any significant change in circumstances, such as new incidents of violence or impending transfer.

In practice, patients in forensic mental health services have their progress and risk management plans reviewed far more often than yearly, with many in-patients discussed by their clinical teams on a weekly basis. However, at the 'annual' update, attention should be paid to the full range of risk factors, and the formulation, scenarios and risk management recommendations should be revised as necessary.

The update meeting

As at the outset of the update process, a risk meeting should be convened by a lead assessor and attended by all the key staff and carers involved in the person's care and management. At this meeting, it is important to present a summary of the background information and a recap of the static risk factors. This reminds everyone of the nature of the risks being managed, helping to reduce the potential bias of focusing on current clinical presentation. It also ensures that those new to the team are properly appraised of the person's situation.

New evidence of static risk factors, e.g. recent acts of violence or substance use, as well as additional evidence of past behaviour which has come to light since the previous assessment should be noted and consideration given to the need to revise the formulation and alter the scenarios. Poor response to rehabilitation should also be addressed. Additional exploration of the person's background and functioning, including specialist investigations such as neuropsychological assessment may be indicated.

No 'new' evidence indicates that the current risk management plan is effective in managing the presenting risks. The focus for discussion should then be on the dynamic risk factors on which treatment and rehabilitation will hopefully have had an impact. If improvements are noted, there is likely to be a relaxation of risk management strategies and/or further testing opportunities.

Conclusions and the next stage

Best practice

Box 7 outlines the key features of a modern clinical risk assessment. In our view, the structured clinical judgement approach to risk assessment and management currently provides by far the best method of assessing and managing the risk posed by an individual. The strengths of structured clinical judgement lie in four areas.

First, it ensures that comprehensive information about the individual is gathered and that it is evaluated against the background of risk factors which have been identified and validated by research.

Second, it encourages case-specific judgements, which take account of any unusual features and the particular combination of risk factors that are present.

Third, it provides a basis for risk formulation and scenario and risk management planning, and is sufficiently flexible that reassessment from time to time will capture and evaluate change.

[‡]Readers might also be interested in the recent article in *Advances* (May 2013) by Dumindu Witharana & Gwen Adshead: Mindfulness-based interventions in secure settings: challenges and opportunities. 19: 191–200. Ed.

MCQ answers

1 d 2 e 3 d 4 d 5 c

BOX 7 Key features of modern clinical risk assessment

- Led by an assessor with relevant professional training and the necessary competencies
- Multidisciplinary team involvement
- Multiple sources of information
- Structured professional judgement instruments used to identify the presence and relevance of risk and protective factors
- The circumstances of previous offences are examined and patterns identified
- The risk formulation contains hypotheses to explain the offending
- Those risk factors which are relevant to risk management are accounted for in a risk management plan
- The risk management plan allows the risk to be managed but progress to be made
- The risk assessment and the risk management plan are updated periodically and particularly if circumstances have changed

Fourth, it is a transparent process that allows patients and their advocates to understand and evaluate team decision-making.

Although we have drawn a clear distinction between structured and unstructured clinical judgement, the differences are more apparent than real. Structured clinical judgement instruments list factors that must be considered when assessing risk level and each is dealt with in turn against the details of the individual, but it is the clinician who decides the relevance of each risk factor in the individual case. This decision, often discussed by the clinical team, ultimately relies on the experience and knowledge of the team members. It is a myth to believe that there is a 'right' answer. As with many other clinical decisions, it is reached by reflection, discussion and debate between team members, and the lead assessor's task is to support this process.

In some cases, and despite thorough and systematic assessment, the offending behaviour may remain poorly understood and this will inevitably lead to difficulties for those whose task it is to make a judgement on the ongoing risks that may be present. Rightly or wrongly, the likelihood is that when risk levels are difficult to quantify, estimates will tend to err on the side of more rather than less concern. However, even when there is greater certainty, it is inevitable that things will not always work out as expected. In the worst case scenario, a patient will commit another

serious violent offence. What is important is that the team's decisions and risk management plans are reasonable and defensible (Risk Management Authority 2011). Adopting a structured professional judgement approach is currently the most likely means of achieving this.

What of the future?

The whole field of risk assessment and management is still evolving. A foretaste of the future may be one of the more recently introduced structured clinical judgement instruments, the Stalking Risk Profile (SRP; MacKenzie 2009). This instrument goes further in terms of the structure it provides than the earlier instrument for stalking, Stalking Assessment and Management (Kropp 2008), or the equivalent instruments for violence or sexual offending, the Historical Clinical Risk Tool – Version 2 (Webster 1997) and the Risk of Sexual Violence Protocol (Hart 2003).

The SRP includes an examination of the typologies of stalking, which essentially describe the various motivations for stalking. Having identified an offender's particular motivation, interventions that may reduce the risk are more readily apparent. For example, a 'rejected' stalker, whose offending is linked to anger and impulsiveness, might benefit from emotional control training. An 'intimacy seeker', whose actions appear to be underpinned by limited self-awareness and perspective-taking skills, might be offered therapy aimed at improved thinking and social skills.

Another development could be a greater focus in risk manuals on offence analysis and risk formulation. Although the general process is covered in current training courses, these tasks rely heavily on the assessor's knowledge. If the manuals included summaries of the relevant literature on offending as well as guidance on how to look for patterns in offence histories, assessors might be better placed to reflect on the various possible motivations of offenders and develop more sophisticated formulations.

Related to the above, better advice is required to inform decisions on relaxing risk management and moving patients on. Treatment and rehabilitation should target dynamic risk factors, with the overall aim of strengthening self-management strategies and protective factors. However, there is as yet little understanding of the nature and extent of the change necessary to reduce risk meaningfully and further study in this area would be of benefit.

These are only a few ideas. Inevitably, in such a young science, much more is still to come.

References

- Cooke DJ, Michie C (2010) Limitations of diagnostic precision and predictive utility in the individual case: a challenge for forensic practice. *Law and Human Behavior* **34**: 259–74.
- de Vogel V, de Ruiter C, Bouman Y, et al (2009) *SAPROF: Guidelines for the Assessment of Protective Factors for Violence Risk*. Forum Educatief.
- Hanson RK, Thornton D (2003) *Notes on the development of the Static-2002* (User Report No. 2003-01). Solicitor General Canada
- Hanson RK, Harris AJR, Scott TL, et al (2007) *Assessing the Risk of Sex Offenders on Community Supervision: The Dynamic Supervision Project (2007–05)*. Public Safety Canada.
- Hanson RK, Howard PD (2010) Individual confidence intervals do not inform decision-makers about the accuracy of risk assessment evaluations. *Law and Human Behavior* **34**: 275–81.
- Hare RD (2003) *Psychopathy Checklist – Revised (PCL-R): 2nd Edition Technical Manual*. Multi-Health Systems.
- Hart SD, Kropp PR, Laws DR, et al (2003) *The Risk for Sexual Violence Protocol (RSVP): Structured Professional Guidelines for Assessing Risk of Sexual Violence*. Mental Health, Law and Policy Institute, Simon Fraser University.
- Hart SD, Michie C, Cooke DJ (2007) Precision of actuarial risk assessment instruments: evaluating the ‘margins of error’ of group v. individual predictions of violence. *British Journal of Psychiatry* **190** (suppl 49): s60–5.
- Kropp P, Hart S, Webster C, et al (1999) *Spousal Assault Risk Assessment Guide User’s Manual*. Toronto Multi-Health Systems/B.C. Institute Against Family Violence.
- Kropp PR, Hart SD, Lyon DR (2008) *Guidelines for Stalking Assessment and Management (SAM): User Manual*. ProActive Resolutions.
- Laws RD, Ward T (2011) *Desistance from Sex Offending: Alternatives to Throwing away the Keys*. Guilford Press.
- MacKenzie RD, McEwan TE, Pathe MT, et al (2009) *Stalking Risk Profile: Guidelines for the Assessment and Management of Stalkers*. StalkInc/Centre for Forensic Behavioural Science, Monash University.
- Monahan J (1981) *The Clinical Prediction of Violent Behaviour*. Cited in Monahan J, Steadman HJ, Silver E, et al (2001) *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence*. Oxford University Press.
- Quinsey L, Harris GT, Rice ME, et al (1998) *Violent Offenders: Appraising and Managing the Risk*. American Psychological Association.
- Risk Management Authority (2011) *Framework for Risk Assessment, Management and Evaluation: FRAME*. RMA Scotland.
- Thornton D (2007) *Scoring Guide for Risk Matrix 2000.9/SVC*. University of Birmingham (<http://www.bhamlive1.bham.ac.uk/Documents/colleges/psych/RM2000scoringinstructions.pdf>). Accessed 25 Apr 2013.
- Ward T, Gannon T (2004) The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime and the Law* **10**: 243–57.
- Webster CD, Douglas KS, Eaves D, et al (1997) *HCR-20: Assessing Risk for Violence. Version 2*. Mental Health, Law, and Policy Institute, Simon Fraser University.
- Webster CD, Martin M, Brink J, et al (2004) *Short-Term Assessment of Risk and Treatability (START)*. St Joseph’s Healthcare/Forensic Psychiatric Services Commission.

MCQs

Select the single best option for each question stem

1 Risk assessment using structured clinical judgement method is:

- a predictive
- b accurate
- c stable over time
- d reliable when undertaken by experienced clinicians
- e reliable.

2 Actuarial risk assessment:

- a has high interrater reliability
- b is concerned with prediction
- c is informative about recidivism rates among populations of offenders
- d is uninformative about an individual’s recidivism risk
- e is all of the above.

3 Updating the risk assessment:

- a could only be undertaken annually
- b can be undertaken by one team member
- c is a task best undertaken by someone not familiar with the patient
- d takes account of changes since the last assessment
- e is not required while a patient remains in hospital.

4 Unstructured clinical judgement risk assessment is:

- a no better than chance
- b completely unreliable
- c thoroughly reliable
- d of variable reliability
- e reliable when undertaken by experienced clinicians.

5 Risk assessment and management:

- a is a task specific to forensic psychiatry
- b has been invented within the past 10 years
- c is used by mothers when caring for their children
- d is not part of clinical practice
- e was imported into health services from the criminal justice system.