Chapter 4
Risk Formulation: The New Frontier in Risk Assessment and Management

Caroline Logan

Introduction

This chapter focuses on the structured professional judgement (SPJ) approach to the clinical risk assessment and management of men and women whose sexual behaviour is harmful to others. The SPJ approach promotes the use of clinical guidelines—such as the *Risk for Sexual Violence Protocol* (RSVP; Hart et al., 2003)—to help practitioners appraise the relevance of risk factors to the individual client and to create an understanding of that person's risk potential, on the basis of which comprehensive and proportionate risk management plans can be prepared, implemented, evaluated, and repeatedly updated towards managed risk. This chapter makes the case that the most important part of the clinical risk assessment and management process using the SPJ approach is risk formulation—the process of generating an understanding of harmful behaviour that directly links assessment findings to management actions.

Individuals who are not well understood—whose actions challenge our understanding—may not be risk managed with focus, clarity of objectives, or confidence (Hart & Logan, 2011; Logan, Nathan, & Brown, 2011; Reid & Thorne, 2007). For example, the behaviour of men and women who have in the past committed one single act of serious harm (e.g. sexual assault or homicide) in the context of a relatively managed lifestyle can often be a problem to risk assess because past behaviour was not part of a pattern from which the form of possible future acts can be extrapolated. Also challenging is the assessment and management of the risks posed by clients who cannot or who outright refuse to cooperate with evaluations

C. Logan (✉)
Greater Manchester West Mental Health NHS Foundation Trust, Prestwich Hospital, Bury New Road, Prestwich, Manchester M25 3BL, UK

University of Manchester, Manchester, UK
e-mail: caroline.logan@gmw.nhs.uk

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for whatever reason or who deny any involvement in the offences of which they have been accused. In such cases, restrictive interventions may be more likely to prevail as a consequence of the assessor's ignorance or uncertainty about the origins and circumstances of past and therefore future possible offending behaviour. However, in such cases and similar others, the process of risk formulation offers a means by which as broad and relevant an understanding as possible may be acquired in a systematic way; formulation links empirically based risk assessment to practical risk management and outlines the practitioner's current understanding of the underlying mechanism of an individual's harm potential in order to develop hypotheses about action to facilitate change (embodied in the risk management plan). Therefore, because of its utility to the complex and challenging cases that are a feature of the caseloads of so many practitioners working with sexual offenders, this chapter will describe the SPJ process with particular focus on risk formulation.

Formulation is an essential clinical activity for practitioners in mental health settings (e.g. Eells, 2007; Tarrier, 2006) and especially in forensic mental health and corrections (Hart, Sturmey, Logan, & McMurran, 2011; Sturmey & McMurran, 2011). What is discussed here will not be unfamiliar to anyone who is a practitioner. What *is* more novel, however, is the focus on formulation practice as it applies to risk and, on the discussion that follows, on determining the quality of formulations. Because it is only when practitioners and researchers have a sound basis for telling a good formulation from a poor one that we can really move forward in terms of demonstrating that formulation has a role to play in risk management—and clinical practice more generally—and defining what that role is (Bieling & Kuyken, 2003; Hart et al., 2011). Consequently, this chapter will also describe ongoing work towards determining the efficacy of risk formulation and how it might be possible to tell good formulations from poor, and effective formulations from those that contribute little to risk management. This chapter will conclude with a review of the key issues and learning points and a set of good practice recommendations.

The SPJ Approach to Clinical Risk Assessment and Management

In the last two decades, research and practice in the risk assessment field has been informed by the publication of a variety of instruments, tools, and guidelines structuring the assessment process and—though much less frequently—risk management. These guidelines have emerged from a broad range of research studies seeking to characterise and identify the individual and contextual variables that are most strongly or commonly associated with the harmful outcome that is of interest to the practitioner and which he or she is motivated to prevent (Logan & Johnstone, 2013; Otto & Douglas, 2010). For example, it is a well-established fact that a history of deviant sexual arousal is strongly associated with sexual violence recidivism (e.g. Hanson & Morton-Bourgon, 2009). Therefore, it follows that deviant sexual arousal is a risk factor for sexual violence in a number of risk assessment guides focused on sexual violence as a specific harmful outcome (e.g. the RSVP). The risk assessment

guidelines currently available to practitioners vary in content—that is, they vary in the range of risk factors described and, in some cases, the weight of each factor in the final judgement about risk. Such variance among guidelines is justified because the different outcomes—such as non-sexual violence, intimate partner violence, suicide, as well as sexual violence, and so on—emerge from sometimes quite different developmental pathways, which the guidance seeks to capture. Guidelines assist the practitioner in their examination of individual clients against all the risk factors described in the specific risk assessment guide they have chosen to use and to denote through a rating whether each factor is present or not and, if present, the extent to which each is present (e.g. definitely or partially). What happens next depends on whether the guidance stipulates a discretionary or non-discretionary approach to the development of final judgements or conclusions about risk (e.g. Hart & Logan, 2011; Meehl, 1954/1996; Mossman, 2006).

Non-discretionary approaches, which may be described as actuarial or statistical, guide decision-making about risk according to the application of a set of predetermined, explicit, and fixed rules. The outcome of the application of such approaches, as exemplified by, for example, the *Static-99R* and the *Static-2002R* (e.g. Brouillette-Alarie & Proulx, 2013; Hanson, Babchishin, Helmus, & Thornton, 2013; Phenix, Helmus, & Hanson, 2012), the *Violence Risk Appraisal Guide-Revised* (VRAG-R; Rice, Harris, & Lang, 2013), and the *Sex Offender Risk Appraisal Guide* (Harris, Rice, Quinsey, & Cormier, 2015), is a finding about level or volume of risk over a specific time frame. Such non-discretionary approaches offer no clear support to decision-making about the optimal nature of risk management or the conditions in which nature and level of risk may alter. In addition, non-discretionary approaches support judgements about risk at the group rather than individual level (Hart, Michie, & Cooke, 2007, but see also Mossman, 2015). There is no place for risk formulation in the use of such guides—understanding the individual's past harmful behaviour is not a factor in measuring or managing its risk of recurrence. Non-discretionary approaches are commonly used in research and in court hearings and practice settings where a simple quantification of risk is all that is required, such as to guide sentencing or level of supervision.

On the other hand, discretionary approaches to risk assessment permit assessors to exercise a degree of professional judgement in their decision-making about risk, in relation to the weighing and combination of risk-relevant information (Hart & Logan, 2011); guidelines provide either very little structure (as in unaided clinical judgement) or a considerable degree of structure (as in the SPJ approach). Structured discretionary approaches promote the use of formulation as the essential bridge between risk assessment and risk management (e.g. Logan, 2014). Further, discretionary approaches support the development of risk management plans based specifically on the risk formulation, that is, the assessors understanding of the client's risk potential. Such approaches have applications in cases where risk management and prevented harm are the objectives, making them more attractive to practitioners in correctional and forensic mental health settings required to manage over the medium to long term those with a history of harmful behaviour. Examples of such discretionary risk assessment guidelines include the RSVP and the *Historical-Clinical-Risk Management-20* (HCR-20 version 3 (HCR-20^{V3}); Douglas, Hart, Webster, & Belfrage, 2013).

Operationalising SPJ in Risk Assessment and Management

The SPJ approach is operationalised by clinical guidelines developed for practitioners to apply with professional discretion to clients whose risk potential they are attempting to understand and manage. SPJ guidelines are presented in the form of a manual and accompanying worksheet. The assessor proceeds through the worksheet with the aid of the manual, which offers guidance on the collection of relevant information, decision-making about its relevance to the risk to be prevented, the combination of relevant information in formulation, scenario planning, risk management decision-making, and case prioritisation. In general, practitioners commence assessments without a clear understanding of the risks posed by their client or the most optimal risk management strategies to prevent or at least limit harmful outcomes, and the evaluation process should enable them to derive both in a systematic, evidence-based, and transparent way.

SPJ guidelines for risk assessment and management require the practitioner to work through six distinct evaluation stages or steps. In the first step, relevant information is gathered from a variety of key sources, including the client, if he or she chooses to collaborate with the assessment and to the extent to which he or she can be encouraged to do so willingly and honestly (Logan, 2013). Under some circumstances, it is possible and indeed necessary to undertake assessments of clients who refuse to engage with the assessor (e.g. Heilbrun, 2001). For example, if a client is reasonably thought to be at risk of engaging in a harmful act yet he or she refuses to be assessed by a concerned practitioner, it would be ethical to proceed with a risk assessment in order to protect the client and others via the application of an informed risk management plan (e.g. British Psychological Society, 2009). The information gathered at this step, whether the client collaborates or not, will pertain to his or her history of harmful behaviour and the circumstances in which it occurred previously and to evidence relating to the possible recurrence of such harmful conduct (e.g. the existence of plans or feasible preparations). Practitioners are prompted to collect specific types of information by the risk factors contained within the guidelines chosen for use.

In the second step of the SPJ process and based on all the information collected, the practitioner makes a judgement as to whether each of the risk factors identified in the guidance is *present* and to what degree (not at all, partially, definitely). In the RSVP, there is an additional consideration—recent change—that also features in the SVR-20 although not in the HCR-20^{V3}. In the third and very important step of the SPJ process, practitioners determine whether and the extent to which in their opinion those risk factors that are present are also *relevant* to the client's potential to be harmful again in the future, where relevance is defined in terms of the factor's role in the direct occurrence of harmful incidents or to future risk management. To illustrate, one client may have identified the past victims of his sexual assaults directly through his employment (e.g. as a postal delivery worker, which gave him the opportunity to identify women living alone whom he could safely burglarise and assault). This fact would make employment problems both present and directly relevant to his

future offending—he uses purposeful activity to hunt for potential victims. However, another client may struggle to gain employment because of learning difficulties or limited opportunities, but his sexual offending is not related in any way to his employment status or specific job. In this latter case, problems with employment may be present but they are not in any way relevant to his future potential. Therefore, a risk factor can be present in a client's history but not relevant to his or her future sexual offending behaviour. As with presence ratings, the relevance of individual risk factors is rated on a three-point scale—that is, not relevant, somewhat or partially relevant, or definitely relevant.

In the fourth step, the important formulation step, the risk factors identified as relevant are added to with clinical judgements about potential protective factors of importance to the individual case. Protective factors may be defined as those characteristics of the individual and his or her environment that appear to limit the severity or frequency of harmful behaviour by moderating the effect of one or more risk factors (e.g. positive attitudes towards treatment and risk management, which maximise engagement and permit close supervision and monitoring). All of the information most relevant to the risk of sexual violence in the client is then organised. This is in order to understand the range and operation—the codependency—of vulnerability factors, triggers, maintenance, and protective factors. Once organised, consideration is given to what would appear to be the key motivational drivers for sexually harmful behaviour in that individual, based on what is understood about the person and his or her past conduct, and the decisions that would appear to have been made then and on what basis (Hart & Logan, 2011). Future scenarios are then detailed—at least two—and used to elaborate on what is understood (Chermack & Lynham, 2002; van der Heijden, 1994), in particular, about triggers and protective factors.

Scenario planning 'is a process of positing several informed, plausible and imagined alternative future environments in which decisions about the future may be played out, for the purpose of changing current thinking, improving decision-making, enhancing human and organization learning and improving performance' (Chermack & Lynham, 2002, p. 366). It is a particularly useful technique to use in situations in which there is uncertainty yet a strong need to prepare for all or the most serious eventualities (van der Heijden, 1994). For example, scenario planning is used extensively in military operations where the consequences of inadequate preparation and anticipation of problems could be measured in lives lost and serious injuries sustained. Scenarios are descriptions of possible futures; in the case of sexual violence, possible ways in which a particular client might be sexually harmful again in the future given what is known about his or her past and current situation and decision-making processes. Therefore, scenarios are not predictions. Instead they are forecasts based on what and the evaluator's understanding of why the client has acted in a similar way in the past. As a consequence of their uniqueness to the client's personal circumstances, preferences, and decision-making, only a limited number of scenarios are likely to be plausible. And it is these scenarios, with their origins laid bare by the evidence-based risk assessment and formulation process, which underpin risk management.

On the basis of the work undertaken at this important scenario-planning step, it is then possible to start preparing the actual formulation—a narrative statement of understanding about the client's sexual violence risk, which will explain why they are at risk and under what circumstances and why that potential may become realised. Due to such an exposé of the individual's risk, it is possible to design action—risk management—that is based directly upon what matters most to the individual. Risk formulation will be described in a little more detail shortly.

Specific risk management actions or strategies are then elaborated upon in the fifth step of the SPJ process. Strategies are hypotheses for action intended to influence the operation of relevant risk and protective factors on overall risk potential, thus minimising or preventing future harmful conduct on the part of the client. This leads to the sixth and final step wherein summary judgements are made regarding the urgency of risk management action (case prioritisation), the identification of any risks that exist in other areas (e.g. self-harm or suicide, non-sexual violence, and so on), any immediate preventative action required, and the date for next case review including reassessment of risk.

These six steps are the SPJ process in a nutshell. Figure 4.1 illustrates each of its component parts and how they are linked together.

Focus on Risk Management

Risk management is the collection of actions taken to prevent potentially harmful outcomes, where the nature of those potential outcomes has been speculated about in some detail during in the formulation and scenario-planning step (step four above). Therefore, risk management should be based directly on the practitioner's explanation—or understanding—of the client's harm potential. Risk management strategies for sexual offenders include direct *treatment* interventions for offending behaviour and conditions linked to offending (e.g. mental health problems, substance misuse, relationship problems), *supervision* strategies such as limited opportunities to access potential victims through the imposition of curfews or indefinite detention, the active

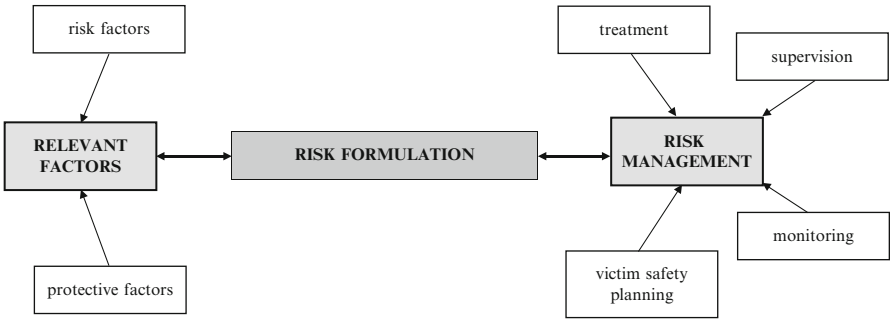

Fig. 4.1 Structured professional judgement in a nutshell

monitoring of risk factors through their surveillance in the course of supervisory and other supportive contacts, and *victim safety planning* in the event that a previous victim may be re-victimised or new potential victims become identifiable. Risk management per se has not been subject to a great deal of research (re. Heilbrun, 2001), certainly nothing commensurate with the research carried out into risk assessment. This is unfortunate. While it is the case that, on the whole, interventions with sexual offenders have had a positive impact on the frequency and severity of offending (e.g. Kim, Benekos, & Merlo, 2015), it remains unclear what combination of strategies works best for whom under what circumstances to prevent the recurrence of harmful sexual behaviour. The potential for risk management to exceed the risks presented by the individual cannot be overlooked or minimised, certainly in Europe in the age of the *European Convention on Human Rights* and the requirement for demonstrably proportionate legal sanctioning. This situation as regards evidence is only likely to change when the link between risk assessment and risk management processes is better conceptualised, which is why risk formulation has assumed such importance in the last few years. Each risk management option will now be discussed in more detail before we turn to risk formulation.

Treatment

Treatment strategies oriented towards managed risk are those proactive interventions that are intended to repair or restore deficits in functioning linked to sexual violence risk. Therefore, treatment strategies are intended to diminish the potency of risk factors most relevant to the sexually harmful conduct of the client. Treatment strategies include but are not limited to psychological and psychosocial interventions for the range of interpersonal, cognitive, emotional, and social deficits experienced by many sexual offenders and that are often encapsulated in a sexual offender treatment programme (e.g. Marshall, Fernandez, Hudson, & Ward, 2013). In addition, interventions for substance misuse problems that can co-occur with sexually harmful behaviour (e.g. Kraanen & Emmelkamp, 2011) and, where indicated, medication for the symptoms of the mental disorders that disinhibit the client (Kingston, Olver, Harris, Wong, & Bradford, 2015) are also common treatment strategies. Treatment strategies may also be directed towards the enhancement of protective factors in order to make them more effective in moderating or mediating risk factors. For example, individual or couple therapy may help to improve a client's self-awareness and capacity to utilise and benefit from close social support, thus weakening the link between stress and loneliness and sexual offending. Very broadly, treatment strategies for sexual offenders will include psychological therapies (e.g. cognitive behaviour therapy for mood problems, cognitive behavioural interventions for criminogenic needs), psychopharmacological interventions (e.g. antipsychotic medication, mood stabilisers, anti-libidinals), and psychosocial interventions (e.g. detention in a therapeutic community or in a setting offering neurocognitive rehabilitation or compensation) delivered one-to-one or in groups, in institutions, or in the community, where compliance is voluntary or required by legal order (e.g. Marshall et al., 2013).

Supervision

Supervision strategies target the environment or the setting in which the client is based now or likely to be based in the future in order to limit the power of risk factors and improve the effectiveness of protective factors, thus diminishing risk potential overall. Supervision strategies can be applied in two different ways. First, supervision may involve the imposition of restrictions on the client's activities, movements, associations, or communications, which is intended to limit his or her access or exposure to the circumstances that could trigger one (or more) of the hypothesised risk scenarios (Hart et al., 2003). Examples of supervisory risk management strategies would include denial of unsupervised—or any—access to preferred victim groups, such as children, a ban on drinking alcohol or drug-taking, non-association lists as part of conditional release requirements, and imprisonment, which serves the joint purpose of punishment and the restriction of access to potential victims. Second, supervisory strategies also include those adjustments—or enhancements—to the individual's lifestyle that are intended to improve the performance of protective strategies. Examples of such supervisory strategies may include training and support to secure and maintain suitable paid employment offering routine, purpose, financial reward, and an opportunity for positive self-regard, in addition to regular contact with an understanding person or organisation sensitive to the needs of sexual offenders, such as through involvement with Circles of Support and Accountability (Elliott & Beech, 2013; McCartan et al., 2014). Supervision strategies are particularly important in cases where the client denies involvement in sexual offending, thus severely limiting treatment options.

Monitoring

Monitoring in risk management terms is the identification of early warning signs of a relapse to sexually harmful behaviour (e.g. an increasing level of sexual preoccupation, watching or even following preferred victim types in public places), ideally derived from the client through their engagement with treatment and supervision. However, monitoring also refers to the collaborative preparation of plans to be implemented when evidence is provided for the presence of such early warning signs. Such plans would include the actions to be taken to prevent early warning signs from evolving into new offences, like the ones mapped out in the formulation and scenario-planning stage, and might include recall to prison or an increase in the frequency of meetings with a supervisor. Monitoring strategies are intended to be implemented by the client and by others (e.g. probation officers, managers of approved premises, etc.), where others will be relied upon more if the client's insight into his or her offending behaviour is limited or motivation to engage is only partial or wavering. In risk management terms, monitoring differs from supervision because monitoring focuses on surveillance rather than on controlling or managing the client's activities. This makes monitoring a much less intrusive risk management strategy although just as essential as all the others.

Victim Safety Planning

Finally, victim safety planning refers to the action that might be recommended to a past or possible future victim of the client—and his or her carers or guardians—in order to keep them safe. The client may have targeted a potential future victim previously (e.g. their child), but contact is nonetheless possible and desired by the parties involved (e.g. both parents, who choose to stay in some kind of contact with one another because they have several children together). A potential victim could also be an as yet unknown partner (e.g. a future boyfriend or girlfriend) or provider of treatment or supervision (e.g. a social worker or probation officer, a psychologist) who may become victimised when, for example, they make demands of the client or endeavour to enforce the limitations that were an agreed requirement of conditional release. Victim safety plans should include provision of emergency safety procedures, personal alarms, prohibition of unaccompanied meetings, communication strategies, and so on, all of which are intended to make victimisation either less likely to happen or less damaging in its effects.

Concluding Comments

In this section, the SPJ process has been described in some detail. SPJ should be regarded as evidence-based guidelines for risk assessment and management that are tailored to the needs of individual clients, to the practitioners who work with them over lengthy periods of time, and to the harmful conduct to be prevented. The SPJ approach to risk assessment and management is most applicable to practice settings in which convicted sexual offenders are subject to long-term treatment and supervision, in institutions or in the community (such as correctional or forensic mental health facilities), and in legal contexts where risk management is a primary consideration (e.g. parole board hearings). However, assessment is not understanding, and risk management that is not based on an understanding of the problems experienced by the client in trying to manage his or her own behaviour is at risk of being poorly designed and executed. It is therefore to risk formulation that we will now turn.

Risk Formulation

Formulation is the process in clinical and forensic practice whereby an organisational framework is applied to our current knowledge of a client in order to produce an explanation for the underlying mechanism of his or her presenting problems and thereby generate linked hypotheses for action that will facilitate positive and progressive change (e.g. Johnstone & Dallos, 2013; Persons, 1989; Sturmey & McMurran, 2011; Tarrier, 2006). The knowledge to which the formulation process is applied is the collection of that gleaned from clinical interviews and direct

observations of the client (if available); relevant information from collateral sources, both professional and personal (e.g. family members); and data derived from the application of formal structured assessments (e.g. a set of guidelines for the assessment of risk factors, such as the RSVP or the HCR-20^{V3}). It is acceptable to formulate risk on less than this ideal collection of information (re. Heilbrun, 2001), as when a risk assessment has to proceed for public safety reasons. In which case, the formulation would be described as preliminary and would be updated as soon as additional relevant information is received.

A formulation is a length of narrative text—perhaps between one and several paragraphs in length—in which the presenting problems are described, explanations in the form of hypotheses offered for their occurrence, origins, and potential recurrence (usually underpinned by one or more theoretical models relevant to the nature of the problem), and options for comprehensive action thereby proposed (e.g. Hart & Logan, 2011; Logan & Hird, 2014). The formulation should be accessible to the reader, including the client. Further, the formulation should be the product of collaboration between the assessor and the client—or if not the client then between the assessor and a key other person, such as the client's main carer, or their probation or prison officer, or their forensic mental health nurse. A theory relevant to the problem of interest will underpin the formulation (e.g. a theory of sexual offending), thus enabling or facilitating connections between relevant pieces of information. Over time, the formulation becomes the basis for determining the nature and quality of change achieved in the period until the client is next reviewed and the changes detected used to determine whether the original formulation was correct and any adjustments required to the explanation provided therein. Thus, the formulation remains a 'live' document—a statement of current understanding, which is updated regularly with new information and insights—and the driver of progressive action based on an evolving understanding of the person and their behaviour.

The formulation process may be applied to one specific problem or a range of linked problems. For example, the process can be used to understand harmful behaviour as a specific problem—such as sexual or non-sexual violence towards others, or harm directed towards the self, or all of these potential outcomes in the same complex person. Such formulations—risk formulations—when prepared will tend to have a narrow focus and are often comparatively short (one or maybe two pages of text). However, the formulation process may also be applied to the whole person, or 'case'. Case formulations, by virtue of the need to describe the developmental origins of the range of current problems and how they interconnect, will be much broader in focus and consequently lengthier (maybe two to four pages of text).

What Is the Purpose of Formulation?

Whatever the focus—on one or more specific problems such as risk of sexual violence, or the whole case, the journey taken by the sexually harmful person to reach the point where they are at now—a formulation must by definition go beyond the

findings of individual structured assessments or diagnoses to provide a rational and evidence-based theory of the client and the matter or matters of concern (Eells, Kendjelic, & Lucas, 1998; Hart et al., 2011; Nezu & Nezu, 1989; Persons, 1989; Tarrier, 2006). Numbers—such as summary test scores—or diagnoses are not in themselves explanatory and reduce a person to a banal abstraction that will bear little relationship to the lived experience of the client and of who he or she is and the problems they experience. For people with complex problems to be understood, they need to be considered as fully as possible, and formulation is a clinically meaningful process for achieving that outcome (Persons, 1989). Further, for complex problems and damaging people to be managed safely, they ought to be explained and understood if rational and proportionate action is to follow with at least some degree of cooperation from the client (Hart & Logan, 2011; Logan et al., 2011; Reid & Thorne, 2007).

The primary purpose of formulation is to organise and make systematic what is known about the client (Hart & Logan, 2011). A number of organisational models have been proposed for this purpose (e.g. the 4Ps model of Weerasekera (1996) or generating a comprehensive timeline), which are intended to highlight to the evaluator what is known and not known about the client, as a prompt to further and more targeted information gathering around the problem (or problems) of concern. The secondary purpose of formulation is to make connections between relevant pieces of information in order to create a psychological explanation of the client and his or her problems (Hart & Logan, 2011)—to link the biological, psychological, and social characteristics and experiences to one another in a rational explanation for past and possible future outcomes. The application of a relevant theoretical model assists with making these connections. The outcome of this endeavour should be an answer to the following questions: *Why has this person been sexually harmful in the past*, *and why might she or he decide to do so again in the future and under what circumstances*?

Its third purpose relates to the essential collaborative nature of its generation; formulation should be an explanatory narrative generated by the labour of the evaluator working alongside others, principally the client. In this way, collaborative formulation gives the process a role to play in both explaining the client and in motivating him or her to become involved in understanding the need for change and what is required; by contributing to the formulation, the client is encouraged to invest in it and change. However, a mutually agreed understanding between the client and the evaluator is not always possible—or desirable—as when an evaluator is supporting practitioners such as probation officers to work effectively with complex clients that the evaluator may never meet. Formulation through the process of consultation then becomes like a route map for such a practitioner, encouraging a more psychologically informed way of working.

Fourth, hypotheses for action to facilitate change emerge from the formulation because of its expression of the underlying mechanism of the presenting problems, making action linked directly to understanding. Indeed, a formulation cannot be described as such unless the understanding communicated is paired with proposals for action. Finally, the finished product, the explanatory narrative, becomes the focus of communicating and engaging with others, including the client (Hart & Logan, 2011). A challenge to write, and write well, the formulation is and should always be the most

meaningful and interesting part of any report, and the emphasis on the relatively brief length of this part of the work is in order to ensure it is read and regarded as such. Formulations of 20 or 200 pages or more may be very interesting indeed. However, they are unlikely to engage the reader, including the client, which is the essential final purpose of formulation, and an unread formulation is no formulation at all.

How Is a Risk Formulation Prepared?

Risk formulations may be prepared in one of two ways. First, a risk formulation may be prepared in collaboration with the client. Such a formulation will draw from several sources of information, as suggested above, including the client (Logan, 2014). The client may be engaged in a general assessment of sexual violence risk and relevant other variables, such as substance misuse, deviant sexual arousal, psychopathy, and so on. Once these assessments have been completed, the assessor may then sit with the client and the formulation process commences. The assessor might begin by summarising the findings of the assessments completed: 'Let me go over what I have observed about you from the time we have spent together', an opening statement that offers the assessor the opportunity to determine the extent to which the formulation can be prepared collaboratively based on the client's response to feedback. In the event that some degree of collaboration appears possible, the assessor may then say something like the following: 'What I would like to do now is to prepare a paragraph or two that describe what we agree on about your risk of being sexually harmful again in the future—and what we all need to do to manage that risk and prevent any such harm from occurring. I'd like what we write to represent what we disagree on too. Are you okay with that?' Were the client denies all or part of the offending behaviour of which he or she has been accused or already convicted, the focus could instead be on their risk of being accused again. Such an approach offers more opportunities for fruitful discussion than does the prospect of an argument over whether the client was truly guilty or not. The assessor can then start to write something there in the room with the client: for example, 'This risk formulation describes what we understand about Mr Smith's risk of being sexually harmful again in the future. Mr Smith has helped me to understand that he has carried out sexually motivated assaults on women who are strangers to him because he is attracted to them but anticipates that if he approached them, they would reject him. When Mr Smith sees a woman he is attracted to, he can visualise her rejection—this makes him angry with her before he has even spoken to her, and then he attacks and humiliates her with a sexualised assault as a way of punishing her for what he believes she would have done. Mr Smith told me about his early experiences with women' … and so on. The assessor would take the lead with the writing, and the client would be encouraged to help, and at the end of the meeting, there would be a rough draft of a formulation that could be prepared in typed form for the next meeting, where it would be edited and eventually completed.

A slightly different approach would be for the assessor to agree to prepare such a narrative for their next meeting and to bring a copy then for the assessor and client to go through together. This approach is generally quicker, but it offers the client less control. The alternative approach, that of preparing the formulation together in session, may be more helpful with clients for whom having some control is important—because they generally feel powerless yet want to have a say or because feeling less in control will make them agitate to obtain more. The potential gain from such a collaborative approach to risk formulation is the investment it signals in collaborative risk management; keeping clients involved offers more opportunities to monitor risk.

A second way of preparing a risk formulation on a client is to do so through a third party, such as a probation officer, a forensic mental health nurse, a prison officer working closely with the client in a special prison unit, or a whole multidisciplinary team. The assessor may not be able or available to work directly with the client (e.g. because there is one assessor and dozens of clients), or perhaps the purpose of the service is to enhance psychological ways of working by all practitioners in the facility and not just by the assessor. In whichever case, the assessor takes the information he or she can gain about the client directly from the practitioner (or the multidisciplinary team), and working together they prepare a formulation of the client. Assisting the practitioner (or team) to understand the client's behaviour and risks is intended to help the practitioner think more psychologically about the client and to generate more compassion for challenging individuals with whom it can often be hard to establish and maintain rapport (Johnstone, 2013; Minoudis et al., 2013; Minoudis, Shaw, & Craissati, 2012).

Concluding Comments

Risk formulation is a theory about a particular client's sexual harm potential based on what we understand to be the most relevant risk and protective factors related to this particular outcome. Risk assessment guidelines can help assessors select information most important to this outcome. Risk formulation is the stage where all that relevant information is woven together into an account that will help assessors, those with whom they must communicate (e.g. the courts, the parole board), and their clients understand and agree on the circumstances in which sexually harmful behaviour may happen again and why and what has to change in order to prevent such an outcome. However, preparing risk formulations is a very intense undertaking, with huge individual variation in style, content, theoretical orientation, and presentation. And assessors can easily disagree with their colleagues about the value of alternative formulations—an often time-wasting process of competitive formulation—because there is little agreement about what a good formulation looks like. So, what are the essential component parts of acceptable formulations, and how might we tell a good risk formulation from a poor one?

Evaluating the Quality of Risk Formulations

The ultimate measure of the quality of a risk formulation is that it has a direct and positive impact on managed risk, which would not have been achieved at all, as effectively, or as quickly, in its absence. How might we test this? We can undertake studies in which we compare sexual offenders whose risk management has and has not been informed by a formulation in order to examine whether the simple presence of a formulation is associated with positive outcomes. Alternatively, we can devise standards against which the quality of individual risk formulations can be measured. Such standards would allow us to explore the difference to risk management made by good formulations as opposed to any old piece of writing that calls itself by this name. But what might these standards be? By what qualities should we differentiate good from indifferent from poor risk formulations?

In 2011, Professors Peter Sturmey of the City University of New York and Mary McMurran of the University of Nottingham in England published an edited book entitled *Forensic Case Formulation* (Sturmey & McMurran, 2011). While much has been written about formulation before this publication, this particular work set in motion the first real effort to identify the basic definition of formulation in forensic practice, the essential features of formulations, and evaluative criteria or standards by which the quality of formulations could start to be determined in forensic settings—all as a basis for moving this essential clinical practice from something of an art form into the realm of scientific endeavour. A subsequent publication (Hart et al., 2011) consolidated their work in this book and suggested ten standards by which formulations may be judged. The focus of this paper was on wider case formulations, but the ten standards set down are a starting point for the consideration of risk formulations also. A later publication by McMurran and Bruford (2016), following research with focus groups evaluating the standards themselves, has refined and simplified the definitions originally described, which are presented below:

1. The formulation should be a *narrative*—therefore, risk formulations should be presented in text (as opposed to a drawing subject to ambiguous or inconsistent interpretations), written in everyday language (as opposed to numbers or lists of facts or diagnoses), which tells a coherent, ordered, and meaningful story about the risks posed by the client.
2. The formulation should have *external coherence*—therefore, a risk formulation should be explicitly consistent with (or anchored by) an empirically supported psychosocial theory of problematic behaviour, such as sexual offending or decision-making, which provides both (a) essential guidance to the assessor in determining which facts are noteworthy or identifying which explanations are legitimate and (b) a critical evidence base to the process.
3. The formulation should have *factual foundation*—therefore, risk formulations should be based on information about the client that is relevant to risk and adequate in terms of its quality and quantity, and any limitations in this requirement are clearly indicated and the risk formulation identified as preliminary if so.

4. The formulation should have *internal coherence*—therefore, risk formulations should rest on propositions or make assumptions about the client's behaviour that are compatible or noncontradictory, cogent, and consistent.
5. The formulation should exercise a high degree of *completeness*—therefore, risk formulations should have explanatory breadth; they should account for a substantial amount of the critical evidence (the information anchors) and have a plot that ties together as much as possible all the information relevant to the reason why the risk formulation has been prepared.
6. The formulation represents *events that are understood by the way they relate over time*—that is, the risk formulation ties together information about the past, the present, and the future; it describes the developmental trajectory of risk from the past into the possible future and accounts for the critical vulnerability factors, triggers, maintenance, and protective factors.
7. The formulation should be *simple*—that is, it should be free from unnecessary, overly complex, or superfluous details, propositions, and assumptions.
8. The formulation should be *predictive*—that is, a risk formulation should go beyond mere description, statement of factor, or classification, to generate a new or more developed understanding about individual risk, in particular, to make detailed and testable forecasts about outcomes in the event of the implementation of specific treatment and management strategies.
9. The formulation should be *action oriented*—that is, risk formulations should be tied to action; they should assist with the planning and, importantly, the prioritisation of a range of management interventions over the period of time until next review.
10. Finally, the formulation should demonstrate a degree of *overall quality*—that is, risk formulations should be comprehensive, logical, coherent, focused, informative, acceptable, and useful to those who are required to make use of them.

Minoudis et al. (2013) examined the statistical properties of the above standards—compiled as the McMurran *Case Formulation Quality Checklist* (McMurran, Logan, & Hart, 2012)—in a study involving probation officers in the London area. The inter-rater reliability, the test-retest reliability, and the internal consistency of the checklist were all calculated from the scores derived from randomised formulations generated by a sample of 64 probation officers from fictitious case vignettes. The study found that all the statistical properties of the checklist were acceptable—inter-rater agreement was judged to be moderate to good, test-retest reliability was excellent, and internal validity was also excellent—all suggesting that the checklist is an appropriate tool for evaluating the construct of formulation. More recently, McMurran and Bruford (2016), in attempting to evolve the original standards proposed in 2011, have sought to improve its overall validity and reliability as well as to firmly establish in the literature the expectation that risk formulations can and should be evaluated. Work will and should continue to develop this and indeed other frameworks for determining the quality of formulations in order to standardise this essential area of practice and overall raise its quality.

Risk Formulation in Practice: An Example

In order to demonstrate risk formulation, an example will now be offered—Mr Smith, who was referred to in a previous section. This example is necessarily brief, but it will offer an opportunity to demonstrate what a risk formulation could look like, something of the value it adds to assessment findings, and how the evaluative criteria listed above may be applied.

Mr Smith

Mr Smith is a 47-year-old man, who is approaching the end of an 8-year prison sentence for grievous bodily harm with intent to rape. His victim was Ms Cooper, a 28-year-old woman, whom he followed from a nightclub and attacked while she was walking from there to her home in the small hours of a Saturday morning. Ms Cooper reported that Mr Smith had approached her twice while she was in the nightclub sitting with friends, asking her to dance and to allow him to buy her a drink. However, she was wary of him because he appeared too demanding and aggressive—and also intoxicated—and so she refused him on both occasions. She had not seen him leave the nightclub, and when she left for home, she assumed that she was making the short journey alone and in safety. Ms Cooper had consumed some alcohol in the course of the evening but she was not intoxicated. When approached again by Mr Smith while walking home, she understood the danger she was in immediately and tried to attract the attention of neighbours by shouting for help. Mr Smith immediately struck her repeatedly with a hammer causing injuries to her head, face, shoulders, and arms. However, the attack was stopped quite quickly when two neighbours intervened and wrestled Mr Smith to the ground. When the police arrived and arrested Mr Smith, they found in his possession a length of rope, adhesive tape, and a long and very sharp boning knife. When questioned, Mr Smith indicated that he had been greatly angered by Ms Cooper's rejections of him during the course of the evening—he stated to interviewing officers that she had no right to treat him that way. When he saw the victim prepare to leave the nightclub, Mr Smith left immediately and fetched the rope, tape, knife, and hammer from the boot of his nearby car. He watched her depart and her route of travel, and he followed her till the point at which he attacked her. As he did so, Ms Cooper recalls—and witnesses confirm—that he called her a variety of obscene and derogatory names in an angry manner.

Mr Smith has eight previous convictions, all for violent offences, all of which targeted adult women who were strangers to him. A sexual motive has been assumed in all these prior offences, but his convictions are variously for assault, burglary, grievous bodily harm, indecent assault, and rape. His first offence—burglary (of the home of a single female occupant)—was committed when he was 17 years of age. His first conviction for an explicit sexual offence was when he was 23 years of

age—indecent assault, against a 19-year-old student in a railway underpass. When he was 32 years of age, Mr Smith was convicted of the rape of a 17-year-old schoolgirl on a train. Since the age of 17 years, Mr Smith has spent a total of 16 years in prison and 8 years subject to various community licence conditions and sexual offence prevention orders. His most recent offence that against Ms Cooper was committed when he was 41 years of age and just over 2 years following his release from his previous conviction for indecent assault. Mr Smith was living alone at the time of the offence and working as a forklift truck driver in a builder's yard. Mr Smith has no current partner although he has had long-term relationships with women in the past. He has two now adult children with whom he has no contact.

While in prison on his current sentence, Mr Smith undertook the sexual offender treatment programme. He has completed this programme on two occasions before, during previous prison sentences. He has also undertaken treatment programmes relating to violent offending generally and thinking skills. While he has engaged with these programmes, reports suggest that his engagement has been superficial at best. He has been subject to various assessments, the conclusions of which indicate that he is a man with no acute mental health problems, but with a long-standing diagnosis of narcissistic personality disorder with paranoid traits (as assessed using the *International Personality Disorder Examination*; Loranger, 1999), in addition to prominent traits of psychopathy (as assessed by the *Psychopathy Checklist-Revised*; Hare, 2003; total score of 26 where an arrogant and deceitful interpersonal style and deficient affective experience are especially pronounced). Mr Smith has behaved reasonably well while he has been in prison—he has been subject to occasional punishment relating to bullying activity only—and he is due to be released on licence during the next 6 months. An evaluation of risk has been prepared by a forensic psychologist using the RSVP. The purpose of this evaluation is to inform the conditions of Mr Smith's licence.

In brief, the risk assessment clarified that Mr Smith demonstrates a chronic and escalating pattern of violent sexually motivated offending against adult women involving high levels of physical (and no psychological) coercion. Personality pathology is a critical factor, and his presentation suggests significant traits of antagonism, dominance, deceitfulness, lack of emotional depth, self-centredness, sense of entitlement, and a detached and unempathic style of relating to others. These traits are especially pronounced in his relations with women. Deviant sexual arousal is suspected—specifically, sexual sadism—but it has not been formally assessed. Mr Smith's discussions of his offending behaviour suggest a pattern of minimisation and either a lack of or a reluctance to develop any real degree of self-awareness. Problems with treatment response and supervision were also noted.

Mr Smith was broadly cooperative with the assessment; he appeared to see it as a necessary evil. He flirted with the female psychologist at the beginning of the assessment, but, when he realised that her professional stance was unwavering and that she was achieving some success in exposing aspects of himself that he would prefer remained hidden, his attitude towards her became dismissive and at times hostile. However, he completed the assessment, and he provided quite a lot of information the psychologist could use alongside credible collateral information.

Following the assessment phase, the psychologist would have preferred to write the formulation together with Mr Smith. However, he was not interested in doing this and told her to write it herself. He did wish to see it, however, and he brought a red pen to the session during which they were to discuss its contents as he anticipated that much would be wrong with it. The psychologist prepared the following text, which she went through with Mr Smith line by line, changing very little in response to Mr Smith's feedback.

This risk formulation describes what we understand about Mr Smith's risk of being sexually harmful to women again in the future. During the course of five meetings over approximately 7 h, and following a review of his records, Mr Smith has helped me to understand that he has carried out sexually motivated assaults on adult women who are strangers to him because he is attracted to them—but he anticipates that if he approached them, they would reject him. When Mr Smith sees a woman he is attracted to, he can visualise a perfect relationship between them. However, very quickly, he can also visualise her rejection of him. The belief that she will reject him floods him with anger and resentment, which motivates him to act towards the woman as if she really had rejected him. Therefore, Mr Smith explains his attacks on women as if they were reasonable punishments for their very rude, unkind, and unjust treatment of him. Mr Smith's stance in describing what he has done is that of victim—and his attitude towards his incarceration that it is unfair and undeserved. Mr Smith believes himself to have been justified in attacking his victims as viciously as he has because of the very dreadful pain and humiliation he felt they caused him by their imagined rejection—thus, his actions were in his view proportionate to the pain he believes they caused him.

Mr Smith told me about his early experiences with women. His mother was a single parent of Mr Smith and his two siblings—an older brother and a younger sister. His mother worked very hard to raise money for the family, but she was frequently depressed and drank alcohol most days to numb her pain. Therefore, it was often the case that she was not there physically while Mr Smith was growing up, or she was there in body but not available to him emotionally. It seems that Mr Smith, who had always been a strong willed and self-centred child, spent large parts of his childhood imagining what it would be like to be really cared for and at the centre of a really loving family—the most favoured, the most beloved son. And he grew resentful of his mother for not providing this for him. As he grew into adolescence, Mr Smith spent more and more time fantasising about perfect relationships with teachers and friends and, increasingly, with perfect young women in order to make himself feel better. However, such a pattern of coping evolved at the same time as an increasing problem with controlling his anger when frustrated, and increasing dependence on alcohol—and all his coping strategies became fused.

Mr Smith's offending behaviour was primarily motivated by anger at his victims for not being the perfect, loving and accepting women he wanted them to be; over time, his resentment at the role women have played in his incarceration when he is at least as much a victim as they are, has at least maintained if not increased both his anger and his risk of reoffending. Therefore, the key to managing Mr Smith's risk of harm to women in the future is to impose both restrictions on his movements

through strict and extended licence conditions *and* to attempt to modify his attitudes towards women. Mr Smith accepts that the licence conditions imposed on him will be comprehensive. However, he has expressed an interest in considering the possibility of making more deep-rooted changes to his attitudes towards women. Why now? Because Mr Smith wishes not to return to prison. He understands that it is his beliefs about women and what he thinks they owe him that are major factors in having him act such that he is returned to prison over and over. Therefore, Mr Smith is interested in trying to understand himself more so that he might not return to prison again. If such a process enables him to understand the experience of those whom he has attacked, that would be okay although this is not his primary consideration—and it may be hard for him to do this because of the kind of personality he has. However, behaviour change in order to stay out of prison is possible, he thinks, and such change would limit if not prevent his victimisation of others, and that would be a very good outcome indeed.

Mr Smith found it quite hard to go through this formulation with me—he has protected himself from feelings of shame and loneliness for so long with beliefs about his right to be angry towards women and to humiliate them as he feels they humiliate him. However, his wish not to return to prison is very strong now because there is so much that he would really like to see and to do in the community while he is still young enough to enjoy them—for example, he used to love fishing when he was a child and he loves to go to soccer matches, both with his older brother who has stood by him through all his prison sentences. Therefore, although working on this formulation together has been hard, it has enabled us to agree on a future pathway for Mr Smith. Now we can begin plotting the different supports we have to put in place to help him to get and to stay there, and to keep others safe from him.

Mr Smith and I have agreed that we will review this formulation again in 5 months time once we have all our plans in place to manage his risk of reoffending in the community. At that meeting, we will add to this formulation with more details on how he will try to manage situations that put him at risk of re-offending and we will review all the measures that will be taken to prevent him from actually doing so.

Comment on Mr Smith's Formulation

In terms of quality, the above formulation demonstrates most key requirements, albeit very briefly. The text states clearly what it is attempting to explain—Mr Smith's risk of sexual violence towards adult women who are strangers to him—and gives an indication of the range of information on which the opinions have been based (it has *factual foundation*). The formulation goes into some detail on the developmental origins of his harmful behaviour (*events are understood over time*), and it offers a psychological explanation for Mr Smith's harmfulness in which his behaviour is linked to possible motivational drivers consistent with accepted theories of sexually violent behaviour (e.g. Baumeister, Catanese, & Wallace, 2002; Malamuth, 1996; Marshall, 1989; Marchall & Barbaree, 1990; it attempts to achieve

external coherence). As a consequence of such a psychological explanation, it is possible to develop hypotheses for action that will facilitate change, whether generated from within Mr Smith or directed by the range of services likely to be supervising him in the months and years to come (the formulation is *action oriented*). Also, the formulation has been written in a style that tries to avoid the use of jargon and that is intended to be readable, comprehensible, interesting, and engaging (the formulation has a *narrative* and is of reasonable *overall quality*). Finally, it offers a coherent summary of Mr Smith's situation now (it has *internal coherence*), containing information relevant only to his risk of sexual harm (the formulation demonstrates *completeness* and *simplicity*). Subsequent follow-ups of Mr Smith, in which risk management and change are reviewed, will allow the veracity of the formulation to be tested (the formulation is *predictive*).

Conclusions and Good Practice Recommendations

This chapter has focused on the SPJ approach to the clinical risk assessment and management of men and women whose sexual behaviour is harmful to others. In this chapter, the case has been made that the most important part of the risk assessment and management process using the SPJ approach is risk formulation—the process of generating an understanding of harmful behaviour that directly links assessment findings to management actions. As such, risk formulation offers a means by which as broad and as relevant an understanding as possible may be acquired in a systematic way such that a practitioner's current understanding of the underlying mechanism of an individual's harm potential may be used to develop hypotheses about action to facilitate change. This chapter has also given attention to recent work attempting to establish quality standards for formulation, a process intended to generate thought and research in order to improve both the frequency with which formulation is a part of risk evaluations and the confidence with which practitioners prepare, communicate, and evolve them over time in a collaborative way. It is only when we have such a means of determining efficacy that we will move from the art to the science of formulation practice (Bieling & Kuyken, 2003).

So, what are the good practice recommendations emerging from the work reviewed in this chapter? Two are proposed as follows:

1. Risk formulation should be an essential part of sexual violence risk assessment and management—in fact, in clinical risk assessment and management in all areas. Assessment findings need to be explained with relevance to the subject of the evaluation, and risk management has to be linked directly to that explanation in order to be acceptable, proportionate, and effective, especially in complex cases. This is specially the case for those practitioners whose job is to manage clients with a history of sexually harmful behaviour as oppose to offer a judgement about the likelihood of reoffending. The latter application of risk assessment technology has dominated the field for much of the last 20 years. Risk formulation is the new frontier in *clinical* risk assessment and management

because once identified as at risk of sexual reoffending, it is formulation that offers the best hope of maintaining over time the focus, interest, and engagement of this most challenging of client groups.

2. Risk formulation is a challenging task—in part because, while core business for most practitioners, it is not clear what are the essential component parts of a formulation whatever its theoretical underpinnings and how we can know a good formulation from a poor one. This chapter has proposed one quality assurance framework for formulation—others are sure to be prepared. Research on their application, and the demonstration that formulations judged to be good are effective in managing risk, is strongly recommended in order to improve the quality and the confidence with which this most important endeavour is discharged.

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