About the Faculty of Forensic Clinical Psychology

The Faculty of Forensic Clinical Psychology (FFCP) is comprised of clinical psychologists who work in the public and private sector within a range of forensic settings within the UK. The FFCP is a special interest group within the Division of Clinical Psychology of the British Psychological Society and aims to:

- promote the development of clinical psychology within forensic setting;
- promote the highest standards in practice, of the application of professional education and knowledge of forensic clinical problems;
- disseminate knowledge of applications in research in order to promote effective services;
- influence planning of services and policy in relation to forensic clinical psychology; and
- provide scientific meetings, opportunities for exchange of information and mutual support for clinical psychologists working within forensic settings.

The Faculty holds twice yearly meetings for its members.

About Occasional Briefing Papers

The occasional briefing papers are written by members of the Faculty with specialist expertise in the area under review are designed to:

- review the literature and research base of a topic with direct relevance to forensic clinical psychology;
- act as a reference document for current best practice in an area both for members of the faculty and other interested professionals; and
- reflect the position of the membership as a whole on the topic area.
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PART 1

1. Rationale

In 2003, the Forensic Clinical Psychology Special Interest Group (now named the Faculty of Forensic Clinical Psychology) agreed to develop a position paper on risk assessment and management in clinical practice. To that end, this document is informed by the best available evidence from four key areas of inquiry:

1. The literature on risk in mental health and forensic practice.
2. The empirical research on risk.
3. Recommendations from homicide and suicide inquiries into the treatment and care of people with mental disorder.
4. Lessons learned in clinical practice.

The latter was captured through group work at the Forensic Clinical Psychology Special Interest Group 2003 Autumn Conference in Berkshire.

Clinical psychologists working within forensic settings have skills and knowledge in relation to legal processes and context in addition to specialist assessment and treatment competence in areas such as offending behaviours and people at or presenting risk.

The notion of ‘risk’ is at the very heart of professional practice in forensic services. Those working in this challenging area of practice have three principal areas of concern:

1. The safety of the public.
2. The current functioning and future behaviour of the individual with whom they are working.
3. The personal safety of themselves and their colleagues.

Risk assessment and management has always been a high profile and high priority issue for clinical psychologists and other practitioners involved with forensic mental health services and the criminal justice system (Prins, 1998; Webster & Bailes, 2001). This paper is an attempt to summarise key areas of information and guidance with regards to good risk assessment and management practice. Although written for forensic clinical psychologists, the information will also be of interest and value to other professions. Any enquiries regarding this document should be directed to either of the authors.

2. Risk, mental health and forensic practice

2.1. The relationship between risk and mental health.

The concept of ‘risk’ is frequently discussed in relation to people with mental health problems. Mental health professionals are increasingly seen as ‘risk managers’ responsible for assessing and managing the risk to and from mental health service users. However, the concept of risk is often associated only with dangerousness rather than with a more holistic approach to working with people’s needs, vulnerabilities, and risk to self.

Alaszewski and colleagues asked service providers and users how they defined risk. Not surprisingly, most service providers within mental health services viewed risk in terms of danger and hazards.

‘We need to develop a more holistic approach to risk management in which performance is assessed in terms of both the process and consequences of decisions.’

Alaszewski, A. (2000)
The media representation of people with mental health problems has tended to reinforce this link. The term ‘risk’ itself has, therefore, become stigmatising and disempowering. Yet effective risk assessment and management, which actively involves the user in the process can and should be empowering.

It should also be noted that mental health service users are more likely to be a risk to themselves than to others. Although homicide figures as a whole have increased, the proportion of homicides by people with a diagnosis of mental illness has fallen, by an average of three per cent every year (Department of Health, 1999). Therefore, although risk is typically seen within the context of ‘risk to others’ the concept of risk is much broader than this.

2.2. Definitions of risk
There are a number of ideas and terms that are commonly used in relation to risk. For the purposes of this paper, the following definitions are used.

**Risk assessment**
The systematic collection of information to determine the degree to which harm (to self or others) is likely at some point in time.

**Risk prediction**
The assigning of a probability to a person, indexing the likelihood of that person engaging in the specific risk behaviour (typically harm to self or others) such as violence (criminal or otherwise), within or outside of hospital/custody.

**Risk management**
The implementation of a set of values and principles integrated with a set of operational procedures and supports that enable a dynamic sensitivity to the individual’s needs, vulnerabilities and evolving behaviours associated with risk. The purpose of these procedures is risk minimisation and the provision of safe, sound and supportive services.

Safe, sound and supportive services were defined by the Department of Health (DATE) as:

**Safe** – to protect the public and provide effective care for those with mental illness when they need it.

**Sound** – to ensure that individuals and service users have access to the full range of services that they need.

**Supportive** – working with individuals and service users, their families and carers to build healthier communities.

Once again, the concept of public safety needs to be balanced by an awareness of the risks to individuals themselves.

2.3. Legislation and policy context
Major areas of legislation and policy on interagency collaboration now underpin services for people who pose a risk to themselves or others (Health Act, 1999; Crime and Disorder Act 1998; Department of Health, 1995, 1996; Criminal Justice and Court Services Act, 2000). Public safety has become a major outcome for Primary Care, Mental Health, Social Care and Criminal Justice Agencies.

The White Paper *The New NHS: Modern, Dependable* (Department of Health, 1997) sets out the Government’s strategy for modernising the health service. It covers a variety of issues relevant to mental health service provision, including the integration of services across health and social care, human resources and the

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1 This document uses the legislation of England and Wales in order to provide context and information. However, the principles of practice in this document are considered to be applicable when used within the context of other legal frameworks across the UK.
effective use of information technology for improving the quality of care. The quality strategy is described in the paper *A first class service: Quality in the new NHS* (Department of Health, 1998), which describes the way in which national agencies, for example the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHIMP), collate and use an evidence-based practice approach and inspect services, while in parallel local agencies address effectiveness through clinical governance.

The National Service Framework (NSF, 1998) sets out the policy context, values, standards and implementation programme for ‘safe, sound and supportive’ mental health services. The NSF recognises that over 90 per cent of mental health care is provided in primary care settings (families, GP practices and community) and emphasises shared responsibility and partnerships across all agencies providing care. There are seven national standards for Mental Health, summarised in Box 1.

<table>
<thead>
<tr>
<th>Box 1: National Service Framework for Mental Health NSF Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Equal opportunities to all in mental health promotion.</td>
</tr>
<tr>
<td>2. Common Mental Disorders CMD (e.g. Depression, Anxiety) sufferers should have needs assessed and access to effective treatment.</td>
</tr>
<tr>
<td>3. CMD sufferers should have 24 hours to access local care and NHS Direct.</td>
</tr>
<tr>
<td>4. Effective services for severe mental illness (SMI), e.g. written patient care plans which include advice on action to take in crisis and on responding to special needs.</td>
</tr>
<tr>
<td>5. SMI patients should have timely access to ‘least restrictive’ local bed and written aftercare plan.</td>
</tr>
<tr>
<td>6. Carers of CPA patients should have their own care plan.</td>
</tr>
<tr>
<td>7. Preventing suicides should be further helped by risk assessment training, suicide adults and support to local prison staff.</td>
</tr>
</tbody>
</table>

The NSF is to be welcomed and sets a common agenda for all levels of health and social care services to work to. The NSF aims to facilitate national and local progress through its comprehensive, flexible and positive direction. The NSF sets standards, milestones and outcome indicators over the 10-year period to 2009.

**2.4. Recommendations from independent inquiries**

There have been a number of reports of inquiry into the treatment and care of people with a mental illness diagnosis who have killed or been involved in violent incidents.

‘...inquiries are not set up only to prevent recurrences. They also provide explanations and insights for bereaved relatives and, in the case of homicides, also for the family of the mentally ill person who often feel abandoned and let down by the services. As public servants surely managers and clinicians must be ready to have their practice scrutinised and should demonstrate a positive willingness to be criticised when criticism is justified.’

Professor Elaine Murphy, Former Vice Chair of the Mental Health Act Commission (1996).

Parker and McCulloch (1999) examined a number of inquiry reports into homicides by people with a diagnosis of mental illness, together with some existing views of homicide inquiries. They identified the critical factors involved in all the reports, and highlighted 12 key issues. These are as follows, in roughly descending of importance or frequency:
a. Poor risk management;
b. Communication problems;
c. Inadequate care planning;
d. Lack of inter-agency working;
e. Procedural failures – both administrative and legal;
f. Lack of suitable accommodation;
g. Lack of resources;
h. Substance misuse;
i. Non-compliance with medication;
j. Lack of involvement of carers;
k. Minority ethnic issues, e.g. staff being too ready to make incorrect and stereotype assumptions about black service users;
l. The need for reform of the framework for community care, and in particular the Mental Health Act (1983).

Many reports make recommendations for improving practice. Such recommendations include the need for:

■ standardised, evidence-based assessments of risk and of individual need;
■ actuarial and psychometric approaches to risk assessment and risk prevention;
■ accurate, complete and communicable information about risk;
■ effective information sharing among professionals, agencies, the individual and their families;
■ multi-agency risk management;
■ audit and review;
■ the full inclusion of service users and their families.

‘The irony is that an alarming number of published inquiry reports reveal that, had the family and/or those close to the family been listened to by professionals in the first place, there is every chance the homicide would not have taken place.’

Dave Sheppard (1996).

2.5. National confidential inquiry into homicides and suicides by mentally ill people

Risk management also emerges as a key feature in the National Confidential Inquiry into Homicides and Suicides by Mentally Ill People. This was set up in 1994 and was funded by the Department of Health, the Scottish Office, the Welsh Office, and the Department of Health and Social Services, and has been conducted in association with the Royal College of Psychiatrists.

The aims of the inquiry were:

■ to collect detailed clinical data on people who die by suicide or commit homicide, and who have been in contact with mental health services; and
■ to make recommendation on clinical practice and policy that will reduce this risk.

The most recent report arising from the National Inquiry (Appleby et al., 1999) outlined 79 key findings, and 31 recommendations around suicide and homicide by people with a diagnosis of mental illness. Extracts from these are detailed below.
2.5.1. Suicide

- Twenty-four per cent of suicides were by people who had been in contact with mental health services in the year prior to death.
- Of these, half of the people who killed themselves had been in contact with mental health services in the previous week. At final contact, immediate risk of suicide was estimated to be low or absent in 85 per cent of cases.
- The most common diagnoses were depression, schizophrenia, personality disorder and alcohol or drug dependence.
- Sixty-three per cent had a history of self-harm; 19 per cent had a history of violence.
- The most common drugs used in overdose were prescribed drugs, particularly psychotropic drugs.
- Sixteen per cent of suicides were by people in individual care; a third of these suicides occurred on the ward, the most common method being hanging.
- Twenty-eight per cent of suicides in the community were by people who had lost contact with mental health services.
- Twenty-four per cent of suicides occurred within a month of discharge; most of these were within the first week, and before the first follow-up appointment.
- Five per cent of suicides were people from minority ethnic groups.
- Three per cent of suicides were by people who were homeless, usually young unemployed men with alcohol dependence or schizophrenia.
- Around half had a second diagnosis, and 17 per cent were misusing both alcohol and drugs.
- Mental health teams believed that more than 20 per cent of suicides were preventable, and that more could have been done to reduce the risk in two-thirds of cases.

2.5.2. Homicide

- Fourteen per cent of people convicted of homicide (for whom reports were available) had symptoms of mental illness at the time of their offence.
- For this group of people, only a minority had previous convictions for violence, and they were less likely than other people who had committed homicide to have been under the influence of alcohol or drugs at the time of the incident.
- In these cases, the victims were more likely to be family members or a spouse compared with the homicides by people who did not have symptoms of mental illness at the time of the offence.
- Only 20 per cent of people with mental illness at the time of the offence had been in contact with mental health services in the previous year.
- More than half had a second diagnosis indicating complex treatment needs.
- Amongst those who had been in contact with mental health services, 88 per cent had been assessed as being of ‘low’ or ‘no risk’ at their final service contact.
Therefore, the National Inquiry has implications for:

- The training of all staff in contact with users who are at risk of suicide or violence. The Inquiry recommends that training should include the recognition, assessment and management of risk.

- Documentation procedures – the Inquiry recommends that there should be a single simplified system of documentation for the Care Programme Approach, the transfer of information and risk management.

In conclusion, effective risk management is crucial to the provision of good quality mental health services. Although risk will never be eliminated completely, it can be minimised by implementing good procedures for measuring and working with risk.

3. The scientific background

The literature on psychiatric risk assessment reveals a host of difficulties which have militated against the practical application of much of the important research. There appear to be four main difficulties. First, the constructs of dangerousness and risk are not well defined. Second, the outcomes by which risk assessments may be validated are often unclear and unreliable. Third, there is still insufficient understanding of the interaction between risk indicators. Finally, the essentially normative focus of much risk assessment research does not always map onto the essentially idiographic task of assessing an individual.

There have been a number of reviews of the history, philosophy and legal implications of dangerousness (McGinley, 1995), which serve merely to highlight the diversity of the concept. The Butler Committee (1975) defined dangerousness as ‘a propensity to cause serious physical harm or lasting psychological harm’ while Scott (1977) defined it as ‘an unpredictable and untreatable tendency to inflict or risk serious, irreversible injury or destruction, or to induce others to do so’. These definitions are widely used but they are not universally accepted (Faulk, 1988).

The bulk of the literature on risk assessment rejects, either explicitly or implicitly, the use of Scott’s term unpredictable. Resource and effort are expended in order to clarify those characteristics that may be utilised in the prediction of dangerous behaviour (Klassen & O’Connor, 1988; Clark, Fischer & McDougall, 1993; Monahan & Steadman 1994; Harris, Rice & Quinsey 1993). McGinley (1995) argues that ‘…if dangerousness is by definition unpredictable, in the fullest sense of the term, referring to the irreversible injury of the index offence and the possibility of its re-occurrence, then only the option of total and limitless secure provision would be available to guarantee the protection of the public.’

What emerges from this literature is that measures of risk are based upon the judgement of observers that problematic behaviour may reoccur in the future. Furthermore, these judgements are based largely upon what the individual has done, or threatened to do (Copas, Ditchfield & Marshall, 1994; Clark, Fischer & McDougall, 1993; Monahan & Steadman, 1994). This implies that dangerousness is a latent characteristic of the person in question.

The research focus is mainly centred upon dangerousness or the risk of violence or harm to others. This emphasis is understandable given growing public concern towards acts of violence perpetrated by psychiatric individuals in the community (Ritchie, Dick & Lingham, 1992; Reed, 1992; O’Rourke, Hammond & Davies, 1997). However, it serves to hide other important areas of risk that pertain to the psychiatric services. Thus the risk of self-harm and suicide should also take a central place in risk assessment (Strosahl, Chiles & Linehan, 1992; Banger, 1994). Equally the risk of mental deterioration and impending breakdown is a vital aspect of monitoring care (Dott, 1993; O’Rourke, 1995).
4. Measurement or prediction

A further problem facing those wishing to integrate the literature of risk assessment into their own practice is the discrepancy between the practitioner with an inherently idiographic problem and the researcher who typically approaches the problem from a normative perspective. Research in psychiatric risk assessment has largely concerned the building of statistical models for the prediction of a dangerous or problematic behaviour (Hassin, 1986; Christiansen, 1986; Monahan & Steadman, 1994; Copas, Ditchfield & Marshall, 1994; Harris & Rice, 1997). These require analysis of substantial samples from which generalisations are to be drawn.

An assumption upon which these analyses are based is that the outcome, or dependent, variable, is reliably identified and measured. Unfortunately this assumption is often difficult to justify. Putting aside problems in defining the outcome variable there are issues concerning the independence of the predictor variables with each other and also with the therapeutic context. Thus, for example, if an individual begins to show the precursors to self-harming behaviour, health care practitioners have a duty of care to act to minimise this occurrence. In this way research within a clinical context is never likely to provide the background for the random effects that prediction/classification models often require.

Since Paul Meehl's seminal monograph in 1954 in the area of clinical decision making, there has been a clear divide between the procedures of clinically informed judgement and statistical prediction. It is generally found that statistical prediction is more accurate than pure clinical judgement and this has led to suggestions that risk assessment must be actuarially based and built around a transparent statistical model (Monahan, 1981; Miller & Morris, 1988; Klassen & O’Conner, 1988; Monahan & Steadman, 1994). The typical statistical approach is to build a linear or logistic regression model. However, a number of clinicians are uneasy about this trend since it relies very heavily on normative information and ignores valuable idiographic insights (Pollack, 1990; Hammond, 1995). Thus, findings drawn from large-scale statistical models, while of some general use, may not be directly applicable in a specific individual assessment. For example, Mullen (1984) has argued that dangerousness is a quality of an individual’s actions rather than of the individual himself. The question to be posed in clinical practice is not ‘is this person dangerous?’ but rather ‘might this person in certain circumstances behave in a dangerous way?’ Given that these circumstances are likely to be specific to the individual in question, it is important to recognise the value of the idiographic context in making an assessment of risk for a specific individual.

The dominance of the prediction/classification approach to risk assessment has led to a dearth of research exploring actuarial alternatives. It is perhaps not surprising, therefore, that there has been very little work on psychometric risk modelling. Under this approach the problem of risk assessment shifts from the prediction or classification of harmful behaviour to the measurement of underlying latencies. A psychometric latency is best viewed as a potential. Thus, a latent trait of dangerousness is a measurable construct indicating the potential for dangerous behaviour. The measurement is not direct but involves the modelling of a number of indicators to provide a reliable estimate of the trait.

Many existing risk assessment devices are simply lists of risk indicators or items, chosen for their perceived importance but not related to each other through any theoretically defensible structure. Risk scores are then commonly generated by a weighted or unweighted summation of the indicators (Nuffield, 1989; Harris, Rice & Quinsey, 1993; Copas, Ditchfield & Marshall, 1994). Two serious limitations of this approach exist. First, this approach implies that the indicators conform to an additive measurement model and yet this assumption is rarely
tested. Second, the underlying latent structure, defined by the relationships between the indicators, is rarely made explicit so the construct validity of the resulting scores is usually suspect.

One of the founding fathers of modern psychometrics, Louis Guttman (1941) stated that, in the absence of reliable criteria for validation, one has to look at the relationships between the items themselves. This is a widely supported position (Niemuller & van Schuur, 1983; De Jong & Molenaar, 1987) and is the basic premise of all latent trait models of measurement. Fitting empirical data to an a priori model of systematic relationships between risk indicators (items) allows the construct validation of a risk assessment device. In addition, such a model can be used empirically to evaluate any theoretically justified ordering of items.

Psychometric modelling of risk has a number of distinct advantages over the traditional statistical models of prediction and classification. First, it imposes a clear and transparent measurement model on the assessment procedure, which may utilise a mixture of clinical judgement and actuarial data. Second, the relationships between the risk factors, or predictors, are explicitly modelled. This provides the means for examining the structure and meaning of the risk behaviour under examination. Third, using appropriate item response theory models it is possible to generate a statistical estimate of the underlying latent trait of dangerousness that is sample independent. Based on this principle, the assessor is able examine the degree to which an individual fits the model, thus, unpredictable or ill-fitting profiles can be readily identified. Finally, the reliability and validity of the risk assessment may be easily estimated using standard psychometric procedures.

5. Risk assessment systems

5.1. General points

A great many tools and systems have emerged within the generic form of risk assessment in mental health. In this section, we take a necessarily brief look at five such systems the PCL-R, the HCR-20, RAMAS, the LSI-R and OASYS. The PCL-R is, strictly speaking, not a risk assessment instrument at all but it is so widely cited as one, especially in work with personality disordered offenders, that it was felt appropriate to mention it here.

We will not be comparing efficacy of these systems because to do so would imply that such a thing was possible. Instead, we wish to simply give a flavour of each tool and when it may be appropriate for use.

5.2. PCL-R

The Psychopathy Checklist – Revised (PCL-R) was published by Robert Hare in 1991. This is a 20-item checklist that purports to measure Psychopathy as originally conceptualised by Cleckey. It requires the administration of a semi-structured interview that can last between 90 and 120 minutes. Hart, Hare and Forth (1994) stated that the full administration of the PCL-R requires intensive work and is time-consuming and they, therefore, devised an assessment measure that required less time and training. This measure is known as the Psychopathy Checklist: Screening Version (PCL:SV). This is used by clinicians and researchers as a screening instrument with limited time and case history information. Both the PCL-R and the PCL:SV assess a range of demographic, criminological, social and psychological information in a systematic manner.

The PCL-R has been shown to be a strong predictor of recidivism and violence in offenders and psychiatric individuals, even though it is not a risk assessment device. It plays an important role in current risk assessment procedures and in
many judicial decisions (Hare, 1998; Hemphill, Hare & Wong, 1998; Monahan & Steadman, 1994) and is indisputably an important tool in the assessment and diagnosis of psychopathy and antisocial personality disorder. However, as a generalised tool to aid in the assessment and management of risk it has a number of drawbacks. First, it is heavily oriented towards the forensic context and tells us nothing about risk to self, mental instability or vulnerability. Second, it is not sensitive to mental illness. Third, there are some disquieting signs that it is used naïvely and unethically, a situation exacerbated by its reliance on ‘cut-off’ scores for classification of ‘high-risk’ individuals. This latter point has been raised in a paper (Hammond, 2001) where it is argued that the psychometric model upon which the PCL-R is based cannot support the use to which it is being put.

5.3. HCR-20

A tool with a wider applicability is the HCR-20 (Webster et al., 1997). The name refers to Historical, Clinical, Risk management and the number 20 refers to the number of items. Unlike the PCL-R this is a broad instrument with potential applicability to a variety of different settings. However, its focus upon violence appraisal weighs it heavily towards forensic services.

The HCR-20 takes account of the individual/client’s current mental, emotional and behavioural functioning and seeks to integrate information from a number of sources such as face-to-face interviews, observation, clinical notes, ward notes, and psychological and neurological testing. The emphasis still rests upon historical rather than clinical constructs however, within the HCR-20, clinical aspects of the individual do receive concerted consideration. The HCR-20 also considers the issue of risk management with five of its 20 items dedicated to this issue.

In addition, the HCR-20 suggests ways of enhancing prediction accuracy, yields a summary risk statement, allows for the monitoring of current clinical status, and the development of risk management strategies. The HCR-20 is a popular choice in the forensic field. It incorporates most of the lessons learned from the research literature in a relatively simple and accessible form. However, its emphasis upon brevity militates against a comprehensive multi-agency approach to risk assessment and management. In addition, there is no clearly formalised measurement model specified to explain the collation of the information gathered.

5.4. RAMAS

Risk Assessment, Management and Audit Systems (RAMAS) (www.ramas.co.uk) was developed by psychologists O’Rourke and Hammond (1996) in an effort to incorporate ‘lessons learned’ from public inquiries with ‘what works’ principles in public safety, risk management and clinical care. RAMAS proposes a cumulative model of risk for mental health risk assessment and management and is based on data from UK samples as follows, CMHT clients, crisis response/assertive outreach patients, Forensic inpatients and community Forensic patients.

RAMAS provides for structured professional judgement and measures four types risk: (1) Dangerousness (Risk to others); (2) Mental Instability; (3) Suicide/Self-Harm; and (4) Vulnerability.

RAMAS seeks to improve upon and complement existing practices by being an objective and comprehensive approach, which will ultimately allow actuarial audit of professional judgement of risk to be possible. It attempts to provide a profile of an individual’s risk factor together with demographics, specific risk indicators and needs assessment. It also summarises information to enable practitioners to plan targets for intervention and change and to monitor and manage risk effectively.
A vital component of RAMAS is the recognition that there may be highly individual-specific (‘case sensitive’) situation(s) or set of conditions that undermine the objective measurement of the risk assessment. Thus the clinician can apply an override mechanism by calling upon information not reflected in the assessment. RAMAS is flexible enough to incorporate information from other sources also such as families/carers.

RAMAS does not depend totally on its risk indicator checklist in order to make an assessment of risk; however, the scores derived from the checklist are designed to inform the clinical judgement of the assessor. The scale score indicates how far along the risk continuum the individual is and the assessor must then make a clinical judgement of the best action for managing that individual. The greater the objectivity and reliability of the scale structure the more powerful the information. The cumulative model that forms the basis for the scales provides the user the benefit of truly additive scales as well as the possibility of identifying ill-fitting individuals who may manifest idiosyncratic and unpredictable profiles.

RAMAS supports both the content and process of risk need and responsivity assessment and management by providing four main risk and communication protocols namely: (1) Risk identification; (2) Crisis Alert; (3) Risk and Care Manager; and (4) Supervision Review.

5.5. ‘Giraffe’

‘Giraffe’ (Generic integrated risk assessment for forensic environments) is a modular database framework for use in forensic and related health care settings (Fuller, Lewis & Hawkins, 2000; www.GiraffeOnline.co.uk). Spurs to its creation were public inquiries into homicides that repeatedly identified process failures around risk communication and co-ordination (Ritchie, Dick & Lingham, 1994, Monahan, 1996, Fuller & Cowan, 1999).

‘Giraffe’ is designed around the presumption that optimal risk assessment and risk management may depend less upon prediction instruments or checklists, than upon care teams which are alert, questioning, well-connected, jointly informed and evidence-driven.

The system guides multi-disciplinary activity throughout a care episode including compilation of risk and forensic histories; risk formulation: targeted scanning and rating of current behaviour; care plans and risk management interventions, logging of adverse outcomes, identification of future concerns, and onward transmission of risk management advice along the care pathway. ‘Giraffe’ incorporates qualitative and quantitative measures as required, e.g. scores from established risk assessment instruments.

‘Giraffe’ s core module compiles an individualised risk formulation, selecting salient risk and protective factors from a broad range of domains. Each putative factor is evidenced by a set of obvious and subtle risk markers or ‘flags’. Risk marker sets can be locally developed so as to include risk factors of choice, to match particular client groups and settings, and to reflect preferred theoretical orientations of the core team.

As an aid to evaluating risk status over time, ‘Giraffe’ produces longitudinal plots from serial ratings of the risk markers. Relative risk graphics derived from local actuarial calculations also help to flag up risk management priorities. Since numerical estimations of individual risk inherently lack precision (Hart, 1998) output is framed and interpreted in ordinal terms (higher-lower; more-same-less). ‘Giraffe’ eschews decision-making-by-algorithm in favour of general decision-support through a wide range of textual and graphical reports.
5.6. LSI-R

The Level of Service Inventory-Revised (LSI-R) combines risk and needs information in a systematic format to inform offender treatment planning (Andrews & Bonta, 1995). It is presented as a 54-item ‘quantitative survey of attributes of offenders and their situations relevant to level of service decisions’ (Andrews & Bonta, 1995). Within its components are items that tap changeable (or dynamic) factors and these are used to evaluate change following intervention. Andrews and Robinson (1984) discovered that changes in LSI-R scores were related to changes in reconviction rates.

Interpretation of the LSI-R scores involves several steps. The first step is to examine the overall total score of the LSI-R. A profile sheet exists whereby the raw scores are converted to percentiles automatically and can indicate the level of risk for various situations (e.g. probation or institution settings). The second step is to examine the different subcomponents. Those subcomponents that have numerous endorsements are seen as problem areas. Finally, the profile of the 54 individual item responses must also be carefully examined.

Another vital component of the LSI-R is the recognition that there may be a highly individual-specific situation or set of conditions that undermine the objective recommendation of the instrument. Thus the clinician can apply an override mechanism by calling upon information not reflected in the form.

The authors recommend using the LSI-R in numerous ways: to provide a record of factors to be reviewed prior to case classification; as a quantitative decision aid in case classification; and to assist in the appropriate allocation of resources both within and among offices. More specifically, the criteria are provided for: identifying treatment targets and for monitoring offender risk whilst under supervision and/or treatment services; making probation supervision decisions; making decisions with regard to placement into halfway houses; determining the appropriate security level with regard to classification within institutions; and for assessing the likelihood of recidivism. It is, however, important to note that the authors strongly recommend the use of this assessment tool by professionals who understand the basic principles of psychological testing and interpretation. However, again the actual measurement principles upon which it is based are rather naïve and unsophisticated.

5.7. OASys

The Offender Assessment System (OASys) was designed by the UK Home Office to serve as a tool to be used by both prison and probation services. It is based on literature reviews and research on risk assessment and management of dangerous offenders, particularly that by Kemshall, HM Inspectorate of Probation reports on current practice, and on research into the use of other risk/needs assessment tools used by the probation service (Aubrey & Hough, 1997, Aye Maung & Hammond, 2000). OASys combines an assessment of offenders’ criminogenic needs, an assessment of risk of serious harm and other risks, and a format for planning and reviewing offender supervision.

The first component of OASys identifies problems linked to offending (‘criminogenic needs’) and measures the likelihood of reconviction. This section of OASys examines offending history, social and economic factors, which are divided into 12 categories (e.g. alcohol, accommodation, thinking skills and relationships). Each category contains a number of items, some of which require a simple yes/no answer, and some of which are scored 0 to 2, depending on the severity of the problem identified. The items have been selected on the basis of

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2 The information relating to the LSI-R has been taken from the literature emanating from Canadian research. Adaptations have been made for use in the UK. Further information regarding these can be obtained from The Cognitive Centre Foundation.
research linking them to likelihood of re-offending. Most of the items covered relate to dynamic risk factors. Each section is scored, and the raw score is then converted into a weighted score and entered on a score sheet. This sheet gives a graphic representation of the relative severity of each problem area and also allows a total score to be calculated. The total is then put into a band, indicating low, medium or high likelihood of reconviction within two years.

The second component of OASys is an assessment of risk of harm, (broken down into risk of harm to others i.e. serious harm to the public, risk to children, staff, specific individual and other prisoners) risks to the individual and other risks (e.g. absconson). OASys has three subcomponents: an initial risk screening, full analysis of risks identified by screening, and a summary and management plan.

The Risk Screening tool is a checklist of previous and current convictions or behaviours indicative of risk of harm to others including concerns of risk to children, risk of self-harm and suicide and vulnerability. Risks and concerns are registered on the screening checklist with a simple tick. Any item checked requires the user to complete a full analysis of the risk or concern identified. Additionally, an override option allows the user to proceed with a full analysis even when no risks have been identified on the checklist.

In the full analysis, the user is prompted to describe the risks in greater detail. Analysis of risks of harm to others and to children is guided by a series of questions, followed by a summary section, which requires the user to rate the risks of serious harm to others on a four-point scale between low and very high. This rating is then used to decide the level of supervision and management oversight given to the case. If the level of risk is high or very high, a further section must be completed, outlining risk management action to be taken, including referral to mental health and other specialised assessments.

The final component is a supervision and sentence planning tool, used to plan and review the supervision of community or prison based court sentences. It incorporates items previously identified as criminogenic risk factors, as well as risk management issues highlighted by the risk assessment component. This component uses a self-assessment questionnaire to involve the client in identifying their own offending related problems. The supervision planning and risk assessment components are designed to be reviewed at a minimum of four monthly intervals.

OASys is intended to replace the wide range of risk and needs assessment tools currently in use in the prison and probation services and to standardise the supervision and sentence planning process.

5.8. Summary

All of these devices require that the users should be properly trained before using them. The PCL-R and LSI-R further stipulate that users should have an understanding of psychological testing and interpretation. This carries the implication that the assessor will be a psychologist. The HCR-20 and the RAMAS do not make this assumption and the RAMAS is specifically designed so that the language and presentation of the device is interpretable across professions and agencies. The public inquiries have taught us much about what is required for public safety and individual care (risk reduction and prevention). On the basis of this, Table 1 (alongside) examines a number of features taken from the inquiries are listed and each of the six systems is rated against each. As can be seen, the PCL-R has the least in common with other tools which is not surprising given that it is not strictly speaking a risk tool.
6. Risk assessment in clinical practice

Danger … liability of exposure to harm, risk, peril

Dangerousness … causing danger, unsafe

Risk … hazard, chance of bad consequences

Given the words and definitions above, it is not surprising that individuals and organisations may at times take a somewhat ‘fight or flight’ approach to risk assessment and management. The former is characterised by over-reaction, rigidity, excessive controls and the perception or identification of risk where none exist. The latter can involve avoidance, complacency and the denial and minimisation of risk. Anxiety and other emotions can, therefore, exert a significant influence on risk assessment, and management, strategy, practice and policy.

It is important to be particularly aware that the prediction of dangerousness and risk, particularly amongst the mentally disordered, can involve a high rate of error, usually in the direction of over-prediction. There are many myths and stereotypes about people with mental illness and the risks they may present to other people and society in general. Over-prediction means that more individuals may be assessed as being ‘dangerous’ or ‘a risk’ than is actually the case. This type of ‘false positive’ assessment can lead to unnecessary and restrictive practices in a variety of situations and cases. The concept can be applied to a range of potential risk behaviours, e.g. aggression and violence, suicide, self-harm or self-neglect. For example, an elderly patient with dementia and a tendency to wander off may be excessively restricted or a suicidal individual may be kept under close observations for too long.

In the context of mentally disordered offenders, applying the concept of ‘dangerousness’ through mental health statutes and legislation could result in individuals being detained indefinitely, and often longer, than offenders who are not considered to be mentally disordered.

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3 Some information on the reliability and validity of the LSI-R in the UK is available. Those interested in the latest information in these areas should contact The Cognitive Centre Foundation.
There is a great deal of debate, discussion and research in the area of dangerousness, risk assessment, management and prediction. Theoretical ideas come from a variety of different perspectives, e.g. clinical, psychological, psychiatric, moral, sociological, legal and political (Campbell, 1995). Descriptions and definitions of dangerousness have usually involved the notion of someone having the propensity to cause serious physical injury and/or lasting psychological harm to themselves or others (Butler Committee, 1975).

When thinking about dangerousness and risk, there is an implication that we are required to make some sort of prediction about future conduct and behaviour. In effect this means trying to read the future, which has obvious problems associated with it. However, dangerousness is an ascribed quality, like trustworthiness, and not an easily definable, objective or constant quality. If we were deciding how trustworthy someone was for example how would you do this: how exact could our assessment be, what would our judgement be based on, what type or level of trust is being considered, etc.

When assessing risk, one has to balance the seriousness of the possible outcomes with the probability they will occur, based on specific risk factors. Unfortunately, this means that, however confident an individual might be in the assessment and evaluation, there can never be any absolute guarantee. Risk assessment is indeed ‘a risky business’ and this applies to assessments and decisions of either low or high risk.

It is, therefore, important to use an interactive model of behaviour when assessing and managing risk. The equation must include specific and detailed information about any risk behaviour, actual and potential. However, it also considers the nature of the relationship between the risk behaviour, the individual, circumstances, context and environment and other people, especially potential victims.

Research and practice now emphasises the importance of adopting a decision-making model and approach to risk assessment and management (Monahan & Steadman, 1994). Prediction is seen as being a dynamic process on a continuum rather than a simple all or nothing ‘yes’ or ‘no’ decision. A move away from one-time or one-off predictions to ongoing, day-to-day decisions about the assessment and management of risk is required.

In light of the above, there are certain important points that must be considered when considering risk behaviour.

- Risky behaviour(s) occur in a context and is a result of the interaction between individuals, their environments and situations.
- To assume that ‘dangerousness’ or risk is a permanent feature of an individual is to ignore these factors. This is bad practice as it can bias assessment and may lead to risks being missed or being identified when they are not present. Clinicians and assessors should avoid making assumptions and should check information and strive to build a collaborative approach with clients.
- Any risk behaviour, and associated emotions, need to be assessed and understood in connection with the thoughts, perceptions and interpretation an individual has about situations, other people and their own behaviour.
- It is important to record clearly the type of risk, under what conditions it might be present and who is likely to be affected by the risk identified.
- The assessment, reduction and management of risk behaviour needs to be broad based, multi-modal and multi-disciplinary in its approach. It is essential that clinicians take a collaborative and partnership approach to risk.
A detailed and comprehensive multi-modal functional analysis of behaviour (see Appendix 6) needs to be carried out on number of different levels, e.g. behaviour, attitudes, relationships, emotions, cognitions.

A structured framework for risk assessment is important, but it should not restrict practice. Psychometric tools are useful but they are only one piece of the overall ‘jigsaw’. Structure and psychometric evaluation should guide and inform the risk assessment and management process. This can lead to an increased understanding of risk, the development of consistent and more effective baselines and inform risk reduction and management strategies.

It is important to have a common structure, language and understanding with regards to risk assessment, which will facilitate the development of a consistent and professional approach by individuals and organisations.

When assessing risk it is important to strike a balance between objective and subjective assessment and opinion.

Assessment and management plans must be recorded and communicated. It has been suggested that the clinical decision-making process is the central issue, rather than the prediction itself (Pollock, McBain & Webster, 1989). This does not deny the importance of attempting to make predictions about risk behaviour, but combines it with a process of explanation and understanding. The process of clinical decision-making can be improved by:

- Using multiple sources of information (reports, chronologies and case notes, as well as interviews with relatives and with the individual themselves).
- Using standardised protocols and/or psychometric tests to increase objectivity and benchmarking progress/performance.
- Using inter-agency, multi-disciplinary assessments, discussions and joint planning and risk communication.
- Collaboration with the person and asking him/her to collaborate with you.

7. Professional issues

Partnership working is essential when it comes to effective risk management. The link between adverse life conditions and poor mental health is well established. People who pose a risk to themselves or to others often have a wide range of problems including mental health or personality problems and housing, employment or financial difficulties. Consequently they require a spectrum of services. The Spectrum of Care guidance from the Department of Health (1996) reminds purchasers and providers of mental health services of their responsibilities in this respect. These include working together with other interested agencies, identifying and responding to a crisis, giving priority to those in greatest need and making sure people with enduring mental health problems have access to continuing care.

The following principles should be used/observed/adhered to as part of ongoing safe and effective risk assessment and management practice.

7.1. Clinical governance

Clinical governance is essentially a tool for assisting quality. It requires action by health providers to ensure four major activities as follows:

1. Risk are avoided.
2. Adverse events are rapidly detected, openly investigated and lessons learned.
3. Good practice is rapidly disseminated.
4. Systems are in place to ensure continuous improvement in clinical care.
7.2. Duty of care
Professionals and services have a duty of care towards service users, their colleagues and others. Duty of care is about safe, sound and supportive services. To achieve this, for example, untrained staff or staff in training should be assigned appropriate cases and should be supervised.

Duty of care is also about maintaining confidentiality. Service users have a legal right to confidentiality and thus information sharing should be on a ‘need to know’ basis with informed consent.

7.3. Negligence
In the UK, for negligence to be established there must be:
- Harm caused by negligence;
- Recoverable harm (money/income);
- Negligent action.

An error of judgement or decision-making does not necessarily establish negligence. A negligent decision is one that no responsible body of your peers would approve.

7.4. Confidentiality
People with mental health problems have a legal right to expect confidentiality. Primary care and mental health professionals have a duty to protect civil liberties as far as possible.

The information/confidence ‘belongs’ to the user and thus professionals have to ‘negotiate’ information sharing.

Public interest outweighs personal preference; one of the few defences for a breach of confidentiality is that of public interest.

If confidentiality is broken you must:
- Be able to explain your reasoning;
- Have evidence to support your decision;
- Have consulted about the issues.

7.5. Safe practice
Mental Health and Forensic professionals must be able to explain their reasoning/decision-making. They must:
- Be able to ‘evidence’ decisions and decision-making actions.
- Consult about the issues, with the user, his/her carer and other professionals.
- Engage in multi-disciplinary decision-making.
- Engage in retrospectively defensible practice.

However, it should be acknowledged that the pressure on professionals to be able to explain their decision-making can lead to ‘defensive’ as opposed to ‘defensible’ practice, i.e. actions to defend the professional’s position rather than actively defensible decisions taken in co-operation with the service user.

Safe practice requires the professional to have robust systems that allow valid, reliable and retrospectively defensible risk assessment and management, for every patient, every time.
8. Enhancing good practice

Effective working between the different agencies responsible for the various aspects of care is essential. Ineffective joint working can – as many of the Inquiry cases remind us – be a matter of life or death. No individual professional or agency can operate in isolation when working with risk. We need more than good will and regular communication if real progress is to be made in risk management. All those working together must see their input as part of the wider context and as part of the overall effort. Perhaps, the most useful metaphor is to consider each individual contribution as one part of a jigsaw, each part is necessary (but not sufficient) and inescapably part of and interdependent with the work of others.

People who pose a risk to themselves or others often have difficulties continually or intermittently, and at several points through the lifespan. Roughly one-third of people with mental health problems who have multiple needs and vulnerabilities will require mental health and social care throughout adulthood. High risk is most often, (but not exclusively) associated with long-term need. It is argued, therefore, that the earlier we can get into collaborative and supportive relationships with service users the better the planning, the progress and the outcomes.

Ridgely et al. (1998), have demonstrated that developing a collaborative approach to service provision is not just outcome effective, but cost effective also.

Recent comment on why US intelligence services failed ‘to join the dots’ and prevent the events of 11 September, 2001, has focused on how that system was fixated with technology rather than people.

Health care is a complex organisational system because of its combination of treatment, technology processes and people. The key to good practice and to prevention science is communication between processes and people.

8.1. The importance of communication

Research and Clinical Practice has indicated that several aspects of communication are important in order to achieve effective risk and care management, some of these include:

- Listening to all concerned … a full and clear picture is essential.
- Asking the questions … the quality of the assessment is dependant on the information gathered.
- Good written records … if information is not recorded it will not be remembered/discussed or acted on.
- Regularly consult the records … monitoring and recording new information and change.
- A strategy for action points … a communication chain, clear and shared goals.
- Confidentiality … any information sharing should be confidential on a ‘need to know’ basis and not in the public domain.
- Regular Review … Risk is dynamic and so new information needs to be understood and used to inform and develop plans. Debriefing after Risk events is crucial for on-going learning and support.

Missing information can lead to underestimation or risk, and consequently a failure to act when action is required.
When forms are standardised and safe systems implemented, it is important to supply regular updates. Sound safety information and communications systems are a precondition for systematic learning from failures and successes. It is important for teams, practitioners/clinicians to take account of the fact that low-level incidents or ‘near misses’ can provide a useful barometer of more serious risk (‘An Organisation with a Memory’, Department of Health, 2000).

8.2. Staff training and support
The emphasis throughout the health service has changed in the last decade, towards evidence-based practice and treatments. The increasing trend and pressure form the health service and the professional bodies are to provide only services that are of proven therapeutic benefit. In the UK, clinical governance requires, as a minimum, that NHS Staff appraise and apply the research data available to them. Furthermore, it requires that services are able to audit their own practice. The NHS modernisation programme involves a willingness to adapt services to achieve better outcomes for service users and carers.

The training of all staff who are in contact with patients at risk (to themselves or others) is highly recommended. Training should be available at a number of levels to address the learning needs of different staff.

Mental Health and Forensic staff should be supported to exercise professional skills and continuing Professional development in terms of effective information sharing communication and risk management strategies. Professionals should be enabled with knowledge and skills to collaborate with other agencies and disciplines in order to safeguard public safety and the safety and care of people with mental health and/or forensic problems.

8.3. Responding to critical incidents
As with most documents on risk assessment and its management, this position paper has concentrated upon the ‘how’ of risk assessment. However, it is appropriate to have some guidelines for individuals, teams and organisations for when there is either ‘false negative’ in assessment or there is, to use the present term, a ‘critical incident’ (e.g. a homicide, a serious assault (sexual or physical) or a suicide). Such events can result in psychological trauma for those involved.

The public and internal inquiries conducted (viz. ‘Learning the Lessons’ (Sheppard, 1995)), have sought in the main to establish better procedures and systems for the process of risk assessment, with many recommendations for future action. However, they have made little comment on the psychology of the individual decision-maker(s) and how they might best conduct themselves or be reacted to in the situation. There is a danger that the professional, so accustomed to the role of caring for others, is poorly equipped for looking after him/herself or being looked after by others.

The reaction or reactions to a critical incident, therefore, are likely to be the result of criss-crossing multifactorial features. These include the staff member’s role in: (a) decision making; (b) the incident; (c) the organisation; and (d) direct work with the individual(s) concerned. Therefore, the personal meaning the event might have for a particular individual is important, influenced as it may be by the gravity of the event and the responses of others to it (e.g. colleagues, media, etc.). An individual’s response will also be determined by their own personal style and the quality of various personal and professional relationships. However, this will be a novel situation and therefore what the individual experiences is likely to be unique, unlike anything previously experienced. For example, the professional may feel some sense of responsibility for what happened. Occasionally this (and the emotional response to the event)
may lead to a loss of self-esteem and a diminishing of a sense of competence in the performance of risk assessment itself but also other professional roles. There is the danger that this sense of incompetence can also extend into other areas of life, affecting the sense of well-being.

The organisational response to a critical incident can vary from a full public inquiry to a more local or internal one. For staff members, as well as the threat of the process itself such as giving evidence in public, there is that of potential disciplinary action at the end of it. An added stressor is that this process can be somewhat protracted. How the inquiry is conducted by the inquiry team might also add to the stress, varying in attitude from ‘There but for the grace of God go I’ to ‘Heads must roll’.

Although the multidisciplinary team can be expected to be a cohesive and supportive unit, the group dynamics of such operational teams might well be otherwise. A critical incident, therefore, might serve to expose these features. So in addition to any personal responses with which the individual will have to cope, there will also be the challenges of organisational and group dynamics.

Although support will be considered the necessary response, this appears to be a poorly delineated and deconstructed concept in the literature. Support is typically given in the immediate situation however, consideration needs to be given to how it is to be supplied in the intermediate and the long-term. The nature of the support (and the need for support) changes over time. However, it can usefully be divided into cognitive and affective components. For example, the cognitive support would include having the appropriate information available for staff which would include practical elements such as: (1) writing up the event so there is a record; (2) informing the personal indemnity insurance company/trade union; and (3) being aware of what will happen next in terms of any organisational procedure.

Emotional support can be approached by considering what not to do (e.g. being critical, distant and hostile) and how to overcome the sense of personal and/or professional isolation. However, in providing support, there may be a sense of powerlessness for the helper since the situation is beyond his/her experience. People usually feel most supported by others who have themselves been in the same predicament and therefore seeking out such people would be interpreted as helpful.

Managerially, there should be openness in the process and decision-making should be consistent and objective. For staff such practice can help avoid unnecessary paranoid feelings and the sense of being aggrieved.

A judgment might need to be made about whether it is prudent to continue at work or be given a leave of absence. This must not to be confused with suspension, and the nature of the leave will need to be clarified. However, this should be carefully considered to balance the risk of exacerbating any avoidant behaviour with experiences such as reinforcing feelings of inadequacy through staying at work.

This is not meant to be a comprehensive list, but to encourage a thoughtful response to a situation that hopefully people will not encounter. A useful rule of thumb would be to consider how one would behave if the professional colleague in extremis was a patient/client.
PART 2

9. Practice guidelines

9.1. Process and purpose
As commented upon previously, risk assessment and management is a continuous and dynamic decision-making process, rather than a simple ‘yes’ or ‘no’ prediction. This can involve both long- and short-term decisions about the assessment, reduction and management of risk, depending on the individual, behaviour in question, context and situation. The risk assessment and management process, therefore, contains a number of important elements.

■ The collection and communication of information.
■ Asking questions and developing hypotheses about the risk behaviour.
■ Identifying the causes and consequences of the risk behaviour.
■ Consideration of actuarial and clinical knowledge, as well as clinical experience.
■ Identifying any patterns to the risk behaviour.
■ The development of effective risk reduction and management plans and strategies.
■ The monitoring and evaluation of strategies, modifying them where necessary.

When carrying out risk assessment, there are a number of key questions to keep in mind.

■ The nature of the risk behaviour … what?
■ The frequency of the risk behaviour … how often?
■ The severity of the risk behaviour … how serious?
■ The imminence of the risk behaviour … when?
■ The likelihood of the risk behaviour occurring … probability?
■ What are the conditions … circumstances and factors?
■ What can we do about the risk behaviour … reduction and management plan?
■ How do we keep an eye on the risk behaviour … monitoring and feedback?

The purpose of a risk assessment may vary and it is, therefore, also important to think about why it is being done and your role in the process. Listed below are some examples of common reasons for carrying out a risk assessment.

■ Trying to predict future risk behaviour, e.g. violence, suicide, self-harm.
■ Predicting the risk of offending or re-offending.
■ Involvement in decisions about custody, bail conditions, placement, etc.
■ Deciding whether or not to admit an individual to hospital.
■ Deciding whether or not to use a section of the Mental Health Act.
■ Assessing a person’s suitability for a treatment or rehabilitation programme.
■ Assessing a person’s relationship with others, e.g. family members, staff.
■ Reviewing which staff are involved with a particular case.
Trying to assess and evaluate change in an individual and possible risk reduction.

Considering possible contact with a family or children.

Assessing the risks of a person being released from custody.

Assessing the risks of a person being discharged from hospital.

Decisions about suitability for transfer to another ward or hostel.

Assessing the risks in the community and possible supervision needs.

9.2. Information

Collecting and communicating information is a key aspect of any risk assessment and management strategy. It is, therefore, essential that good communication links are developed at all stages of the process. Any assessment and evaluation of risk should be continuously updated wherever possible, if only to be sure that nothing has, or can be, changed. This should happen within teams and organisations as well as between agencies and other professionals. Information may be limited, or take time to collect, but there are a number of potential sources that can be explored.

The aim is to collect as much information as possible about the individual, their circumstances and the risk behaviour in question. It is also important to identify the sources of information used in the risk assessment, e.g. when completing your assessment and writing any reports.

When carrying out any risk assessment and management procedure, it is important to remain aware of the professional, organisational, legal and ethical frameworks within which you practice. This can sometimes mean having to balance individual care and need with professional codes of conduct and organisational protocols that have been developed to promote the protection of vulnerable members of society who might be at risk, particularly children.

This may involve the sharing of information about a particular individual with other professionals and agencies. However, it is important to emphasise that individual practitioners and agencies must also understand and respect the legal and ethical frameworks other colleagues and organisations may be guided by.

The interview not only provides you with information, but also allows a chance to develop some sort of rapport and a positive relationship with the individual. Where possible, it can be helpful to obtain information over a number of regular sessions, arranged to fit in with whatever time limits you might be working within. A number of important areas can then be explored.

- Developmental history.
- Family background and dynamics.
- Social and relationship history.
- Educational history.
- Employment history.
- Significant life-events.
- Psychiatric and medical history.
- Forensic history.
- Alcohol/drug misuse.
- Detailed assessment of past and present risks, including any current concerns.
Reports and documentation can come from a wide range of sources, e.g. case conference reports, case summaries, correspondence, pre-sentence reports, psychological or psychiatric assessments. Although some reports may not always be obtainable, or accessible, it is helpful to keep a record of what information is available (see Appendix 3).

Information from significant others provides other information and perspectives on the individual and behaviour. This can be compared with your assessment and any contradictions or discrepancies explored with the individual. Three main sources of information are: other professionals or agencies who have either worked, or come into contact, with the individual, close family members and other relatives, friends or acquaintances.

Psychological and/or Psychiatric Assessments may be available and can address a number of areas and assessment questions.

- Assessment and analysis of any risk or offending behaviour.
- Assessment of the person’s mental state or illness.
- Assessment of the person’s intellectual level and functioning.
- Assessment of any distorted thinking, attitudes and beliefs.
- Assessment of sexual interest and functioning.
- Assessment of the person’s motivation to change or accept treatment.
- Assessment of any change during treatment.
- Assessment of family dynamics and functioning.
- Assessment of the effects of any abuse on victims.
- Assessment by a child and adolescent psychologist or psychiatrist.

Victim Statements can be very important when carrying out a risk assessment. They provide information and perspectives on the individual’s risk or offending behaviour. This information can be obtained from a number of sources, e.g. case depositions (written statements), case conference information and other reports, verbal accounts.

There can be difficulties obtaining copies of depositions and other witness statements or reports, e.g. permission is not given for a copy to be released or an offence occurred some time ago. With regards to the latter, this problem can sometimes be overcome by contacting either the Probation Department involved in the case or the individual’s solicitor at the time. This usually involves obtaining written consent to do so from the person being assessed.

9.3. Clinical, actuarial and structured risk assessment

Professional clinical judgement is a commonly used risk assessment method, although there may be no constraints on the evaluation made or any management strategies generated. Assessment results may be interpreted and communicated in various ways, with no empirical support. This may result in poor agreement, accuracy and an over-emphasis on static risk factors, e.g. previous history. An exclusive focus on static risk factors, can ignore important dynamic variables and result in limited risk management strategies.

Actuarial (statistical) measures are highly structured, empirically-based and objective approaches that attempt to measure factors that predicts risk, according to previous research evidence. This type of assessment tool has usually been evaluated, using reliability and validity measures, to test the accuracy of decision-making on the basis of the identified risk factors. It, therefore, puts some structure on the risk evaluation and decision-making process. However, a degree
of professional judgment is still required, e.g. what measure to use and how to interpret scores. There is still potential for assessment results to be interpreted incorrectly or in a rigid manner. Important questions are also raised regarding the extent to which risk factors identified in any population used to develop a specific risk assessment measure (e.g. a group of North American mentally disordered offenders) can be generalised to others (e.g. a group of UK mentally disordered offenders).

A structured approach to risk assessment and management will usually consider a specific set of both static, e.g. previous history, and dynamic, e.g. current mental state, risk factors (see Appendix 2). It provides a process for systematic information-gathering, imposes some structure on decision-making and can be helpful in providing a consistent language for communicating risk information. This can facilitate a more active approach to risk management plans and strategy. Treatment aims and criteria for change can be identified and monitored, e.g. reduction in psychotic symptoms, improved insight into risk behaviour, treatment compliance.

It has often been suggested that clinical judgement and decision making is only guesswork and mental health professionals have no special expertise in risk assessment and management. Actuarial measures are said to provide a more scientific and objective assessment of risk factors. However, both approaches have the potential to be subject to bias and this can lead to restrictive practice. We would suggest that good risk assessment and management practice should combine structured clinical judgement and actuarial measures.

It is time that clinicians and researchers abandoned the search for empirically derived ‘predictors’ … and focused instead on the development of theoretically based decision-making procedures for arriving at defensible clinical decisions about dangerousness. Monahan (1981)

9.4. Risk factors and questions

A key aim should be to identify, understand, reduce and/or manage any risks as effectively as possible. Although in practice there is never one specific variable that can be used to accurately predict the likelihood that risk behaviour will occur, there are a number of important factors that can be considered (Blumenthal & Lavender, 2000). An awareness of these, combined with the use of detailed risk management strategies, can lead to risk behaviour being more clearly and effectively identified, managed and monitored.

This section contains a number of important areas to consider when carrying out a risk assessment, however they are intended to help guide and inform the risk assessment and management process, focusing on important areas to consider rather than provide a simple checklist. They also have a number of important aims.

- To provide a common framework, language and perspective for the overall risk assessment and management process.
- To guide and develop individual and team practice in risk assessment and management.
- To facilitate shared understanding of important areas and issues that should be considered.
- To guide staff in the identification of risk factors and issues relevant to the case and risk behaviour(s) being assessed.
- To identify specific risk factors and issues pertinent to the individual case.
- To help develop and monitor a comprehensive risk management plan.
The factors covered, and their associated questions, can be used when assessing a range of behaviours that might be identified as having the potential to put either the individual, or another person at risk, e.g. physical abuse and aggression, verbal abuse and aggression, suicide and self-harm, self-neglect, absconding, sexual offending. Each section and question will not apply to every individual, and recognise the repetition and overlap between them. However, they are provided as a comprehensive overview of potentially relevant and applicable information that could be used for a range of individual cases or issues, when carrying out a risk assessment. We also recognise that this information will already be familiar to many practitioners. However, we would hope that this not only reinforces existing knowledge and skills, but also facilitates increased awareness and confidence about what is already known.

The guidelines below are informed by a combination of sources which take into account research and actuarial risk factors as well as clinical and professional judgements. Risk assessment is a dynamic process carried out in a variety of health, criminal justice, community and social care settings. The importance of clinical experience, professional judgement, individual contact and observation is, therefore, also acknowledged.

It is important to identify all the risk behaviours causing concern and requiring assessment, e.g. physical aggression (to others or property), verbal aggression, suicide, self-harm, absconding, sexual offending, fire-setting, self-neglect, vulnerability to abuse by others, physical health risks.

### 9.4.1. Past history of risk behaviour(s)

Here you are reviewing the individual’s previous history and occasions when risk behaviour has occurred.

- Is there a past history of the risk behaviour(s) you have identified?
- What are the specific details of this?
- What is the frequency, duration and intensity of the risk behaviour?
- Where, when and how has it happened in the past?
- Has the individual used any weapons in the past?
- Who was involved, e.g. victims and accomplices?
- Background or cultural factors that might cause the behaviour to be more accepted?
- Was the risk behaviour and/or offence planned, unintentional, impulsive or opportunistic? Give details of this.

**Forensic history**

This would only apply to someone with a history of offending.

- What are the specific details of any previous violent and/or sexual offences?
- What are the details of any other offences?
- What was the result of any previous convictions, e.g. prison, probation, MHA?
- If there is a forensic history, is it connected with any other risk behaviour(s)?

**Suicide and self-harm**

This section focuses specifically on the individual’s previous history of suicide and self-harm. It suggests questions to ask that will help build-up a picture of the individual’s suicidal and self-injurious behaviour.

- How isolated was the person at the time of a suicide attempt?
Was any suicide attempt timed so that discovery was likely or unlikely?

How premeditated was the attempt, were precautions taken against being discovered?

Did the person do anything to get help during or after the attempt?

Did the person carry out ‘final acts’ or write a suicide note, knowing s/he would die?

Did the person say that s/he wanted to die and believed that the attempt would be fatal? What is the person’s reaction to having recovered?

The factors listed below have been particularly associated with an increased risk of suicide and self-harm.

- Young male or male over 45.
- Depressive or schizophrenic illness.
- Previous psychiatric history.
- Personality disorder.
- Alcohol abuse.
- Suicidal ideation beforehand, talking and planning suicide.
- History of previous attempts.
- Lethal methods were used.
- Social isolation, living alone, few social supports.
- Hopelessness.
- Family history of suicide.
- Unemployment or in a high-risk occupation.
- Separated, divorced or widowed.
- Stressful life events, particularly a recent bereavement.
- Emotional impulsivity.
- Severe physical illness or disability, chronic pain, terminal illness.

9.4.2. Current incident, offence or risk behaviour

Give detailed information about the current, or most recent, incident and/or risk behaviour which is causing concern at the present time.

- What are the details of the current incident, offence or risk behaviour?
- What happened, how, where, when and who was involved?
- What was the individual’s mood and mental state at the time?
- Had there been any deterioration in mental state or mood?
- Was the individual under the influence of alcohol or drugs at the time?
- Was the individual’s behaviour unintentional, impulsive and opportunistic or is there some evidence of planning and preparation?
- Were any weapons involved?
- How aware is the individual of his/her actions and events leading up to the incident, offence or risk behaviour?
- What are the individual’s current circumstances, e.g. accommodation, occupation, associates, personal situation, relatives?
9.4.3. Antecedents to risk behaviour
Consider the individual’s past and current risk behaviour and try to identify the possible antecedents, and any pattern, to the risk behaviour.

- Can you identify any causes or precipitating circumstances leading up to the individual’s risk behaviour or offending?
- Are any of these still present, or likely to occur?
- How often do they, or are they likely to, occur?
- Was there any change in the individual or their circumstances prior to the risk behaviour occurring?
- Is there any particular pattern to the behaviour, e.g. planning or preparation?
- Does the individual have any violent or sexual fantasies?
- What are the details of these?
- How do these relate to the risk behaviour?

9.4.4. Attitude towards risk behaviour
Forming opinions about another person’s attitudes is obviously a task susceptible to influence from one’s own views and feelings. However, it is very important to try and draw some conclusions about an individual’s attitude and beliefs with regards to the risk behaviour. To help maintain a more objective focus, consider the following questions.

- What is the individual’s attitude towards his/her risk behaviour or offences?
- Has the individual shown concern about behaviour and possible risk to others?
- What awareness and insight does the individual have regarding risk behaviour?
- Is the individual aware of the consequences that his/her risk behaviour could have for themselves or others?
- Does the individual try to rationalise or justify his/her actions?
- Is there any evidence of distorted thinking or thinking errors?
- What is the level of denial and minimisation?
- What are the individual’s beliefs with regards to aggressive behaviour?
- What are the individual’s beliefs with regards to sex and sexual relationships?
- Does the individual expect the behaviour to occur again?
- Has the individual made comments or threats that the behaviour will occur again?

9.4.5. Emotions and impulsivity
This section considers how the individual may recognise, manage and express feelings.

- How does the individual deal with his/her feelings?
- Are feelings expressed, or kept bottled up?
- Is the individual prone to emotional outbursts, e.g. anger, anxiety?
- Is the individual impulsive with regards to his/her emotions?
- Does the individual become easily frustrated?
Does the individual become easily distressed?
Does the individual find it difficult to cope with problems?
Is the individual able to recognise their own feelings and those of others?
Can the individual acknowledge and empathise with the feelings of others?
Does the individual become disinhibited under the influence of alcohol or drugs?

9.4.6. Physical, medical and psychiatric factors
Identify any relevant information from the individual’s general physical health status, medical and psychiatric history.

- Is there a previous history of mental illness?
- What were the symptoms of this?
- What is the individual’s current mental state and symptoms?
- Is there any evidence of hallucinations and/or delusional ideas, particularly paranoid or passivity phenomenon; what is the specific nature and content of individual delusions and/or hallucinations?
- Has the individual taken medication in the past and how was this tolerated, e.g. were there any side-effects?
- Does the individual have personality problems/disorder? What are the cognitions, emotions and behaviours associated with this?
- Does the individual have any physical illness or disability?
- Does the individual suffer from any significant medical conditions or problems?
- Are there any organic or neurological problems?
- Is there evidence of any mental impairment or learning disability?
- What is the individual’s level of intellectual/cognitive functioning?
- Is there any evidence of substance misuse, e.g. alcohol, drugs, solvents?

9.4.7. Victim factors
In some cases, other people may have been victims of the individual’s risk behaviour, either intentionally or unintentionally. Victims may have been adults or children, depending upon the risk behaviour(s) being assessed. They could also be either relatives, members of staff or complete strangers.

- Give details of any victim(s), e.g. who, age, relationship to the perpetrator, gender?
- Was the victim targeted by the individual? If yes, how was this done?
- What, in detail, was actually done to the victim(s)?
- What were the effects of the risk behaviour on the victim(s)?
- How able was the victim(s) to protect her or himself?
- Does the victim(s) understand what happened and realise the perpetrator is responsible?
- What is the degree of access to past, current or potential victims?
- Did the individual use coercion, threats or bribes with the victim(s)?
- Was physical force used against the victim(s)?
Did the individual take advantage of the victim(s) sexual and emotional immaturity?

What did the individual do to break down the boundaries with the victim(s) and gain their trust and confidence?

Is the individual able to empathise with the feelings of his/her victim(s)?

Any awareness of the consequences that his/her behaviour has for victim(s)?

Is the individual able to acknowledge the potential effects that the risk behaviour may have had on the victim(s)?

During your assessment, has the individual expressed any feelings of guilt or shame in connection with the risk behaviour or offence?

9.4.8. Self-neglect

Consider issues of self-neglect which are intentional (e.g. life style choices) and non-intentional (person lacks the physical or cognitive ability to care for him/herself or is not motivated to do so. These may be temporary (e.g. in the case of acute mental or physical illness) or more long-standing (e.g. in enduring mental or physical illness).

- **Nutrition**, e.g. problems ranging from significantly diminished appetite; unable to prepare food, unable to feed self, dysphagia, poor diet and nutrition.

- **Mobility**, e.g. prone to falls, wandering or getting ‘lost.’ Physical, cognitive and motivation problems. Consequences of immobility, e.g. pressure sores, stiffness, muscle and joint problems, low level of physical fitness.

- **Safety**, e.g. unable to protect self from domestic and environmental risks such as fire (including casual use of, or disposal of, lighted cigarettes), gas, vehicles, cold. Prone to falls or likely to become ‘lost.’ Other non-intentional self-harm, e.g. accidental overdose, including the risk of mistakenly identifying toxic substances. Intentional, e.g. non-compliance with treatment.

- **Communication and Social Support**, e.g. social and personal isolation, perhaps as a consequence of social or antisocial behaviour, language and comprehension difficulties, speech or learning problems such as dysphasia, dyslexia, literacy/numeracy.

9.4.9. Absconsion

This section would usually only apply to someone living in some form of institutional setting (secure or open), the likelihood of absconding and the risks associated with this.

- Has the person expressed/demonstrated an intention to leave?

- What form has this intention taken?

- How determined has the individual been in carrying out his/her intention?

- Has the individual explained why they wish to leave?

- How aware is the person of the legal basis upon which they are detained?

- Is the person a risk to others?

- Is the person a risk to themselves because of: physical frailty, effects of medication, or vulnerable to exploitation?

- Is the person physically able and liable to use force to effect his intention?

- Has the person absconded on previous occasions?

- What were the circumstances associated with any previous absconding?
9.4.10. Structured assessment measures

Also consider the results of any form of structured psychometric assessments, or actuarial risk assessment measures, that have been used. These may include specific risk assessment measures that focus on violence or sexual offending, e.g. HCR-20, PCL-R, VRAG, RSVP, intellectual or neuropsychological assessments, e.g. WAIS-III, WMS, BADS, personality assessment, e.g. MMPI, MILLON, or other clinical scales, e.g. BDI, BHS, BAS, STAXI. Summarise the results of any measures used and any conclusions with regards to potential and/or significant links with risk behaviours.

9.4.11. Risk reduction factors and positive coping strategies

Consider potential risk reduction factors and the individual’s positive coping strategies.

- Is there any evidence of some control over the risk behaviour?
- Does the individual show any evidence of positive skills or coping strategies?
- What are the limitations of the individual’s coping abilities and strategies?
- Is there any evidence that risk is reduced as a result of treatment? If yes, how?
- In what ways does the individual change as a result of any treatment received?
- Realistically, what treatment options are currently available for the individual?
- What factors might reduce any current or future stress on the individual?
- Does the individual have unrealistic expectations about his/her ability to cope with any difficulties and control risk behaviour or offending?

9.4.12. Risk evaluation

Consider all the information collected during the risk assessment and try to evaluate the level of risk presented by the individual, as well as specific risk factors and situations. The evaluation of risk is not something which is easily quantifiable and descriptions such as low, medium and high are commonly used, but often unhelpful. It is more useful to identify specific risk factors and balance these with any risk reduction factors. To help assess the presence of potential risk indicators you are also referred to Appendix 2.

- What are the risk factors that have been identified from your assessment?
- Are there any specific high risk situations that have been identified?
- What level of risk do you feel the individual presents?

9.5. Risk reduction and management plans

After completing any risk assessment and evaluation, consider the potential strategies for reducing and managing any risk behaviour(s) presented by the individual. Different disciplines and agencies may have varying roles and responsibilities in this part of the process. However, it is important to share the risk assessment and management plan with everyone involved in the individual’s care.

- What factors or strategies are important in reducing and managing any risks?
- How are these likely to bring about a reduction in the risks?
- How feasible or practical are these risk reduction and management strategies?
- If the individual presents a risk to specific individuals, how can this be reduced?
If the individual presents a specific risk to members of staff, how can this be reduced?

- How motivated/co-operative is individual regarding need to control risk behaviour?
- What is the individual’s attitude towards change and a realistic risk reduction plan?
- Does individual have unrealistic expectations with regards to their risk behaviour and the importance of future monitoring?

9.6. Treatment programmes

In some cases, the individual being assessed may have been involved in some form of specific treatment programme aimed at reducing risk, e.g. sex offender treatment programme, anger management group, individual therapy. You may also be considering whether or not a treatment option would be appropriate for the individual. An assessment of previous experience, or current motivation, regarding treatment is important. As well as liaising with those who provided the treatment, consider the questions below.

- What is the actual presenting problem that treatment was/is being considered for?
- Give details of previous treatment, e.g. what, when, where, for how long, who from?
- Give details of progress, and any changes, during the treatment?
- How has the individual changed as a result of treatment received?
- Have these changes been maintained over a period of time? For how long?
- What has been learnt from treatment and how has it helped to control risk behaviour?
- Are problems externalised and blame projected onto others or external factors?
- Does the individual actually believe that s/he genuinely has a problem?
- How and why is it a problem for the individual?
- What is the level of emotional distress experienced because of this problem?
- Does the individual accept full responsibility for their problem?
- Does the individual accept the need for, and importance of, change?
- Is the individual simply ‘going through the motions’, e.g. to keep others quiet, pressure from referral source, statutory obligations, to avoid further restrictions?
- Realistically, what treatment options are currently available for the individual?
- If mental illness or learning disability is present, is this likely to influence outcomes?
10. References


11. Bibliography


Appendices: Assessment frameworks for risk behaviour

An assessment of risk behaviour should aim to provide a comprehensive look at the various causes and consequences linked to that behaviour. The appendices, provide a few examples of the ways in which information obtained from the risk assessment can be linked together to provide a more consistent approach to the assessment, discussion and perception of behaviour.

Appendix 1: Risk assessment information record
Wherever possible, collect relevant information from a range of sources. This information record identifies what some of these are, what information has been obtained, is available, etc.

Appendix 2: Potential risk indicators
These factors can be associated with an increase in risk. They are intended to assist in deciding what level of risk the person may present. However, they must not be used simply as a checklist and need to be linked to the overall assessment of the individual and the information have gathered.

Appendix 3: Multi-modal analysis of behaviour
This is a very useful framework for assessing the causes and consequences of behaviour and considers how problems are acquired (i.e. the person’s history) as well as how they continue to be maintained (i.e. the cycle of behaviour). It can be applied to a wide range of behaviours and the concept is a familiar one.

Appendix 4: Webster et al. (1997) HCR-20 (2nd edition)
The HCR-20 is an example of a structured framework and rating scale for assessing the risk of violence. It contains a number of individual historical, clinical and risk variables that have been identified by the research as having some predictive validity. However, it is not simply a matter of completing a checklist of risk factors to get a numerical score. Emphasis is on a decision making process model when carrying out risk assessments, with actuarial and clinical factors being combined and considered together. The HCR-20 is a structured framework and guide to risk assessment, not a formal psychometric test.

Appendix 5: Finkelhor Four Factor Model
When assessing child sex offenders, the Finkelhor Model is an example of a widely used framework. It can help to identify the various factors that lead to the development of sexually abusive behaviour, as well as any pattern to that behaviour.

Appendix 6: Function of anger
When assessing a person’s anger and aggression it is important to consider what function the behaviour might have for that person. Examples of these are given.

Appendix 7a and 7b: Framework for assessing anger and aggression
It is important to try and breakdown what may actually be happening when an individual becomes angry and aggressive. This approach considers the interaction between the various factors that can lead to anger and aggression. It is particularly helpful when assessing what might have happened during a specific aggressive incident.

Appendix 8: Features of positive treatment outcome and change
This is a list of important questions to consider when assessing whether or not a person may have obtained any positive benefits from being involved in a treatment programme.
Appendix 1: Risk assessment information record.

<table>
<thead>
<tr>
<th>Information Source</th>
<th>Don’t know</th>
<th>Information available</th>
<th>Information obtained</th>
<th>Information unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation Service</td>
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<td>Social Services</td>
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<td>Prison Reports</td>
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<td>Psychology Reports</td>
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<td>Psychiatric Reports</td>
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<td>Medical Information</td>
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<tr>
<td>CPN</td>
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<tr>
<td>General Practitioner</td>
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<tr>
<td>Solicitor</td>
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<td>Case Depositions</td>
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<td>Police Intelligence</td>
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<tr>
<td>Family</td>
<td></td>
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<tr>
<td>Others (NB: Identify source)</td>
<td></td>
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</table>
Appendix 2: Potential risk indicators.

The points below can be used as a guide when trying to evaluate the level of risk a person may present. Some factors may result in a simple ‘yes’ or ‘no’ answer. However, many will require a judgement on the extent or degree to which you believe they apply to the case being assessed.

- Has a previous history of risk behaviour.
- Does not accept any responsibility for the risk behaviour.
- Denies there is a problem or that anything wrong has occurred.
- Refuses to comply with any assessment or treatment plan.
- Refuses to comply with restrictions or conditions, e.g. CPA, risk management plan.
- Gives a passive account of events/incident, rather than an active one.
- Demonstrates distorted thinking and beliefs about risk behaviour.
- High level of denial and minimisation with regards to any risk behaviour.
- Does not understand pattern and cycle of risk behaviour.
- Does not know how to interrupt and control this pattern and cycle of behaviour.
- Cannot identify risk situations or use positive skills and strategies to avoid risk situations.
- Cannot demonstrate or use positive skills and strategies to manage risk situations.
- Does not acknowledge or recognise role of sexual fantasy in sexually abusive behaviour, if this is the risk behaviour.
- Is not aware of, or does not acknowledge, consequences risk behaviour has for others.
- Multiple victims.
- Victim crossover, i.e. male – female, within – outside family, pre – post pubescent.
- Demonstrates no victim empathy.
- Does not acknowledge or appreciate the emotional needs of children.
- Has very rigid, extreme or punitive views about issues such as parenting, child discipline and family roles.
- Cannot acknowledge or appreciate the emotional needs of other people generally.
- Unable to appreciate other peoples’ points of view.
- Poor self-esteem and assertiveness.
- Has poor social, relationship and self-control skills generally.
- Social and personal isolation.
- Unable to deal with feelings of frustration, anger, anxiety and is very impulsive.
- Can become angry and aggressive when frustrated or under stress.
- Can become physically aggressive when angry, assaults others and/or damages property.
- Uses anger and aggression as a way of controlling others.
- Has a history of alcohol or drug abuse.
- Risk behaviour is closely linked to alcohol or drug abuse.
- Evidence of serious personality disorder.
- Evidence of serious mental illness.
- Is in an unstable relationship with communication problems.
- Is able to control and coerce partner, may use threats and aggression.
- Family/partner/carer rationalises any risk behaviour, does not believe any allegations and attempts to conceal risk behaviour.
Appendix 3: Multi-modal functional analysis of behaviour.

<table>
<thead>
<tr>
<th>History</th>
<th>Cycle of Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antecedents</td>
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<tr>
<td>Behaviour</td>
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<tr>
<td>Attitude</td>
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<tr>
<td>Relationship</td>
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<td>Emotions</td>
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<td>Physical Factors</td>
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<tr>
<td>Cognitions</td>
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<td>Sexual Interests</td>
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<tr>
<td>Opportunities</td>
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<tr>
<td>Life Events</td>
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</table>

<table>
<thead>
<tr>
<th>Historical (past)</th>
<th>Clinical (present)</th>
<th>Risk (future)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1 Previous violence</td>
<td>C1 Lack of insight</td>
<td>R1 Plans lack feasibility</td>
</tr>
<tr>
<td>H2 Young age at first incident</td>
<td>C2 Negative attitudes</td>
<td>R2 Exposure to destabilisers</td>
</tr>
<tr>
<td>H3 Relationship instability</td>
<td>C3 Active symptoms of major mental illness</td>
<td>R3 Lack of personal support</td>
</tr>
<tr>
<td>H4 Employment problems</td>
<td>C4 Impulsivity</td>
<td>R4 Non-compliance with remediation attempt</td>
</tr>
<tr>
<td>H5 Substance misuse problems</td>
<td>C5 Unresponsive to treatment</td>
<td>R5 Stress</td>
</tr>
<tr>
<td>H6 Major mental illness</td>
<td></td>
<td></td>
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<tr>
<td>H7 Psychopathy</td>
<td></td>
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<tr>
<td>H8 Early maladjustment</td>
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<tr>
<td>H9 Personality disorder</td>
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<tr>
<td>H10 Prior supervision failure</td>
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</tbody>
</table>
Appendix 5: Finkelhor’s Four Factor Model of Sexual Abuse.

1. **Motivation to abuse**
   - Sexual arousal to inappropriate stimulus, e.g. children, exposing self.
   - Emotional arousal, e.g. to child.
   - ‘Blocked’ alternatives, e.g. social skill deficits, anger problems, sexual and relationship difficulties.

2. **Overcoming internal controls on behaviour**
   - Life stress.
   - Alcohol/Drugs.
   - Organic factors, e.g. dementia, psychosis, mental impairment.
   - Denial and minimisation of sexually abusive/offending behaviour.
   - Distorted thinking and rationalisation, i.e. ways the individual says, ‘… it’s OK’.

3. **Overcoming external controls on behaviour**
   - Creating opportunities to abuse and commit offences, e.g. social or geographical isolation, sleeping arrangements, mother absent, baby-sitting, type of job.

4. **Overcoming victim resistance**
   - Coercion, threats, aggression, physical force, bribes.
   - Abuse of power.
   - Abuse of adult and parental responsibility.
   - Breaking down of boundaries, e.g. between adult and child.
   - Victims’ sexual immaturity.
   - Victims’ lack of assertion.
Appendix 6: Function of anger and aggression.

Consider the function of the anger and aggression for the patient. What is s/he getting out of the behaviour and what is it doing either for, or to him/her? More than one of the points below can apply to an individual at any one time.

- Increases assertion and motivates a person to do something or stand up for themselves.
- Increases a person’s physical arousal and can speed up movement and thinking.
- Disrupts what a person is doing and causes mistakes to be made.
- Impairs a person’s concentration, attention and judgement.
- Causes a person to become more impulsive and say or do something which is regretted later on, or causes further problems.
- Person gets own way and achieves control or power over other people or in situations.
- A normal and understandable reaction to a stressful or distressing life event.
- A person’s usual reaction to being frustrated and not getting their own way.
- The usual way in which a person releases pent-up feelings or tension.
- A person’s response to feeling threatened, criticised or rejected.
- How a person reacts if feeling, or made to feel, inadequate or inferior.
- The way a person projects their own problems and faults onto others.
- Anger and tension builds up (accumulates) in one situation and then a person erupts in another (displacement).
Appendix 7a: Framework for assessing aggressive situations.

Getting angry and aggressive is an interaction between a number of factors. The diagram below is a useful way of thinking about what is happening in an aggressive situation. It considers the various causes for behaviour and also, how these may interact together.

This model does not just apply to patients, it also applies to ourselves and can be used in a number of ways.

- To assess what was going on during a specific aggressive incident.
- To provide a general overview of a patient’s anger and aggression.
- To help a patient identify what happens when he/she becomes angry and aggressive.
- To help a patient identify positive coping strategies to use when angry and aggressive.
- As a common framework for staff to use when dealing with anger and aggression.

(i) External Events
What is actually happening to the person at the moment and what was happening before the incident started.
The situation/circumstances the person is in.

(ii) Behaviour
What the person says and does.
How problems are dealt with.
The person’s interaction, assertion and communication with others.

(1) Thoughts and Perception
A person’s thoughts, interpretation and perception about what’s going on.
How the person sees themself, the situation, other people, etc.

(a) Physical Factors
Angry, ‘wound-up,’ stressed, frightened, anxious, depressed, in some emotional distress.
Ill-health, tired, hungry, in pain, alcohol, drugs, mental illness, mental impairment.

(Based on Howells, 1989)
Appendix 7b: Assessment of anger and aggression.

The points below focus on specific aspects of anger and aggression and can be used with the model described above in Appendix 2a. Not every question will be necessary, or appropriate, for every individual. However, they can help as a guide in building up as detailed a picture as possible about a person’s anger and aggression.

**External events and situations**
- What external events and situations lead to anger and aggressive behaviour? Some may be obvious but others may only be significant to the individual.
  - Rating scales and diaries can help to provide information about specific events. Obtain details of events or situations, ask what, when, how, where and who?

**Anger provoking interpretation of events**
- The thoughts or perceptions a person may have about events, situations, other people involved and how they see themselves or their behaviour.
  - Interviews provide information on all aspects of behaviour. When discussing events and feelings, focus on what the person was thinking about at the time.
  - Look for examples of how the person may be misinterpreting what is happening to them or what others say or do. Interpretation of events, and their significance, can be linked to past experiences, upbringing, etc.

**Anger arousal**
- How angry person feels and awareness of this happening. The physical aspect of anger and aggression can cause behaviour, thinking and judgement to get out of control.
- Ask person to describe feelings in various situations and identify signs and level of physical arousal.
- Is there a build-up of tension and anger, what does it feel like, is the person aware it’s happening?
  - Influence of physical factors must be considered, e.g. drugs, alcohol, medication, health.
- Are there occasions when the person’s anger is controlled, how is this done?

**Communication and Interpersonal Skills**
- Person’s communication skills and weaknesses in aggressive or conflict situations.
- Direct observation of individual and interaction with others can be helpful here.
- Give person imaginary situations or arguments and ask what he/she would say or do, or ask them to make a choice from a range of options.
- What skills are relevant to the person?
- What does the person find difficult?
- Get information from other people who come into contact with the person.
- Are there specific problems in certain situations?
- What skills does the person need?
Problem solving skills

■ Is the person able to identify and assess problems/problem situations?
■ How are these dealt with?
■ Is the person over or under-confident?
■ Can the person consider options or solutions to problems?
■ Is the person able to make decisions?
■ Does the person always expect to fail?
■ How does the person cope with frustration?
Appendix 8: Features of positive treatment outcome and change.

The points below can be used as a guide when trying to assess whether or not someone may have benefited from involvement in some form of psychological treatment programme, or other therapeutic intervention. How applicable each point is will vary depending on the nature of the case, the risk behaviour, type of intervention or treatment programme provided, individual patient involved and the eventual outcome of the intervention. Assessing change in aspects of a person’s behaviour, emotions, attitudes or beliefs is not easy. It is a dynamic process that can vary over time, in either a positive or negative direction.

- Accepts full responsibility for risk behaviour and actions.
- Gives an active account of events/incident rather than a passive one.
- Understands their own particular pattern and cycle of risk behaviour.
- Knows how to interrupt and control this pattern and cycle of behaviour.
- Can identify risk situations.
- Can demonstrate and use positive skills and strategies to avoid risk situations.
- Can demonstrate and use positive skills/strategies to manage risk situations.
- Demonstrates a good understanding of relapse prevention.
- Has been able to challenge distorted thinking/beliefs about risk behaviour.
- Denial and minimisation regarding risk behaviour is significantly reduced.
- Is fully aware of the consequences his/her risk behaviour has for others.
- Consistently demonstrates genuine empathy with others, maintained over time.
- Has been able to develop relevant social, relationship and self-control skills.
- More able to deal with negative feelings of frustration, anger, anxiety.
- More able to appreciate other peoples’ points of view and emotional needs generally.
- More able to appreciate the emotional needs of children.
- Positive increase in self-esteem and assertiveness.
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