

**Assessing Risk in a Community Intellectual Disability Sample.
The Clinical Utility of the Dynamic Risk Assessment and Management System
(DRAMS): A Study of Clinician Evaluations.**

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This thesis submitted for the degree of Doctor of Clinical Psychology entitled, 'Assessing Risk in a Community Intellectual Disability Sample. The Clinical Utility of the Dynamic Risk Assessment and Management System (DRAMS): A Study of Clinician Evaluations' is based on work conducted by the author in the School of Psychology between 2003 and 2007. All of the work recorded in this thesis is original unless otherwise acknowledged in the text or by the references.

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The literature review, research report and critical appraisal sections are largely self-contained in accordance with university regulations (see Appendix B for a summary of the thesis structure guidelines).

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ABSTRACT

Assessing Risk in a Community Intellectual Disability Sample. The Clinical Utility of the Dynamic Risk Assessment and Management System (DRAMS): A Study of Clinician Evaluations.

K. M. Gaskin

Literature Review

Growing numbers of people with intellectual disabilities are now living in the community and as a result are more exposed to the risk of offending. Assessment of risk is therefore becoming progressively within the remit of professionals working within community settings. The aim of the current review was to critically evaluate the literature on assessing the risk of offending in people with intellectual disabilities living within the community. The review highlighted that there are a number of barriers to assessing risk in such settings and that services which do exist for this population are often variable in their availability. In addition to this, unlike non-intellectually disabled populations, there is currently no standardised tool specifically for assessing risk in people with intellectual disabilities. Further research is needed to develop specialised risk assessment tools and to better understand and meet the needs of this client group.

Research Report

The clinical utility of a newly-developed risk assessment tool, the Dynamic Risk Assessment and Management System (DRAMS), designed specifically for offenders with intellectual disabilities was investigated on a sample of 8 participants. The experience of clinicians' in carrying out the DRAMS was compared with their experience of carrying out the Functional Analysis of Care Environments Risk Profile (FACE) for the same participants. A randomised cross-over design found a significant difference between the two conditions, indicating that the DRAMS was favoured by the clinicians in terms of clinical utility and usability with intellectually impaired offenders. A thematic analysis of clinician experiences in administering the two measures supported this finding. In addition, verbal IQ of the offenders was found to be more highly correlated with the difference in scores on the Clinician Feedback Questionnaires than performance IQ, indicating that the clinicians found the DRAMS to be a more clinically useful tool with those offenders with a higher verbal IQ.

Critical Appraisal

Reflections on research process, origins of the research question, and conducting the project are discussed.

SECTION 1

LITERATURE REVIEW

Assessing the risk of offending behaviour in people with intellectual disabilities

ABSTRACT

Background

Growing numbers of people with intellectual disabilities are now living in the community and as a result, are more exposed to the risk of offending. The assessment of risk is therefore becoming progressively within the remit of professionals working within community intellectual disability settings.

Method

A search of the literature in the area was carried out using the following computerised databases: Web of Science, PubMed, PsychInfo/PsychArticles, Ingenta and OVID.

Results

The current review highlighted that there are a number of barriers to assessing risk in community settings. Moreover, services for people with intellectual disabilities who offend are patchily available and where they do exist there is often a lack of clear policies, procedures and guidance. In addition to this, there is currently no standardised tool for assessing risk within this population which has led services to develop idiosyncratic tools which may be based on unreliable evidence.

Conclusions

There is an urgent need for additional research in the area. A small number of studies have begun to apply risk assessment tools, standardised on populations without intellectual disabilities to people with intellectual disabilities with some promising results. This work needs to be further developed or the costs of the offending behaviour will continue to be met by the individuals themselves and by their victims.

Keywords

Learning disability and offending, intellectual disability and offending, developmental disability and offending, learning disability and risk assessment, intellectual disability and risk assessment, developmental disability and risk assessment, sexual offending and learning disability.

1. Introduction

1.1 Risk Assessment: Definition and Context

Risk assessment has been described as: ‘a probability calculation that a harmful behaviour or event will occur, and involves an assessment about the frequency of the behaviour/event, its likely impact and who it will affect’ (Kemshall, 2002, p. v). Such issues of risk assessment concern a broad range of disciplines including economics, engineering, sociology, anthropology (Towl & Crighton, 1996) but the process is becoming increasingly within the remit of mental health professionals, who are often asked to make predictions about the level of risk an individual may pose.

The goal of risk assessment is risk management that is, the prevention of harm. Furthermore, risk assessment serves a number of functions within health care settings. This can include establishing an individual’s current presentation; making judgements about where to intervene in a treatment or management programme; considering decisions about future placements and determining supervision and staffing levels (Lindsay, Murphy, Smith, Murphy, Edwards, Chittock, Grieve, & Young, 2004a).

Moore (1996) stated that accuracy, along with the avoidance of either over-prediction or under prediction, was the key issue in risk assessment and further, that there were four possible outcomes to risk assessment. These are displayed below in Figure 1.

Firstly, risk predictions can be right by predicting correctly that a harmful behaviour will occur (Box A) or secondly, by predicting that a harmful behaviour will not occur and it does not (Box D). However, errors are also likely and they carry significant costs for both workers and their agencies. Box B highlights those cases in which a risk of harm is not identified but does occur, and fourthly, Box C identifies those cases in which harm is predicted but does not occur.

Figure 1. Risk assessment prediction outcomes (Moore, 1996).

| | | Prediction | |
|---------------------------------|-----|--|--|
| | | Yes | No |
| O U T C O M E | Yes | A True positive prediction | B False negative Prediction |
| | No | C False positive prediction | D True negative Prediction |

Furthermore, Moore (1996) described how in ‘Box B’ cases, the consequences can be very high; for example, victims may be harmed or killed. In ‘Box C’ cases, the Criminal Justice System (CJS) can over-intervene with significant impact upon civil liberties and a waste of resources. In addition, ‘Box B’ cases can result in defensive practice, caution and over-prediction amongst practitioners whereas ‘Box C’ cases can raise significant ethical dilemmas for practitioners and resistance from those concerned with the erosion of civil liberties.

It is not informative to state that a person is, or is not dangerous (Blackburn & McGuire, 1999). Rather, there is a need to gather information that allows the clinician to specify not only whether certain risk factors are present that make the person more likely to engage in harmful acts, but also the type of harm, the probability of the behaviour occurring, the type of victim and the time frame in which the behaviour may occur.

1.2 The Literature Search

The aim of the present review was to critically examine the literature relating to the risk assessment of offending behaviour in people with intellectual disabilities living within a community setting. In order to undertake this, a number of approaches were adopted to

identify the relevant literature. Firstly, searches were carried out on a number of electronic databases: Web of Science, PubMed, PsychInfo/PsychArticles, Ingenta and OVID. The following search terms were used: ¹learning disability and offending, learning disability and risk assessment, sexual offending and learning disability, risk assessment. In addition to the search of electronic databases, a 'snowball' method (Robson, 1993) was employed to seek out further references and secondary sources in papers already obtained.

1.3 Risk Assessment Methodologies

The risk assessment literature typically draws a distinction between two broad approaches: clinical judgement of risk and actuarial measurement of risk using historical factors (Beech & Ward, 2004). Grove and Meehl (1996, p. 293-294) distinguish between these two approaches in terms of the process by which the prediction is made. Moreover, they define actuarial methods as those that use 'a formal, algorithmic, objective procedure (e.g., equation) to reach the decision' and clinical prediction as 'an informal, 'in the head,' impressionistic, subjective conclusion, reached (somehow) by a human clinical judge.' Embedded within these two perspectives are six further methods which are used to measure risk (Doren, 2002). These are outlined below:

1.3.1 Unstructured/Unguided Clinical Judgement

An unstructured clinical approach is where a clinician may review case material without any structured assessment in mind and where decisions are made as intuitive or experiential (Hart, Laws, & Kropp, 2003). Clinical judgement of risk gained from material elicited on interviewing a client can be seen as arising from this type of assessment (Beech &

¹ The terms 'intellectual impairment,' 'intellectual disability,' 'developmental disability,' 'mental retardation,' and 'mental handicap' were also used during the search due to terminology variations within the literature.

Ward, 2004). Although it can be argued that such approaches take into account rare or idiosyncratic features of an individual case, (Meehl, 1954) clinical prediction relies on human judgement. In the face of extensive theoretical and empirical literature on the presence of human information processing limitations and biases (e.g. Kahneman, Slovic, & Tversky, 1982) this could be problematic (McMillan, Hastings, & Coldwell, 2004).

1.3.2 Guided Clinical Judgement

Clinicians adopting this type of approach to risk assessment may begin with their own ideas without relating these to current theories and findings in the specific area of risk (Beech & Ward, 2004). Furthermore, Limandri and Sheridan (1995) suggested that this approach may utilise linear rationalist or hypoeductive methods.

1.3.3 Research-Guided Clinical Judgement

This is where a predefined set of risk factors, derived from research are used as a guide to assessment (Beech & Ward, 2004). This type of approach could include for example, using a standardised risk assessment measure as a guide to carrying out an assessment.

1.3.4 Anamnestic Risk Assessment

This type of approach examines an individual's life history and current circumstances to see whether specific risk factors are present. Moreover, this approach is more likely to take into account contextual factors in the individual's life, rather than clinical judgement alone (Beech & Ward, 2004).

1.3.5 Purely Actuarial Approach

Actuarial risk assessment is based upon statistical calculations of probability and is a well used method within the insurance industry (Green, 1997). This approach was pioneered by Burgess (1936) to examine parole violation and the basic methodology is now used within the forensic field for assessing the risk of recidivism.

From the study of a large number of cases, certain factors that statistically relate to risk are selected. These are then retrospectively validated by application to cases with a low expectancy of risk and to those with a high expectancy of risk. Risk factors are then retrospectively validated in terms of statistical probabilities. Such factors are often referred to as *static* risk factors as they are deemed largely unchangeable and rooted in historical and demographic factors (Kemshall, 2002).

Static risk factors believed to indicate or contribute to the risk of offending include childhood behavioural problems, being male, being young, or having experienced parental divorce (Green *et al.*, 2003). Moreover, several assessments have been developed which are based on these and other variables and are generally used with large groups of incarcerated offenders (Lindsay *et al.*, 2004a). These allow the offender to be placed in categories of low, medium or high risk of future offending or challenging behaviour, which represents the known rate of offending among individuals in the original research who shared characteristics with the subject of the assessment (Lindsay *et al.*, 2004a). Therefore, the assumption is made that if the individual being assessed shares the same risk factors as a research sample with a known rate of reoffending (e.g. 50%), then that individual has a likelihood of reoffending comparable to that observed in the sample (Logan, 2005).

Actuarial risk assessment instruments have demonstrated good predictive power for general and violent recidivism. Moreover, the Psychopathy Checklist-Revisited (PCL-R; Hare, 1991) has been shown to correctly classify 77% of violent male offenders (Harris *et al.*,

1991) and is equally proficient at predicting violence among individuals with psychiatric disorders, such as schizophrenia (Rice & Harris, 1992). In addition, such methods generate confidence that discrimination between those individuals who will and will not reoffend will be good and that those individuals who will reoffend will be identified and as a result, effectively managed to reduce their risk of harm (Logan, 2005). Furthermore, Kemshall (2002) asserted that actuarial risk assessment can be used to (1) establish those risk predictors which have a proven track record; (2) establish the relevant base rates for clinical assessment; (3) increase the accuracy of risk assessments; and (4) increase levels of consistency and reliability.

1.3.6 Clinically Adjusted Actuarial Approach

This approach involves a clinician assessing risk by initially employing one or more actuarial instruments before making potential adjustments based on clinical, contextual or dispositional considerations. For example, this type of assessment may draw on aspects of an individual's personality and factors within an individual's current circumstances (Beech & Ward, 2004).

Notwithstanding the advantages of actuarial risk assessment methods, there are a number of limitations associated with their usage. For example, Grubin and Wingate (1996) queried the extent to which information from a group population can be generalised to an individual. Furthermore, a strict actuarial assessment cannot take into account variables that change, otherwise known as 'dynamic' factors (Grubin, 1997).

1.4 Dynamic Risk Assessment

Dynamic risk factors have been broadly described as those factors which change over time, or which can be made to change through treatment and intervention (Quinsey *et al.*,

1998). A number of such variables were described by Green *et al.* (2003), including an individual's response to treatment, their knowledge and attitudes, maturation or changes in circumstance. Moreover, Green *et al.* (2003) asserted that dynamic variables may be further divided into: static factors (or tombstone), which have the potential of changing but typically endure for long periods of time, such as alcohol misuse or deviant sexual interests; and acute factors, which are rapidly changing states such as intoxication or sexual arousal that may indicate heightened likelihood of an offence in the near future (Hanson & Harris, 2000).

The research on dynamic risk factors, although on the increase, is nowhere near the level of sophistication of the research on actuarial or static risk factors (Hanson & Harris, 2000), although dynamic factors such as drug misuse, accommodation and employment have been found to have a 'clear link' to reconviction rates (May, 1999). In addition to this, the role of dynamic factors in establishing treatment and intervention plans is now well established (HMIP, 1998).

The contribution of dynamic risk factors to the assessment of violent offending has also been explored. Moreover, Hagell (1998) stated that there was evidence to support that multiple indicators were more successful than individual factors in predicting risk and that personal factors, such as the offender's general disposition or temperament and cognitive factors were important risk factors. Similarly, Limandri and Sheridan (1995) reported that their assessments of violent behaviour were enhanced by the inclusion of dynamic factors such as use and availability of weapons and access and proximity to victims.

Raynor (1997) asserted that although dynamic variables are important, how they should be weighted within risk assessments can present significant problems. Moreover, that dynamic variables are more difficult to measure than criminal history as they are often compiled from many different sources, including the self-report of the offender and are open to interpretation by the assessor (Kemshall, 2002).

1.5 Receiver Operator Characteristic (ROC) Curve

Prediction is best assessed through the receiver operating characteristics (ROC) area under the curve (AUC) statistic (Hanson, Morton & Harris 2003). This can be interpreted as the probability that a randomly selected recidivist would have a more deviant score (i.e., the sensitivity of the measure) than a randomly selected non-recidivist (i.e., the specificity of the measure; Beech & Ward, 2004). Other terms for sensitivity include the 'hit rate' and the 'true positive rate,' whilst specificity is also termed the 'false alarm rate' and the 'false positive rate' (McMillan *et al.*, 2004).

The ROC Curve plots sensitivity against 1 - specificity for each possible score (or cutting point) on a predictive instrument and provides a visual description of the discriminatory capacity of that predictor (McMillan *et al.*, 2004). The AUC statistic can vary from 0.5 (meaning no predictive accuracy) to 1.0 (meaning perfect predictive accuracy; Hanson *et al.*, 2003). In an example cited by McMillan *et al.* (2004), the actuarial predictor was the number of violent incidents in a 6-month period, scored to a maximum of 10. Therefore, the cutting points for the actuarial predictor were 0, 1, 2, 3, and so through to 10. Separate sensitivity and 1 – specificity values are calculated for each cutting point. For example, for a cutting point of 1, everyone scoring 1 or above is classified as 'predicted to be violent' and then sensitivity and 1 – specificity values are calculated. Once this has been repeated for each cutting point, the ROC-curve can be constructed.

The AUC is the part of the boxed section of the graph that is underneath the line of the ROC-curve. If the instrument predicts at a level no better than chance, the 'curve' would be a straight line and 50% of the boxed area would be under it. Further, if an instrument is to predict at a level better than chance, more than 50% of the area must be under the curve. A 95% confidence interval can also be calculated for the AUC in that, if the lower boundary of

this interval is above 0.50, the AUC is significantly larger than 50% and the instrument predicts at a level significantly better than chance (McMillan *et al.*, 2004).

Hanson *et al.* (2003) reported the average AUC statistics for a number of risk assessment methodologies. Moreover, they asserted that the average AUC calculated from 50 actuarial instruments was 0.68; for 6 research-guided clinical judgements the AUC was 0.64 and for 12 unstructured/unguided clinical judgements the AUC statistic was 0.58. From these findings, Hanson *et al.* (2003) advocated the increased utility of actuarial assessment over clinical judgement.

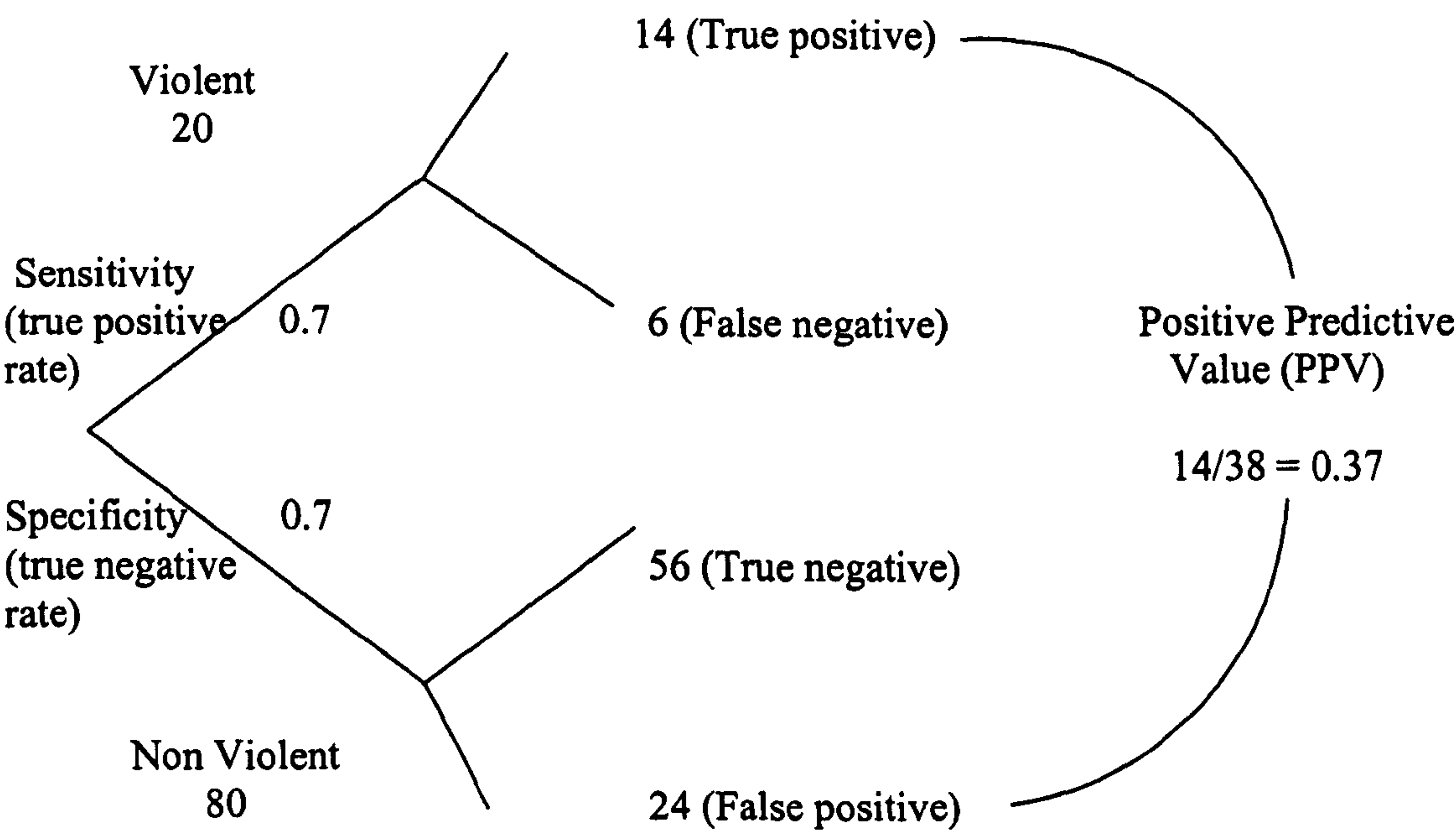
1.6 Low Base Rates

Szmukler (2001a) asserted that it is the rate at which violent acts occur in any target population which is key to the predictive abilities of any instrument. Further, that a ROC curve of a well-performing instrument may indeed show the trade-off between the true positive rate and the false positive rate but where this trade-off should lie is dependent on the relative costs of false positives versus false negatives. Further, Szmukler (2001a) raises the question as to just how well the best instruments perform in the real clinical world where prediction leads to action, including restrictions on the liberty of patients regarded as dangerous and where false positives are ethically very serious.

Szmukler (2001a) used a probability tree, shown below in Figure 2, to demonstrate how prediction instruments perform. Furthermore, Figure 2 depicts a probability tree whereby the relevant data is presented in relation to a population where 20% of individuals are violent during the follow-up period. Using an optimum ROC curve, with a true positive rate of 0.7 and a false positive rate of 0.3 (equivalent to a true negative rate of 0.7), the positive predictive value, that is, the proportion of individuals predicted by the test to be violent who indeed turn

out to be violent, is 0.37. This however, also means that the prediction will be incorrect on six out of ten occasions.

Figure 2. Probability tree for determining the predictive ability of a test for violence (Szmukler, 2001a).



Szmukler (2001a) developed the point further by citing the example of an inner-city community mental health team, where the rate of violent acts of any severity, over a six-month period would more likely to be around 6% (Sergill & Szmukler, 1998 as cited in Szmukler, 2001a). Consequently, by substituting the figures 6 and 94 in the probability tree, the positive predictive value drops to 0.14, which in practice means that the prediction will be incorrect almost nine times out of ten. Further, for acts of very serious violence, perhaps at a rate of 1%, the risk assessment measure would be incorrect approximately 97 times out of a possible 100 (Szmukler, 2001a). In addition to this, serious violence perpetrated by individuals with a diagnosis of schizophrenia has been reported to result in conviction in 0.5% of males and 0.05% of females, over a period of 3 years (Wallace, Mullen, Burgess, Palmer, Ruschena, &

Browne, 1998). In this case, Szmukler (2001b) stated that the positive predictive value is quite 'useless' as the prediction will be wrong more than 99 times out of 100. Further, even if the rate reported by the Wallace *et al.* (1998) study occurred in 5% as opposed to 0.5% the positive predictive value would still only be 0.08.

Clearly, rare incidents are inherently difficult to predict. Even instruments with an unachievable accuracy of 0.9 for both true positives and true negatives will incorrectly predict risk more than nine times out of ten at a base rate of 1%. In view of this, even highly statistically ROC curves appear extremely limited in their practical application in a community setting. Szmukler (2001a) therefore asserted 'how unfair is it then that mental health services in the UK seem to be expected to prevent what is, in practice, unpredictable' (p. 85).

1.7 Summary

The issue of predicting risk is, and will become, increasingly important across mental health care settings as clinicians are asked frequently to predict the probability of recidivism in individual cases (Lindsay, Elliot & Astell, 2004b). Moreover, risk assessment tools have reached a level of accuracy where they should be used as a matter of course (Harris & Tough, 2004). However, actuarial and dynamic risk assessment methods each have advantages and disadvantages. Research has shown actuarial methods to have good predictive accuracy but they can be flawed by statistical fallacy and low incidence of risky behaviours in the general population. The lesser researched dynamic risk factors may have lower levels of accuracy and be open to the subjective bias of the assessor but have much to contribute in understanding behaviours, environmental stressors and in establishing treatability and management plans (Kemshall, 2002).

2. Risk Assessment and People with Intellectual Disabilities

2.1 The Current Context

Although risk assessment is carried out across all client groups, over recent years there has been a growing interest in the assessment of risk in people with intellectual disabilities (Turner, 2005). This is thought to be due in part to the deinstitutionalisation movement, which has led to the closure of all but a few of the old long-stay hospitals in England and seen the numbers of people with intellectual disabilities living within these institutions decline from 58,850 in 1969 to 8740 in 2000 (Department of Health, 2001). Although this move towards community care has resulted in many people with intellectual disabilities enjoying greater social inclusion than ever before, one unwelcome effect of these changes is that they are now in many respects more exposed to the risk of offending (Dale, 2005; Department of Health, 1992; Turner, 2000).

McBrien *et al.* (2003) stated that people with intellectual disabilities are not over-represented in the prison population in the UK (Birmingham *et al.*, 1996; Brooke *et al.*, 1996; Murphy *et al.*, 1995) although they are over-represented at various stages of the CJS compared with the general population. Furthermore, it has been suggested that between 5%-9% of people detained at police stations have some level of intellectual disability (Gudjonsson *et al.*, 1993; Lyall *et al.*, 1995) as do around 7% of those on probation orders (Mason & Murphy, 2002). Holland *et al.* (2002) asserted however, that whilst people with intellectual disabilities may be over-represented in parts of the CJS, given the intellectual and other psychosocial disadvantages which they experience, the level of offending behaviour in this particularly vulnerable group is strikingly low.

Lindsay and Taylor (2005) stated that it is not clear whether people with intellectual disabilities commit more or less crime than those without intellectual disabilities, or whether the type and frequency of crimes committed by offenders with intellectual disabilities differ

from those committed by general populations of offenders. Furthermore, various methodological difficulties in prevalence studies within the field have led to this lack of clarity (Holland, 2004; McBrien, 2003). Indeed, studies differ in the inclusion criteria and method used to establish presence and level of intellectual disability. For example, whether or not to include a person whose intellectual functioning is considered to be within the 'borderline' range (i.e. an IQ score between 70-74) and the method used to establish this, whether this be an IQ test or from an educational history (Lindsay & Taylor, 2005). Moreover, Tudway and Darmoody (2005) stated that the majority of (sexual) offences perpetrated by individuals with intellectual disabilities were not reported to the authorities.

Holland *et al.* (2002) asserted that the context of the sample, be it the community, courts, prison or secure hospital will undoubtedly influence the reported offending rates across studies due to sampling bias and filtering effects. Furthermore, Sturmey *et al.* (2004) highlighted the paucity within the literature of well controlled studies whereby the prevalence of offending in whole populations of people with intellectual disabilities is compared with that in general populations of people without intellectual disabilities using the same methodology.

Methodological issues often occur within the context of considerable changes in criminal justice, health and social care policies, whereby definitions of criminality and intellectual disability can change rapidly and significantly which impacts upon the incidence, visibility and reporting of offending behaviour by people with intellectual disabilities (Holland *et al.*, 2002). Consequently, these changes, alongside the deinstitutionalisation movement have led to community service providers becoming under increasing pressure to measure and control the risk of offending in people with intellectual disabilities (Turner, 2005). In turn, this process has changed the nature of research on offenders with learning disabilities, transferring the focus of enquiry from institutions to the community (Lindsay & Taylor, 2005).

McBrien *et al.* (2003) surveyed the total population of adults with intellectual disabilities known to health and social services in one local authority in an attempt to establish the extent of 'risky' and offending behaviour. Face-to-face structured interviews established that, of the 1,326 adults known to services, 348 (26%) exhibited risky behaviours that had been or might be construed as offences, 128 (9.7%) had a history of contact with the CJS and 38 (2.9%) had a history of criminal convictions, while 11 (0.83%) had a current conviction. In addition to this, across the 84 settings surveyed, 48% of staff had experienced caring for individuals with a history of CJS contact, as had 93% of social services and health staff.

2.2 Forensic Intellectual Disability Service Provision

In spite of the numbers of people with intellectual disabilities exhibiting offending behaviours, there are few intellectual disability services specifically set up to address offending and those National Health Service (NHS) forensic intellectual disability services which do exist are 'patchily available' (McBrien *et al.*, 2003). Indeed, Bailey and Cooper (1997) estimated that only 54% of 135 NHS Trusts in England and Wales provided forensic services for people with intellectual disabilities. These findings were echoed by a report produced by the Department of Health (1999) which highlighted the lack of local forensic services for people with intellectual disabilities. Furthermore, Murphy (2000) stated that people with intellectual disabilities who had offended or who were at risk of offending may be rejected by mainstream services as being too difficult and awkward to treat and may also be rejected by services for people with intellectual disabilities as being too intellectually able or presenting too great a risk to others in the service. It would seem therefore, that people with intellectual disabilities who engage in offending behaviour are liable to be doubly stigmatised, and that their needs are likely to go unrecognised or to be poorly served (Dale, 2005).

Variability in services has led to increasing pressure being placed on professionals in generic community intellectual disability teams to take referrals concerned with such cases and furthermore, clinicians are expected to assess risk and contribute to the design of care packages that will minimise risk (McBrien, 2003). As asserted by Sellars (2002), staff looking after people with intellectual disabilities have a duty to identify behaviour which is unacceptable to the community at large and to take steps to prevent, or at least limit its occurrence. However, often staff feel anxious about the idea of doing 'risk assessments' and are rather vague about what these should entail (Sellars, 2002).

McBrien *et al.* (2003) stated that people with intellectual disabilities who offend present 'particular dilemmas' to community-based service providers, a view shared by Clare and Murphy (1998) who asserted that from the limited literature, there was evidence to suggest that variation existed between agencies in terms of attitudes, protocols and skills and that adequate guidance and research-based evidence was lacking. Furthermore, Clare and Murphy (1998) argued that the response to people with intellectual disabilities who offend 'remains arbitrary.'

Similarly, McBrien *et al.* (2003) stated that 'risky individuals' are sometimes moved from one residential home to another in order to protect vulnerable victims or often, expensive out-of-district placements have to be used (Lyall *et al.*, 1995). Moreover, McBrien *et al.* (2003) asserted that criminal justice system agencies often face difficulties in accessing specialist assessment and treatment for people with intellectual disabilities who are charged or convicted of an offence due to the eligibility criteria of such services being unclear. Furthermore, that 'staff from all agencies struggle to know what to do.'

2.3 Assessment of Risk in Intellectual Disability Services

Turner (2000) highlighted a number of difficulties in the assessment of risk within Intellectual Disability Services and in an attempt to discover how problems were reflected in practice, conducted a survey of statutory and independent sector organisations thought to provide services to people with intellectual disabilities in the northwest of England. A two-page questionnaire, containing eight specific questions concerning policy and practice, three open-ended prompts for comments, problems and suggestions in relation to risk assessment and offending was sent to 106 organisations. Out of the 106 services, 61 (58%) were statutory sector providers (24 social services departments, 18 community or primary health trusts, 16 other NHS trusts, 3 joint services) and 45 (42%) were voluntary sector providers.

Out of the seventy providers who responded, Turner (2000) reported that 46 (66%) were from the statutory sector and 24 (34%) from the voluntary sector, indicating a response rate of 66%. In addition, 53 (76%) respondents supplied additional comments or suggestions and 18 (26%) included documentation relating to their risk assessment policy or procedures. The survey found that, while many providers' recognised problems associated with assessing or managing risk, only a minority had adopted relevant policies or procedures to address this. Furthermore, the adoption of such practice was found to be more common among statutory sector providers which Turner (2005) asserted may be due to their role in providing communal accommodation where it has been suggested, greater opportunity for physical and sexual assault may exist (Wilson *et al.*, 1996).

Moreover, Turner (2000) reported that in spite of the majority of respondents stating that assessment formed part of a general assessment of need, risk assessment appeared to be 'a responsive rather than proactive exercise, taking place within the context of heightened concern or new information regarding the behaviour of an individual' (p. 251) In addition, 26 (37%) respondents from organisations with and without risk assessment policies

described problems which were separated into three main headings: (1) resources or service configuration i.e. need for training; (2) interagency or interdisciplinary cooperation or coordination i.e. lack of assessment strategy; and (3) issues relating to the effectiveness, design and content of assessment i.e. no effective, reliable procedure.

In total, 32 suggestions were made in Turner's (2000) study across 2 broad categories relating to: (1) the need for progress; and (2) the need for resources. Furthermore, 16 providers made suggestions about the need for or the nature of a future risk assessment strategy, including 13 respondents who welcomed the idea of greater information sharing, the holding of a regional conference on the subject or the development of guidelines. In addition to this, a total of 10 organisations highlighted the issue of resources for further training; including greater specialist input, assessment facilities, community support funding of local NHS beds. Moreover, six suggestions referred to: more regional support; the development of continuing care criteria relating to high-risk clients; the improvement of discharge planning; the involvement of learning disability teams within court diversion teams; and better liaison between management and grassroots (Turner, 2000).

Although Turner's (2000) study offers a useful insight into the provision of forensic risk assessment within intellectual disability services, the findings are limited to one geographical region of the UK. This has obvious implications for generalisability and as Turner (2000) acknowledged, 'may not be an accurate reflection of procedure nationwide or indeed, provide the best example of good practice' (p. 250). Similarly, the study can be seen as giving a one-sided view as to the forensic issues in intellectual disability services as the focus is upon policies and practice in relation to offenders with intellectual disabilities or potential offenders and not victims. In addition to this, the study was carried out over six years ago and, given the rapidly increasing interest in the area, services may well have expanded apace.

A number of similar conclusions however, were drawn out of a study carried out by Robertson and Clegg (2002). They attempted to identify the dilemmas faced by community staff in gathering information and developing confidence in their risk appraisals of people with intellectual disabilities who exhibited sexually offensive behaviours. Moreover, the study explored the attributions made by community staff about their own risk appraisals, particularly in relation to the sources of internal and external influence on their risk judgement practice and whether or not these were controllable by the offenders and by the staff themselves. In total, six community staff were interviewed from six community teams, jointly managed by a NHS Trust and Social Services Department.

During interview, the staff members were encouraged to discuss male service users with whom they had worked with who had behaved in sexually offensive ways. Then factors affecting the staff member's risk assessments and their confidence in these were gathered through open questions about risk.

The results of Robertson and Clegg's study indicated that staff members felt that their confidence in carrying out risk assessments was adversely effected by a number of factors external to the service users such as: (1) an absence of relevant protocols, (2) lack of support from line management, (3) lack of specialist guidance or training, (4) staff minimising the significance of inappropriate behaviours, (5) too little time and (6) obscure filing leading to an absence of information for making judgements. Moreover, a number of internal factors were also highlighted by staff members as undermining to their risk assessment as follows: (1) service users being generally pleasant towards most people around them, (2) infrequent offending, and (3) service users giving no hint of their attitudes or feelings during interviews.

Robertson and Clegg (2002) reported that confidence in staff members' risk assessments was increased when they were able to (1) have sufficient time to interview the service user, (2) were able to consult with more experience staff for supervision and guidance

and (3) where separate viewpoints could be combined together through multidisciplinary assessments. Furthermore, a number of external factors were raised as being outside the control of the staff members and included: police involvement; the forcefulness of how other staff complained to the participant; definite evidence of offending; relevant people debating different opinions; and the involvement of a skilled counsellor. In order to gain some control over influences on their confidence that were external to both service users and themselves, the staff members said that they would check with colleagues and staff who knew the service user well and maintain effective relationships with staff and organisations where offending might take place (Robertson & Clegg, 2002).

Although the aforementioned study offers some insight into the specific dilemmas encountered by community staff when attempting to assess the risk associated with sexually offensive behaviour perpetrated by men with intellectual disabilities, it is difficult to generalise from the findings to other settings. This is acknowledged by the authors who point to the small number of participants and the 'modest reliabilities of the attribution codes.' In addition, all but one of the staff members who took part were male and it is unclear whether this was due to risk related work with such service users largely falling to male staff or whether it was due to other circumstances such as the sampling method or gender differences within the teams. Furthermore, Robertson and Clegg's (2002) study was concerned only with men exhibiting sexually offensive behaviour and it would be extremely useful to explore if the issues raised by community staff would be similar to those around working with females with intellectual disabilities and for other offending behaviours. However, in spite of these weaknesses, the authors' conclusions were clear that 'unless services address the specialist skills and the modest costs of the 'effort' required, the more significant costs of compromised risk management of men with learning disabilities who sexually offend will continue to be met by the men themselves and by their victims' (p. 175).

2.4 Lack of a Standardised Measure

Although recent years have seen the beginnings of more constructive approaches to the assessment of offending behaviour by people with intellectual disabilities, little practical guidance is available in the literature. Clare and Murphy (1998) suggested that this is a reflection of the uncertainty which exists about whether the difficulties of offenders or alleged offenders can be best understood with reference to 'mainstream' forensic practice (i.e. non-intellectually disabled offenders) or to the literature on intellectual disabilities. Outside of the intellectual disabilities field, there is a considerable literature on the prediction of offending but very few studies have been published focusing specifically on the prediction of offending in people with intellectual disabilities (McMillan *et al.*, 2004; Tudway & Darmoody, 2005). Given that risk management requires the accurate prediction of risk (O'Rourke *et al.*, 1997), McMillan *et al.* (2004) stated that there was an urgent need for research to address the prediction of physical violence and offending by people with intellectual disabilities.

Moreover, frequent enquires are made to intellectual disability services about the availability of risk assessment measures for individuals in services (Lindsay & Beail, 2004). Indeed, Lindsay and Beail (2004) suggested that workers in the field clearly realise the need for such an assessment but are unaware of a relevant assessment tool. In fact, a number of researchers point out that there is no validated risk assessment tool for assessing risk in people with intellectual disabilities (Lindsay, 2002; Boer *et al.*, 2004; Lindsay & Beail, 2004). This shortfall has resulted in units and services for people with intellectual disabilities developing their own idiosyncratic risk assessment tools (Johnston, 2002; Lindsay & Beail, 2004). Unfortunately, this has led to difficulties in establishing what scores on such assessments mean in relation to non offending populations, other similar offenders, or indeed, other types of offender (Lindsay, 2002). In addition, the factors that are sometimes used in these

assessments may have no relevant evidence base so their predictive validity is unknown (Lindsay & Beail, 2004).

The lack of a standardised measure forces frontline staff to make independent risk assessment decisions about what an individual is permitted and not permitted to do (Harris & Tough, 2004). Furthermore, the difficulty with this is that each staff member who interacts with the client would have their own perception of risk, based upon their own unique experiences, their knowledge of the literature along with their depth of familiarity with the individual. Harris and Tough (2004) stated that this often leads to inequitable treatment of individuals, even within the same agency.

Lindsay and Beail (2004) asserted that where services employ idiosyncratic risk assessment tools, communication with other services is compromised. For example, on the basis of such a risk assessment a service may feel that it has a high percentage of clients posing a high risk while another service may feel that it has a moderate percentage of individuals presenting a high risk. As each conclusion may be based on a locally developed risk assessment tool, such comparisons may be meaningless and point to the serious implications for regional and national service planning and collaborative research across areas. In view of this, the authors call for further research in the area, stating that the need for this is 'pressing.'

2.5 Risk Assessment Measures Applied to People with Intellectual Disabilities

Harris and Tough (2004) raised the question that, if no reliable static actuarial measure exists specifically for the population of people with intellectual disabilities, should measures developed on offenders of normal intelligence be used with this client group? Furthermore, they asserted that 'there is no scientific reason to believe that static and stable factors that reliably predict risk for a normal offender will not reliably predict risk for offenders from the

intellectually disabled population' (p. 237). Subsequently, they reported on two risk assessment tools which they argued have 'practical utility' with sex offenders with intellectual disabilities.

2.5.1 The Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR)

Firstly, the Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR; Hanson, 1997 as cited in Harris & Tough, 2004) is a four-item actuarial scale that assigns offenders to one of six risk levels, each with associated risk estimates for sexual recidivism. Harris and Tough (2004) reported how this was used as a measure of static risk with 81 sex offenders with intellectual disabilities, supported in the community from York Central Hospital in Canada. A total of 28% of the sample was assessed as having a borderline intellectual disability, 40% a mild intellectual disability and 24% a moderate intellectual disability.

Harris and Tough (2004) drew on the Andrews and Bonta (2003) 'risk principle' in supporting the individuals within the community. According to this, the most effective use of treatment resources is targeted towards those truly high-risk offenders and lower levels of resources are applied to those offenders assessed as presenting with a lower risk. The greater the level of assessed risk, the higher the levels of supervision and intervention; the lower the level of assessed risk, the lower the levels of supervision and intervention needed. Moreover, Harris and Tough (2004) asserted that the research indicates that offenders may actually be made worse by the imposition of higher levels of treatment and supervision than is warranted given their level of risk.

By using an objective risk assessment tool such as the RRASOR, Harris and Tough (2004) reported that the service was able to focus its resources towards those individuals assessed as presenting with a higher level of risk, rather than presuming that all individuals presented with a high level of risk, therefore avoiding the need to direct the same level of

supervision and intervention towards all individuals. Moreover, the authors asserted that this process of objective and valid risk assessment allowed most clients to be considered for lower levels of supervision which was more adequately tailored to their individual needs.

Harris and Tough (2004) stated that 'most individuals' supported in the community were in the low and moderate risk categories and that although a score of up to six was possible on the RRASOR, nobody in the community sample scored above four. They asserted that as a consequence, resources were freed up for those individuals assessed as being at an elevated risk of reoffending, who were then able to access more targeted treatment and supervision, thus improving their chances of not reoffending.

Furthermore, Harris and Tough (2004) asserted that those individuals assessed as not being of high risk could usually remain in the community and undergo treatment while living with an appropriate amount of supervision. Rather than being subjected to 'house arrest' due to an overly cautious view of the level of risk posed, the authors stated that many of the individuals were able to live with the freedom allowed by their risk category as determined by the risk assessment tool. The authors stated that prior to the implementation of the static risk assessment; the staff had no valid or reliable means of identifying low-risk offenders from high risk offenders.

In spite of these potential advantages, the above study can be questioned in terms of categorising the level of risk posed by individuals by using a short four-item measure. In addition to this, the paper does not cite the evidence to support the RRASOR as a valid and reliable tool or detail the predictive accuracy of the measure. Indeed, Harris and Tough (2004) fail to include any information about recidivism rates so it is difficult to establish the use of the RRASOR in predicting those individuals deemed to be at an elevated risk of offending. Further, being an actuarial measure the RRASOR cannot take into account variables that change (Green *et al.*, 2003).

2.5.2 The STABLE-2000

The second risk assessment tool reported by Harris and Tough (2004) as being used with people with intellectual disabilities was The STABLE-2000 (Hanson & Harris, 2000 as cited in Harris & Tough, 2004) which was used to assess 16 areas of stable dynamic risk that have been empirically associated with the risk of sexual recidivism. In total 52 sex offenders with 'significant' intellectual disabilities who were supervised in the community were assessed using the STABLE-2000. Harris and Tough (2004) stated that individuals should be assessed every six months by appropriately trained parole and probation officers and further, that stable dynamic factors when changed through treatment should lead directly to a reduction in recidivism risk and therefore a reduction of risk to the community and reconviction of the individual.

Although the aforementioned authors argue that 'while not perfect, stable dynamic assessment remains the best option available at this time for the community supervision of all sexual offenders,'(p. 239) they fail to report on any specific data, including recidivism rates for individuals assessed using the STABLE-2000. This makes it difficult to test the theory that stable dynamic factors changed through treatment lead to a reduction in reoffending. In addition to this, no indication is given as to the range of intellectual disability level within the sample or further demographic details.

2.5.3 The Violence Risk Appraisal Guide (VRAG)

A further attempt to apply a risk assessment tool validated on offenders without intellectual disabilities to a population of offenders with intellectual disabilities was reported by Quinsey *et al.* (2004). Moreover, Quinsey *et al.* (2004) selected the Violence Risk Appraisal Guide (VRAG; Harris *et al.*, 1993 as cited in Quinsey *et al.*, 2004) as an actuarial measure due to it being 'currently among the most accurate predictors' of violent and sexual

offences in men within forensic psychiatric and prison settings in addition to providing a specific probability estimate of violent or sexual recidivism. The VRAG contains 12 items which include: lived with both biological parents to the age of 16; primary school maladjustment; history of alcohol problems; marital status; criminal history for non-violent offences; failure on prior conditional release; age at index offence; any female victims; meets DSM-IV criteria for personality disorder; meets DSM-IV criteria for schizophrenia; and Psychopathy checklist score.

Quinsey *et al.* (2004) asserted that the initial VRAG validation sample found it to be as accurate with offenders who had an intellectual disability as those who did not. Therefore, the authors asserted that it was surprising that there have been no previous studies of the VRAG predicting antisocial behaviours with intellectually impaired individuals outside the prison and forensic psychiatric services (Quinsey *et al.*, 2004).

Quinsey *et al.* (2004) carried out a 16-month follow-up of a sample of 58 men with intellectual disabilities and histories of serious antisocial behaviours who were about to be transferred to community settings, following the closure of a long-term institution. The histories of the antisocial behaviours in which the individuals had engaged varied widely in seriousness. Moreover, the most serious offence with which an individual had been charged was manslaughter and approximately 70% of the sample had documented incidents and/or arrests for various sexual offences.

Based on the VRAG, the probability of the individuals reoffending varied from less than 25% over a 10-year period (one client) to more than 80% (one client). Furthermore, the VRAG indicated that approximately half of the sample would be expected to commit a new or violent offence in a 10-year period. The individuals were judged to be unsuitable for unsupervised community access if they had (1) greater than an 80% probability of committing a new violent or sexual offence over a 10-year period or (2) if their likelihood of reoffending

was greater than 50%, alongside difficulties with non-compliance and pro-criminal attitudes or (3) if they had committed very serious and very recent offences. In accordance with these criteria, 19 individuals were denied unsupervised community access (Quinsey *et al.*, 2004).

Quinsey *et al.* (2004) asserted that generally their results indicated that the VRAG significantly predicted new violent or sexual behaviours in supervised settings in a sample of men with intellectual disabilities, although they described the overall predictive accuracy as ‘moderate,’ which they speculated may have been due to missing data. Moreover, a number of static predictors were found to be significantly related to whether individuals were involved in an incident of any type and these were as follows: Mood Problems, Inappropriate and Antisocial Behaviours, Dynamic Antisociality and Denies All Problems. Furthermore, the authors acknowledged the relatively small sample size and the comparatively short time frame. However, it may also be relevant that the men who were identified as posing a higher level of risk on the basis of the VRAG were subjected to increased levels of supervision than those assessed as presenting with a lower risk. In addition, ongoing management of risk and changes in level of supervision require monitoring of any changes in dynamic risk so as to proactively adjust supervision (Quinsey *et al.*, 2004) and the VRAG being a static measure cannot provide this.

2.5.4 Assessments of Dynamic Risk

Some studies have found that dynamic risk factors predict recidivism as well as historical static factors, especially in relation to non-sexual recidivism. Although this work has not been done specifically on offenders with intellectual disabilities, there is some preliminary evidence which indicates that it is equally relevant in this field (Lindsay *et al.*, 2004b). For example, Lindsay *et al.* (2004b) attempted to identify a number of predictive variables and correlate these with reoffending variables in a sample of people with intellectual

disabilities. The sample consisted of 52 sexual offenders who ranged in age from 18 to 64 years, with a mean IQ score of 64. In total, 10 participants were repeat offenders and a further 8 were 'strongly suspected' of reoffending. The authors then derived a checklist of 15 static and 35 dynamic factors from the literature as predictive variables of sexual offending. These were then coded by a Clinical Psychologist and Senior Nurse who both had comprehensive knowledge of each participant for the presence or absence of each variable. This information was then checked through the participants' extensive case records.

The analysis indicated variables which were similar to those found in the mainstream offender literature. Furthermore, that antisocial attitude, poor response to treatment, denial of offending behaviour, low self esteem and lack of assertiveness all emerged as variables predictive of future offending behaviour. Lindsay *et al.* (2004b) noted that these were all dynamic risk factors which were strongly associated with recidivism. In addition, poor response to treatment and unplanned discharge (due to suspicion of reoffending) were both found to be significant predictive variables, whereas Probation Orders of less than a year were not (Lindsay *et al.*, 2004b).

The findings of Lindsay *et al.* (2004b) seem to reinforce the usefulness of carrying out risk assessments per se and offer support to the evidence which suggests that certain dynamic factors can be indicative of future offending. Moreover, the study also highlights a number of risk factors found to be predictive of future offending within non-intellectually disabled populations which may transfer to people with intellectual disabilities who offend.

Lindsay *et al.* (2004b) reported that the only clear correlations found with static predictors were: poor relationship with mother; sexual abuse in childhood; and offences involving violence. However, offences involving children, tolerance of sexual crimes, lack of previous intimate relationships with women and age at first arrest all approached statistical significance. More interesting was that, a number of variables were *not* found to be

predictive: employment history, deviant victim choice, diverse sexual crimes, prior non-sexual offences, criminal lifestyle, criminal companions, social and emotional isolation and mental illness. Lindsay *et al.* (2004b) suggested that these findings warranted further investigation as variables such as 'deviant victim choice' are highly correlated within the mainstream offender population (Harris *et al.*, 2003) and men with intellectual disabilities have previously been found to have an increased tendency to offend against male children, younger children and across victim categories (Blanchard *et al.*, 1999 as cited in Lindsay *et al.*, 2004b).

Although offering a useful insight, the Lindsay *et al.* (2004b) study, can be criticised on a number of points. To begin with the findings may have been influenced by retrospective recall bias as both of the informants were aware of who had and had not reoffended. While the authors made attempts to address this by verifying the information through the case notes, a prospective study with anonymised clinical information or independent raters may produce more reliable results. In addition to this, the statistical method of multiple correlation may increase the likelihood of Type I errors and a subsequent over reliance on analysis of findings that can essentially be accounted for by chance (Lindsay *et al.*, 2004b). However, the authors acknowledge this and advise cautious interpretation of the findings. In addition to this, the inclusion of participants who were under 'suspicion of reoffending' is questionable and open to interpretation. Again the authors acknowledge this and argue that all participants were well known to the service, under regular review and were only deemed to be under 'suspicion of reoffending' when there was 'substantiated, reliable evidence that the participant had been seen in a high-risk situation.'

Finally, the sample in the Lindsay *et al.* (2004b) study was restricted to sexual offences perpetrated by male offenders and it would be extremely useful to explore these findings in relation to other violent offending and with the inclusion of females with intellectual disabilities. Notwithstanding these criticisms, the aforementioned study offers a useful

starting point, particularly in its attempt to avoid reliance on static historical factors and to incorporate dynamic variables in the assessment of risk, thus adopting a convergent approach to the assessment of risk.

2.5.5 Convergent Assessments of Risk

A convergent approach was advocated by Boer *et al.* (2004) as a method of providing a risk assessment whereby relevant actuarial and structured clinical instruments provided an overall 'risk picture' of the individual. Moreover, they asserted that offenders with intellectual disabilities should first be assessed using the RRASOR (Hanson, 1997) in order to calculate a 'risk baseline' and then assessed with reference to a standard set of dynamic risk factors. Furthermore, Boer *et al.* (2004) asserted that these dynamic risk factors should consist of both stable and acute variables and include 'staff and environmental' factors as well as 'offender factors.' Following this, the assessing clinician would determine which factors were most relevant for the individual and provide a risk assessment narrative based on those factors. Consequently, changes in risk manageability would be reflected by changes in dynamic factors, tempered by initial risk baseline (Boer *et al.*, 2004).

2.5.6 Summary

Harris and Tough (2004) concluded that, given the current lack of alternative tools normed on people with intellectual disabilities, it is reasonable to make use of risk assessments that have been validated on the general sex offender population. Furthermore, they asserted that with the advantages and disadvantages of this in mind, clinicians should ask themselves the question that if techniques in common usage within a normal population are not generalised, are potential benefits being denied to people with intellectual disabilities? They

argued further that it would not be helpful to adopt any tool or technique that does not offer specific benefits to individuals with intellectual disabilities.

In a systematic review of the literature on risk assessment, Johnston (2002) concluded that there was no research evidence as to whether: (1) forensic assessment tools are valid for the population with intellectual disability; (2) current risk assessment and management frameworks provide adequate information to predict future offending or to devise risk management plans; or (3) risk factors for the non-intellectually-disabled population are valid for the intellectually-disabled population. Furthermore, Johnston (2002) insisted that before any such instruments are adopted, more research needs to be undertaken to validate their use with this client group and in the UK context.

3. Discussion

The current review has highlighted the impact of deinstitutionalisation on services for and research on people with intellectual disabilities who exhibit offending behaviour. Moreover, how responsibility for assessing and managing the risk presented by this client group is increasingly falling to community services. However, the literature also suggests that these services are often variable and that there is a distinct lack of adequate guidance and research-based evidence on how best to meet the needs of this client group whilst minimising the risk of harm to others.

The scant literature which has addressed these issues has pointed to services lacking in a number of areas including, providing staff with relevant training, cooperation and coordination with other agencies and implementation of effective procedures (Turner, 2000). Furthermore, Robertson and Clegg's (2002) paper highlighted a lack of support from line management, pressures on time, unclear filing systems and lack of supervision and guidance

as some barriers faced by community staff in gathering information and developing confidence in risk assessments of people with intellectual disabilities.

In spite of this, the literature particularly from mainstream offending populations has demonstrated that certain factors can be reliable indicators of future reoffending (for example, Green *et al.*, 2003; Harris *et al.*, 1991; May, 1999; Rice & Harris, 1992) which reinforces the importance of risk assessment. Moreover, non-intellectually disabled offenders are routinely assessed with a wide range of risk assessment tools, a practice which Harris and Tough (2004) argued should be ‘a matter of course,’ although the research base in relation to people with intellectual disabilities who offend has not developed apace with that of mainstream forensic populations. Indeed, numerous risk assessment measures have been extensively researched and validated on prison populations but only a negligible amount of this work has been applied to offenders with intellectual disabilities and no specific tool exists which have been validated on this population (Lindsay & Beail, 2004).

Further, the current review has highlighted how this important gap in the evidence base has led to services developing their own idiosyncratic risk assessment tools for use with people with intellectual disabilities (Johnston, 2002; Lindsay & Beail, 2004), a practice which is fraught with difficulties and as outlined earlier, has far reaching implications for individuals and services alike; making generalisations impossible and conclusions difficult to reach.

The present review has made reference to a small number of examples within the literature where risk assessment measures, standardised on people without intellectual disabilities have been found to have practical utility for offenders with intellectual disabilities (e.g. Harris & Tough, 2004; Quinsey *et al.*, 2004; Lindsay *et al.*, 2004b; Boer *et al.*, 2004). Whilst this work is long overdue and extremely encouraging, there is an urgent and pressing need for further research in the area (Johnston, 2002; Lindsay & Beail, 2004). In addition, as the research on dynamic risk factors is far less sophisticated than that on actuarial or static

factors and even more so within the intellectual disability population, so ongoing research is vital. As asserted by Quinsey *et al.* (2004) 'little research has been done to identify dynamic indicators of changing risk in any at-risk population, even though such indicators would assist clinicians in the day-to-day management of clients whom they supervise' (p. 243).

In conclusion, there remains much to be done in order to build on the knowledge base in relation to this small but highly complex group of individuals (Johnston, 2002). Moreover, the suggestion within the literature that risk assessment in relation to people with intellectual disabilities who offend is to some extent arbitrary, has huge implications for human rights. Indeed, there is a reasonable expectation that arrangements which deprive people of their liberty should be based on sound objective evidence (Green *et al.*, 2003), although the current review of the literature has demonstrated that worryingly, this does not always seem to be the case.

Finally, as asserted by Harris and Tough (2004), not adequately completing risk assessments with people with intellectual disabilities who offend can be deemed as ethically unsound and may even be indicative of a societal attitude that this group of people do not deserve a service or that all are high risk offenders. Furthermore, the authors' point out that in all other areas of service delivery, we strive to enhance and support the individual. People with intellectual disabilities who exhibit offending behaviours, therefore deserve no less, particularly if they are to be better understood and not continually marginalised and excluded in our society.

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SECTION 2

RESEARCH REPORT (Option A)

**Assessing Risk in a Community Intellectual Disability Sample.
The Clinical Utility of the Dynamic Risk Assessment and Management System
(DRAMS): A Study of Clinician Evaluations.**

ABSTRACT

Objectives

To evaluate the face validity of the Dynamic Risk Assessment and Management System (DRAMS) in assessing risk in an intellectual disability sample. The study aimed to investigate clinicians' experiences of using the DRAMS in comparison with the Functional Analysis of Care Environment Risk Profile (FACE). The focus of the study was therefore to examine the usability of the measures rather than the predictive accuracy.

Design

A randomised cross-over design compared clinicians' experiences of carrying out the DRAMS with their experiences of carrying out the FACE Risk Profile for the same participants.

Method

In total, four clinicians were recruited to carry out the DRAMS and FACE Risk Profile on eight offenders with intellectual disabilities who lived in the community. A method of randomisation was used to assign the eight participants to two conditions: one group received the DRAMS followed by the FACE and the other group received the FACE followed by the DRAMS. Clinicians were then interviewed about their experiences of using each risk assessment tool and their responses recorded on Clinician Feedback Questionnaires. Statistical and qualitative analysis were performed on the data provided by these responses.

Results

A significant difference was found between scores on the Clinician Feedback Questionnaires, indicating that the DRAMS was favoured by the clinicians in terms of clinical utility and usability with intellectually impaired offenders. No significant order effect was found. A thematic analysis of clinician experiences in administering the two measures supported these findings. A significant strong correlation was found between the IQ of the offenders and the difference in scores on the Clinician Feedback Questionnaires, indicating that the higher the IQ, the more clinically useful the clinicians reported the DRAMS to be. In addition, verbal IQ of the offenders was found to be more highly correlated with the difference in scores on the Clinician Feedback Questionnaires than performance IQ, indicating that the clinicians found the DRAMS to be more useful with those offenders with a higher verbal IQ.

Conclusions

Although the findings reported here offer some favourable support for the DRAMS in terms of clinical utility, further investigation is needed. Indeed, the discovery that the DRAMS may not be useful with individuals who are less intellectually able has important implications. Several further implications are discussed and consideration is given to future research areas.

1. Introduction

The accurate prediction of violent or harmful incidents remains a complex and somewhat elusive concept and one which relies on the ability of mental health professionals to integrate clinical judgements of risk alongside standardised risk assessment instruments (Serin, 1995). Indeed, considerable progress has been made in the assessment of risk in forensic psychiatric and prison populations in recent years (Quinsey *et al.*, 2004).

The historical progression of risk assessment was described by Bonta (1996), starting with the ‘first generation’ of risk assessment, usually described as ‘clinical judgement.’ This is a subjective process based upon practical clinical experience and theory. The ‘second generation’ of risk assessment is concerned with the assignment of either points or a weighted score to factors that have been shown in the literature to predict future offending behaviour, creating a scale or metric of risk. These metrics are then compared with follow-up recidivism data to determine a valid and reliable measure of risk. This approach is often referred to as ‘actuarial assessment’ and includes risk factors such as offender’s age and number of past offences (Harris & Tough, 2004).

The ‘third generation’ of risk assessments incorporate dynamic factors, which are also variables found to be linked to recidivism but unlike the actuarial factors described above which are static, dynamic variables can be seen to change over time. Dynamic factors can be divided into stable factors, which have the potential for changing but typically endure for long periods of time, such as alcohol misuse or deviant sexual interests; and acute factors, which are rapidly changing states such as drunkenness (Green *et al.*, 2003).

Risk assessment tools have now reached such a level of precision that Harris and Tough (2004) argued that they should be used as a matter of course. Indeed, Andrews and Bonta (2003) stated that the routine use of such tools allows services to determine the level of risk each individual presents and to implement treatment and supervision plans accordingly.

However, whilst considerable progress has been made in the assessment of risk in psychiatric and prison populations, little of this work has been specifically applied to individuals with intellectual disabilities (Quinsey *et al.*, 2004). Indeed, there is no such risk assessment tool standardised on people with intellectual disabilities (Boer *et al.*, 2004; Lindsay & Beail 2004).

Harris and Tough (2004) warned that where actuarial measures, standardised on non-intellectual disabled populations have been applied to people with intellectual disabilities, this has often resulted in the unethical and possibly illegal implementation of behavioural and environmental restrictions that compromise the individual's quality of life and freedom. Furthermore, they asserted that although this has often been done with the intention of protecting the public, due to the static nature of actuarial measures, it is assumed that the level of risk is fixed and non-changeable. This insensitivity means that such measures cannot be used to assess changes in risk over time or indeed, to gauge the efficacy of treatment programmes.

The so-called 'third generation' of risk assessment tools have attempted to overcome this limitation through the inclusion of dynamic factors. However, although increasing, the research on dynamic risk factors is nowhere near the level of sophistication of the research on actuarial risk factors (Hanson & Harris, 2000) and there have been no formal attempts to conduct this work on people with intellectual disabilities (Lindsay, Murphy, Smith, Murphy, Edwards, Chittock, Grieve & Young, 2004a).

2. Dynamic Risk Assessment

A framework for considering dynamic variables in sex offenders was described originally by Thornton (2002) and later elaborated upon by Lindsay *et al.* (2004a) to include other types of offending behaviour. Originally, Thornton (2002) outlined 4 domains of dynamic variables: socio-affective functioning, distorted attitudes, self management and

sexual interests. Lindsay *et al.* (2004a) argued however, that the first 3 domains were not just relevant to sexual offending but also related to general offending.

2.1 Socio-Affective Functioning

The domain of socio-affective functioning refers to the way in which the individual being assessed relates to other people. As asserted by Hanson and Harris (2000), prior to aggressive incidents, negative affect such as anger sharply increases in sex offenders. In addition, Pithers *et al.* (1988) found that anxiety, depression and low self-esteem were significant features prior to incidents of sexual aggression. In support of this, a number of studies on sexual offending have reported low self-esteem and loneliness to be features present prior to incidents of inappropriate or violent sexual behaviour (Beech *et al.*, 2002; Garlick *et al.*, 1996). Although much of this evidence relates to sexual offenders, Lindsay *et al.* (2004a) argued that this ‘certainly has relevance for all other types of clients’ (p. 268).

2.2 Distorted Attitudes and Beliefs

The second domain outlined by Thornton (2002) refers to distorted attitudes and beliefs. Whilst much consideration has been given to the role of these cognitive distortions within the literature on sexual offending (Ward *et al.*, 1997; Ward, Keenan & Hudson, 2000), the importance of these attitudes has also been recognised in work on fire-setting and anger with people with intellectual disabilities (Lindsay *et al.*, 2004a).

2.3 Self Management

Thornton’s (2002) third domain of self-management relates to an individual’s ability to regulate their own behaviour. Lindsay *et al.* (2004a) asserted that this includes engagement in appropriate problem solving and impulse control work. Difficulties in self-

management have frequently been highlighted as the focus of effective treatment interventions in individuals with intellectual disabilities (Haddock *et al.*, 2004; Sturmey 2004; Taylor *et al.*, 2004). Further, general coping ability can improve over time and improved self-efficacy can help to increase risk manageability (Haaven & Coleman, 2000).

2.4 Sexual Interests

Lindsay *et al.* (2004a) broadened Thornton's fourth domain of sexual interests to include other types of offending in addition to sexual offending. The original domain consisted of sexual preference and sexual drive. However, Lindsay *et al.* (2004a) argued that it was possible to consider inappropriate interest /drive as a relevant stable dynamic risk factor in relation to other types of offending such as fire setting and anger.

3. **The Need for a Specialist Tool**

Although research is now beginning to consider the application of dynamic risk factors to people with intellectual disabilities, progress thus far has resulted in the identification of a number of stable and acute factors which have found to be predictive of offending behaviour. What is lacking is the progression of these factors into a standardised measure, which provides a meaningful score and takes into consideration the contribution of the individual being assessed. Moreover, some measures available currently are designed to be carried out in respect of the individual offender but do not always include their thoughts and opinions, although the Sex Offender Assessment Pack (SOAP, as cited by Fisher & Mair, 1998) and the evaluation of treatment programme (Beech, Fisher & Beckett, 1999) are exceptions to this assertion.

As asserted by Clare and Murphy (1998) it is clear that, when interviewed properly, people with intellectual disabilities are perfectly well able to provide information about themselves and their experiences, thoughts and feelings.

Clare and Murphy (1998) however, asserted that self-report measures relating to specific offences developed for use with 'mainstream' forensic populations are with few exceptions, unsuitable for people with intellectual disabilities for the following reasons: (1) such measures usually require reading skills beyond those of the individual and if read out, place very high demands on verbal memory which is often poorer in people with intellectual disabilities than in the general population (Clare & Gudjonsson, 1993); (2) such measures often use long sentences, unusual words or abstract concepts, complex rating scales and refer to experiences which are unlikely to be familiar to people with intellectual disabilities' (3) although there may be instances where the use of 'mainstream' risk assessment measures is justified, there are rarely norms for people with intellectual disabilities (Clare & Murphy, 1998).

3.1 The Dynamic Risk Assessment and Management System (DRAMS)

It was in response to dilemmas such as those outlined above by Clare and Murphy (1998) that members of staff from The State Hospital in Scotland recently developed the Dynamic Risk Assessment and Management System (DRAMS; Lindsey *et al.*, 2004a; see Appendix C), a dynamic risk assessment measure specifically designed for people with intellectual disabilities. Crucially, the DRAMS was developed so that it was easily understood and could be used collaboratively with clients with intellectual disabilities. Lindsay *et al.* (2004a) reported the first published attempt of its kind to apply a measure of dynamic risk to people with intellectual disabilities.

Murphy, Cox & Murphy (2005) described how the DRAMS was developed in response to a clinical problem faced by the clinical team within the intellectual disabilities unit at The State Hospital, Scotland. Moreover, while developing and implementing positive behavioural programmes with patients with intellectual disabilities, it was found that acute dynamic risk situations often arose, sometimes resulting in serious incidents which made it difficult to maintain the positive programme. Murphy *et al.* (2005) asserted that rather than introducing consequences that would prevent individuals from accessing positive outcomes, the implementation of a parallel dynamic risk assessment would allow the positive programme to be temporarily suspended until such time that the level of dynamic risk had reduced sufficiently.

It was anticipated that collaborative use of the DRAMS would allow individuals to retain the rewards they had gained thus far, but would prevent them accessing or achieving further rewards until it was deemed safe for them to do so. Moreover, access to activities, outings and other positive reward systems may place the individual in a situation which increases their dynamic risk (Lindsay *et al.*, 2004a).

In their recent paper, Murphy *et al.* (2005) described how consideration was given to developing a sufficiently straightforward system, which could be used collaboratively with patients to explain why their programme had been suspended. Furthermore, it was envisaged that such a system may assist individuals in understanding why certain procedures were being followed and particular decisions made, in addition to encouraging them to reflect on their own behaviour and through support, reflect on their current level of risk. Murphy *et al.* (2005) stated that when used in this way, the DRAMS would serve as a method of positive feedback as dynamic risk levels decreased.

3.2 The field trial

The DRAMS was initially piloted in a field trial and was reported by Lindsay *et al.* (2004a). For the purpose of this study, the DRAMS was administered to patients with intellectual disabilities, detained within the high secure setting of The State Hospital. The DRAMS was administered to ten individuals for reliability purposes and five individuals were assessed consistently over a 3-month period. The participants had committed a variety of offences from persistent serious assaults to sexual offences against children.

The DRAMS data was taken from the day of an incident, the day prior to an incident and a control day, chosen because it was at least 7 days before or after any recorded incident. Lindsay *et al.* (2004a) asserted that that this design was adopted following a similar methodology employed by Quinsey *et al.* (1997) who collected data from three points. Quinsey *et al.* (1997) reasoned that data taken during the month of re-offence would be contaminated by the knowledge that the individual had re-offended, whereas this would not be the case for data collected in the month prior to the offence and 6 months prior to the re-offence. Indeed, Quinsey *et al.* (1997) discovered that reporting of dynamic risk factors was higher during the month of the re-offence and significantly higher in the month prior to the re-offence when compared with data 6 months before the re-offence. The authors concluded that this provided persuasive evidence of the value of dynamic risk assessment as the increase in dynamic risk factors 1 month prior to the offence could not be attributed to any bias in response to an offence occurring.

In order to investigate the reliability of the DRAMS, 45 assessments were completed by two independent raters and 200 assessments were reviewed for their predictive value. An independent system, the Major Incident Data Analysis System (MIDAS) which is used to record incidents within an institutional setting was used to gain data about each

incident once the study period was over. This was to ensure that incident reporting was independent as possible from the DRAMS assessment (Lindsay *et al.*, 2004a).

The results of the field trial of the DRAMS were reported by Lindsay *et al.* (2004a) as 'somewhat mixed but generally promising' (p. 272). The reliability data gathered across 12 individuals (3 later withdrew consent) was found to be high for five items of dynamic risk: mood; psychotic symptoms; self-regulation; compliance with routine and total score; moderate for two items: antisocial behaviour; and attitudinal/thinking problems); and for three items was not considered relevant because of lack of access e.g. substance abuse, victim access and renewal of emotional relationships. However, the final item, therapeutic alliance was found to have extremely poor reliability. This may have been due to the individual items which made up the therapeutic alliance category being too disparate. For example, 'complaining about staff' and 'blaming others' may be more closely related to other categories such as 'compliance with routine' and 'antisocial behaviour,' rather than therapeutic alliance Lindsay *et al.*, 2004a).

Lindsay *et al.* (2004a) asserted that as seven of the items had good or acceptable reliability, the DRAMS was 'at least worthy of further exploration' (p. 272). Moreover, the authors asserted that as no specific training was given to the raters, the high reliability results were 'correspondingly gratifying' (p. 272) in view of the DRAMS being intended for general clinical use.

Whilst the DRAMS had been developed to help co-ordinate management and therapeutic programmes in residential settings, Lindsay *et al.* (2004a) asserted that there was 'no expectation that dynamic risk assessment should be confined to these settings' (p. 272). Thus, this provided the rationale for the current study: to attempt to investigate the clinical utility of the DRAMS within a community setting. Furthermore, Lindsay *et al.* (2004a) suggested that the DRAMS may also be used with people without intellectual disabilities.

Therefore, a further aim of the current study was to investigate if an individual's IQ had any effect on how useful the clinicians' deemed the DRAMS to be.

The current study proposed to investigate the usefulness of the DRAMS in identifying risk in a sample of people with intellectual disabilities receiving services from an Adult Community Intellectual Disability Service. It was anticipated that the clinical efficacy (rather than the predictive accuracy) of the DRAMS could be compared with the risk assessment tool currently being used by the service where the current study is to be conducted (The Functional Analysis of Care Environments- FACE; see Appendix D).

As the DRAMS has been specifically developed for people with intellectual disabilities and is designed to be used collaboratively, it is envisaged that it will be a more clinically useful tool for this client group than the risk assessment tool currently in use within the service. Moreover, collaboration is an important facet in risk assessment; as asserted by Murphy *et al.* (2005) a collaborative relationship between clinician and client can (1) encourage individuals to consider their own behaviour; (2) allow reflection on their current level of risk; (3) allow positive feedback as dynamic risk levels decrease; (4) help to explain why programmes are suspended; (5) assist the client in understanding why certain procedures are being followed and decisions made; and (6) allow time for clients to discuss issues and consider alternatives to their usual reactions or inaction.

The current study is novel in that it will be the first known attempt to use the DRAMS as a risk assessment tool with a sample of people with intellectual disabilities living in the community. Indeed, much of the literature on risk assessment *per se* is based on captive populations and there is a pressing need to extend the evidence base in this area.

3.3 Research Aims

The aims of the current investigation were to investigate the clinical utility and usability of the Dynamic Risk Assessment and Management System (DRAMS) as a measure of risk within a community sample of offenders with intellectual disabilities. Furthermore, the current study aimed to explore the experiences of staff members in using the DRAMS in relation to their experiences of using the FACE Risk Profile to assess risk in this client group².

3.4 Hypotheses

It is hypothesised that clinicians will find the DRAMS to be a more clinically useful tool and will score it more highly than the FACE Risk Profile on 5-point scaled Clinician Feedback Questionnaires. In addition, it is further hypothesised that the higher a client's IQ score, the more useful the clinicians will deem the DRAMS to be, indicated by higher scores on the Clinician Feedback Questionnaires.

² It was not an aim of the current study to assess the predictive accuracy of either the DRAMS or FACE Risk Profile.

4 Method

4.1 Rationale

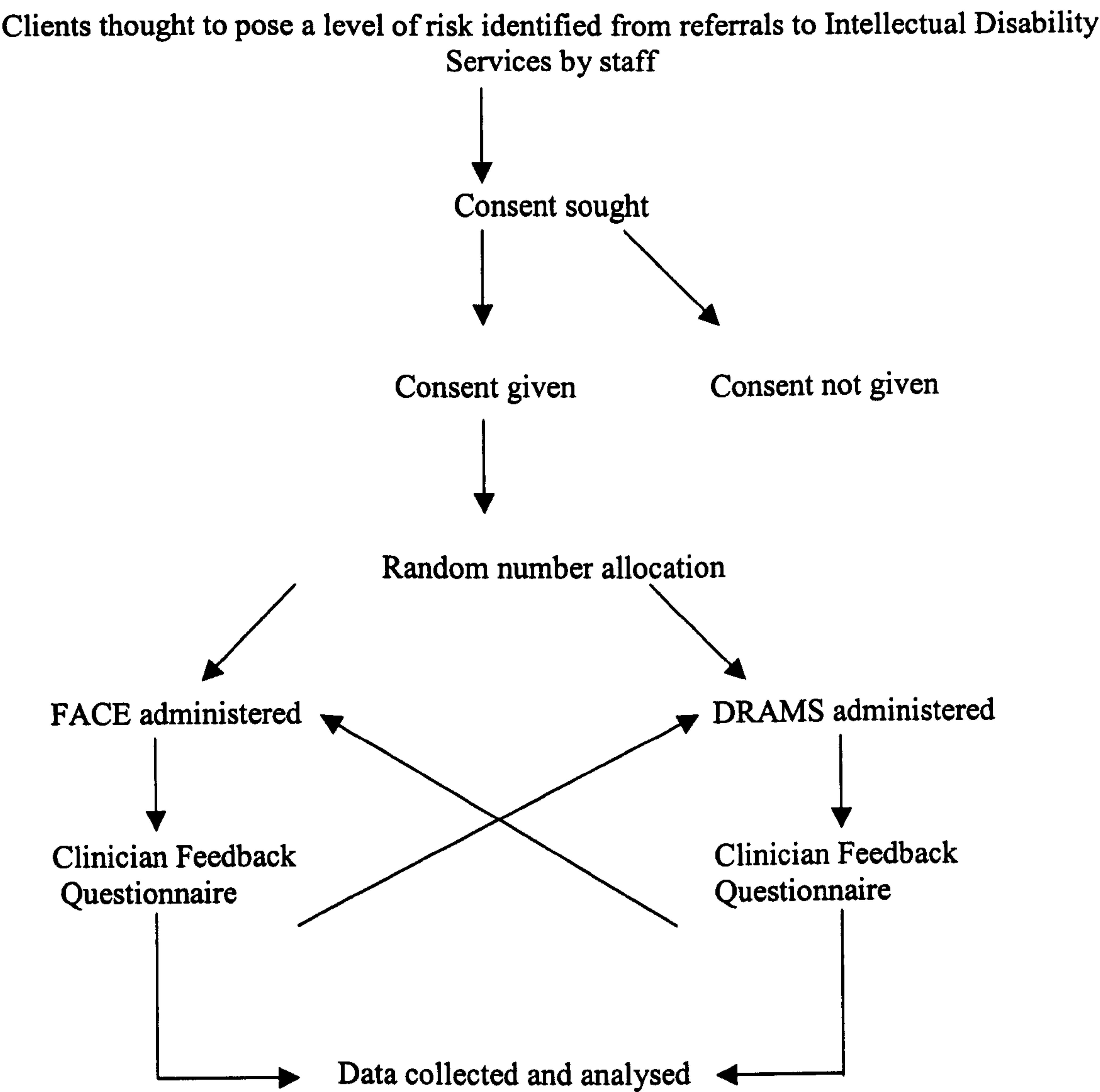
A combination of quantitative and qualitative methods were chosen for the design of this study in order to answer questions regarding the clinical utility of the DRAMS as a risk assessment tool for people with intellectual disabilities living within the community. Using a qualitative approach in conjunction with a quantitative approach can enrich researchers' understandings of findings obtained through traditional research, in addition to producing new material that experimental methods may miss (Foster & Parker, 1995).

The aim of the current study was to investigate clinical utility of the DRAMS as a measure of risk within a community sample of offenders with intellectual disabilities and to explore the experiences of staff members in using the DRAMS in relation to their experiences of using the FACE Risk Profile to assess risk in this client group. It was not an aim of the current study to compare the predictive accuracy of the two measures.

4.2 Design

A randomised cross-over design was adopted for the current study. This type of design is used when participants are given sequences of treatments with the object of studying effects and differences between the treatments (Senn, 1993). In the current study, all clients were subjected to the DRAMS and FACE Risk profile. However, the order in which these tools were administered was subject to a random number allocation. Clinicians' experiences of administering the measures were then compared and explored. A summary of the design is shown below in Figure 1.

Figure 1. Design of the Study.



4.3 Participants

4.3.1 Clients

In total, 12 people with intellectual disabilities were sampled to take part in the study. These were recruited by approaching staff working within the local Adult Community Intellectual Disability Service provided through Statutory Health and Social Services in the United Kingdom. In total, 1 client did not give consent, 1 client was deemed to be unsuitable

for inclusion and 2 were unable to be assessed within the time constraints of the current study. As a result, 8 clients in total were recruited to take part in the study. They were eligible for inclusion in the current study if they had been referred to the service for a risk assessment or if the referral indicated a level of risk to others (physical or sexual). No explicit exclusion criteria were used (see Appendix E for the demographic characteristics of the 8 clients recruited for the current study).

4.3.2 Power Calculation and Sample Size

Statistical power analysis exploits the relationships among the four variables involved in statistical inference: sample size (n), significance criterion (α), population effect size (ES), and statistical power. For any statistical model, these relationships are such that each is a function of the other three. For research planning, it is most useful to determine the n necessary to have a specified power for a given α , and ES (Cohen, 1992).

In the current study a priori power analysis was conducted prior to determine an appropriate sample size to achieve adequate power. In order to do this however, variability of scores on the measure in question is usually required. As the Clinician Feedback Questionnaires were developed by the Principal Investigator and had not been used before, variance of scores was not known. In such cases, this value is often found from pilot studies, previous research or a rule of thumb calculation (Cohen, 1988).

In the absence of previous similar research on which to base estimates of significance level (α), effect size (ES) and appropriate level of power i.e. the probability of detecting a result if the effect exists, sample size can be determined by convention (Cohen, 1988). Using Cohen (1988) figures, i.e. power = .80, large effect size = 0.8, with a t -test, it was calculated that a sample size of 26 participants was required (Erdfelder, Faul & Buchner, 2006).

In spite of the power calculation, only 8 clients were recruited to take part in the study. Difficulties however, in recruiting research participants with intellectual disabilities is well documented within the literature (Department of Health, 2005; Williams, 2003) alongside the implications of this on statistical power and generalisation (Oliver *et al.*, 2002; Willner, 2005).

4.3.3 Staff

Initially, 6 staff members were recruited from 2 Adult Community Intellectual Disability Services to take part in the current study. However, only 4 of these were included in the final sample due to 2 staff members’ difficulties in recruiting clients. Staff were eligible for inclusion in the current study if they had received a referral for a client requesting a risk assessment or if the referral indicated that the client may have posed a level of risk to others (physical or sexual). No explicit exclusion criteria were used. Table 1 below shows the demographic characteristics of the 4 staff members recruited for the current study.

Table 1. Profession, gender and number of years experience working with people with intellectual disabilities for each staff member.

| Staff Member | Profession | Gender | No. years experience in ID |
|--------------|----------------------------------|--------|----------------------------|
| 1 | Assistant Psychologist | Female | 2 years |
| 2 | Trainee Clinical Psychologist | Female | 2.5 years |
| 3 | Consultant Clinical Psychologist | Female | 25 years |
| 4 | Consultant Clinical Psychologist | Female | 26 years |

The participating staff members had varied experience of forensic and structured risk assessment between them. Both Consultant Clinical Psychologists had undergone training in using structured risk assessment measures and all staff members had received specific training in administering the DRAMS and the FACE Risk Profile. As Consultant Clinical

Psychologists, the 2 staff members had 25 and 26 years respectively of clinical experience, including the carrying out of risk assessments with people with intellectual disabilities. In particular, 1 of these staff members had worked within a service specialising in offenders with intellectual disabilities. The experience of the Assistant and Trainee Clinical Psychologists in carrying out risk assessments was more limited. Both however, were supervised closely by Consultant Clinical Psychologists, experienced in the area.

4.4 Measures

4.4.1 The Dynamic Risk Assessment and Management System (DRAMS)

The DRAMS (Lindsay *et al.*, 2004) is a 31-item measure incorporating a number of variables suggested in the literature to be dynamic predictors of risk (Murphy *et al.*, 2005).

These factors are as follows:

- i. **Mood:** inappropriate anger, anxiety, mania and sadness.
- ii. **Antisocial behaviour:** verbal threats, non-verbal threats, violence to self, violence to others, violence to property, sexually inappropriate behaviour, lack of consideration for others, and winding others up.
- iii. **Thoughts:** aberrant sexual thoughts, suspicious thoughts, and criminal thoughts.
- iv. **Psychotic symptoms**
- v. **Self-regulation:** impulsiveness and sexual impulsiveness.
- vi. **Therapeutic alliance:** complaining about staff, blaming others, refusing to engage in therapy and refusing medication.
- vii. **Substance abuse:** alcohol abuse, and drug/solvent abuse.
- viii. **Compliance with routine:** looking after room, looking after self, and daily routine.
- ix. **Recent renewal of emotional relationships**
- x. **Opportunity for victim access**

Each of the above items have been arranged along a continuum from no problem to severe problem and worded to facilitate the understanding of individuals with intellectual disabilities. A traffic light analogy has been adopted in place of a standard Likert scale, with green traffic lights covering the least two problematic categories, an amber traffic light covering the intermediate category and a red traffic light for the categories associated with the greatest risk. The use of smiley, neutral and sad faces have been used alongside the corresponding traffic lights to promote the tool's usability and aid the individual's understanding and collaboration (Murphy *et al.*, 2005).

Continuing the Highway Code metaphor, stop signs have been included on a number of items on the DRAMS which relate to violence to others, drug and solvent abuse and excessive opportunities for victim access. Murphy *et al.* (2005) asserted that in these cases, once the individual had moved back into the less risky categories, they may still not be granted access to their daily routines until the staff group were satisfied that the level of risk has indeed reduced to acceptable and manageable levels. The DRAMS can be scored by item, by category and as a total score but the authors emphasised that it had been developed as a collaborative tool and was best used with individual clients.

4.4.2 The Functional Analysis of Care Environments (FACE) Risk Profile

The FACE Risk Profile (Recording & Management Systems, 2000-3) is a risk assessment and risk management tool that has been designed for use by mental health and learning disability services. It incorporates a number of static and dynamic risk factors including the following:

- i. Clinical symptoms indicative of risk.
- ii. Behaviours indicative of risk.
- iii. Treatment-related indicators.

- iv. Forensic history.
- v. Personal circumstances indicatives of risk.
- vi. Persons potentially at risk.
- vii. Service user's view of risk.
- viii. Protective factors.
- ix. Relapse and risk management plan.

The FACE Risk profile has been developed to provide: (1) a format to guide the practitioner through the process of assessing and deciding what action is necessary to reduce risk; (2) a convenient way of summarising and collating key information that is also easily accessible; (3) a structured method of reminding professionals of areas that should be covered when screening for risk; (4) a means of recording that basic screening for risk has been carried out; (5) a means of recording risk management plans; and (6) a format that is used and understood by all agencies involved in mental health service provision.

The guidance for carrying out the FACE Risk Profile as issued by the Trust where the current study was conducted advised that risk should be considered in all of the following situations and further, that the FACE Risk Profile should be completed or amended if this is necessary:

- i. As soon as is practical after initial assessment of new clients to the mental health services, including mental health liaison and crisis services.
- ii. At every Care Programme Approach (CPA) review.
- iii. Following admission to hospital or residential provision.
- iv. Prior to discharge from hospital.
- v. Prior to the granting of leave from an inpatient area, for informal patients and for patients leave under section 17 of the Mental Health Act (1983).

- vi. Prior to transfer of service users to other areas or agencies.
- vii. Following any major incident or change of circumstances.
- viii. Following non-compliance with medication/treatment.
- ix. When serious concerns are raised by carers, family members or other agencies.

The Trust guidance asserted that the FACE Risk Profile has been designed to be part of the risk management process and as such, may not meet the needs of a comprehensive assessment of risk in a specialist clinical area. Furthermore, that practitioners should supplement the FACE Risk Profile with other evidence based assessment tools that conform to the Trust's Clinical Risk Management Standards.

In the Adult Community Intellectual Disability Service where the current study was carried out, a FACE Risk Profile was completed for all clients at the point of initial contact. For the majority of cases this would not be carried out in the presence of the client, but rather with another professional or with reference to the case notes.

4.4.3 The Clinician Feedback Questionnaires

The Clinician Feedback Questionnaires were designed by the Principal Investigator to investigate the experience of the clinicians in using the DRAMS and the FACE Risk Profile with offenders with intellectual disabilities. The aim of these questionnaires was to allow a direct comparison between the clinicians' experiences of using both measures with the same client. The questionnaires were the same for each measure (FACE & DRAMS) and consisted of 10-items, 6 of which were based on a 5-point Likert scale, 1 item which was forced choice and 2 open-ended questions. The clinicians had the option of adding comments to each of their answers if they wished to elaborate further, thus providing quantitative and qualitative

data about their experiences of administering the FACE Risk Profile and the DRAMS. The items on the Clinician Feedback Questionnaires covered the following areas:

- i. Extent to which the measure informed the treatment plan.
- ii. The relevance of the measure to the risk assessment.
- iii. The clinicians' ability to predict risk following administration.
- iv. The clinicians' confidence in the level of risk predicted.
- v. Ease of use.
- vi. Amount of time taken to complete.
- vii. Usefulness of measure with client.
- viii. Main advantages of measure.
- ix. Main disadvantages of measure.
- x. Further comments relating to the measure.

Questions containing the 5-point Likert scale on the Clinician Feedback Questionnaires were calculated and scored. The higher the scores, the more useful the clinicians' deemed the measure, either FACE or DRAMS to be³. These scores were subjected to statistical analysis.

4.5 Procedure

Ethical approval to carry out the current study was obtained through the Local Research Ethics Committee (see Appendix F). Permission was also obtained through the local Trust's Research and Development Department (see Appendix G). As part of this process, the research proposal and ethics application were peer reviewed by a member of the University's academic staff.

³Differences on the Clinician Feedback Questionnaires were subject to statistical analysis, not the client's scores on the DRAMS and/or FACE Risk Profile.

Staff working within the Adult Community Intellectual Disability Team were approached by the Principal Investigator and asked to identify potential clients from referrals received either specifically for a risk assessment or where a referral indicated a potential for risk (e.g. a referral for anger management). Where a client was identified as meeting the inclusion criteria, the current study was explained to them by their allocated worker at their arranged assessment appointment, in a language appropriate to their level of intellectual disability and with reference to the Participant Information Sheet (see Appendix H)

Each client was then given at least a week to consider if they wanted to take part in the current study. During this time they were encouraged to discuss participation with their family, friends or another professional. If after a week the client agreed to take part in the study and the clinician was sure that informed consent had been given written consent was obtained (see Appendix I).

Clients were then assigned to one of two groups using a ⁴computer generated random number programme. The FACE Risk Profile was completed first with those participants obtaining an even number and the DRAMS was carried out first with those clients assigned an odd number. Within a day of each risk assessment being carried out, the Principal Investigator carried out a semi-structured interview either face to face or over the telephone with the staff member about their experiences of using the tool with that particular client. This interview was based on the questions contained within the Clinician Feedback Questionnaire (see Appendix J).

The second risk assessment tool was carried out with the same client during their next appointment, which was usually within a week of the initial risk assessment being carried out. Once this had been done, the member of staff was interviewed again about their

⁴geographyfieldwork.com/random_number_table.htm_9k

experiences of using the second risk assessment tool with that specific client, using the Clinician Feedback Questionnaire.

The clinicians' responses on the Clinician Feedback Questionnaires provided quantitative and qualitative about their experiences of administering the DRAMS and the FACE Risk Profile with the same client and formed the basis of the statistical analyses.

4.6 Data Collection

Once a client had given consent to take part in the study, the clinician who had obtained the consent contacted the Principal Investigator and was given a client number. This number was then used, in place of the client's name on the FACE Risk Profile, The DRAMS and the Clinician Feedback Questionnaires. In addition to this, each participating clinician was also allocated a number in order that the number of assessments carried out by each of them could be recorded.

In addition to clinicians' scores on the Clinician Feedback Questionnaires, basic demographic information was obtained from each clinician including their gender, profession, and number of years experience working with people with intellectual disabilities. Demographic information regarding the clients was also obtained from the clinicians and this included gender, age, verbal IQ score, performance IQ score, full scale IQ score (if available) and details of their offence or offending behaviour.

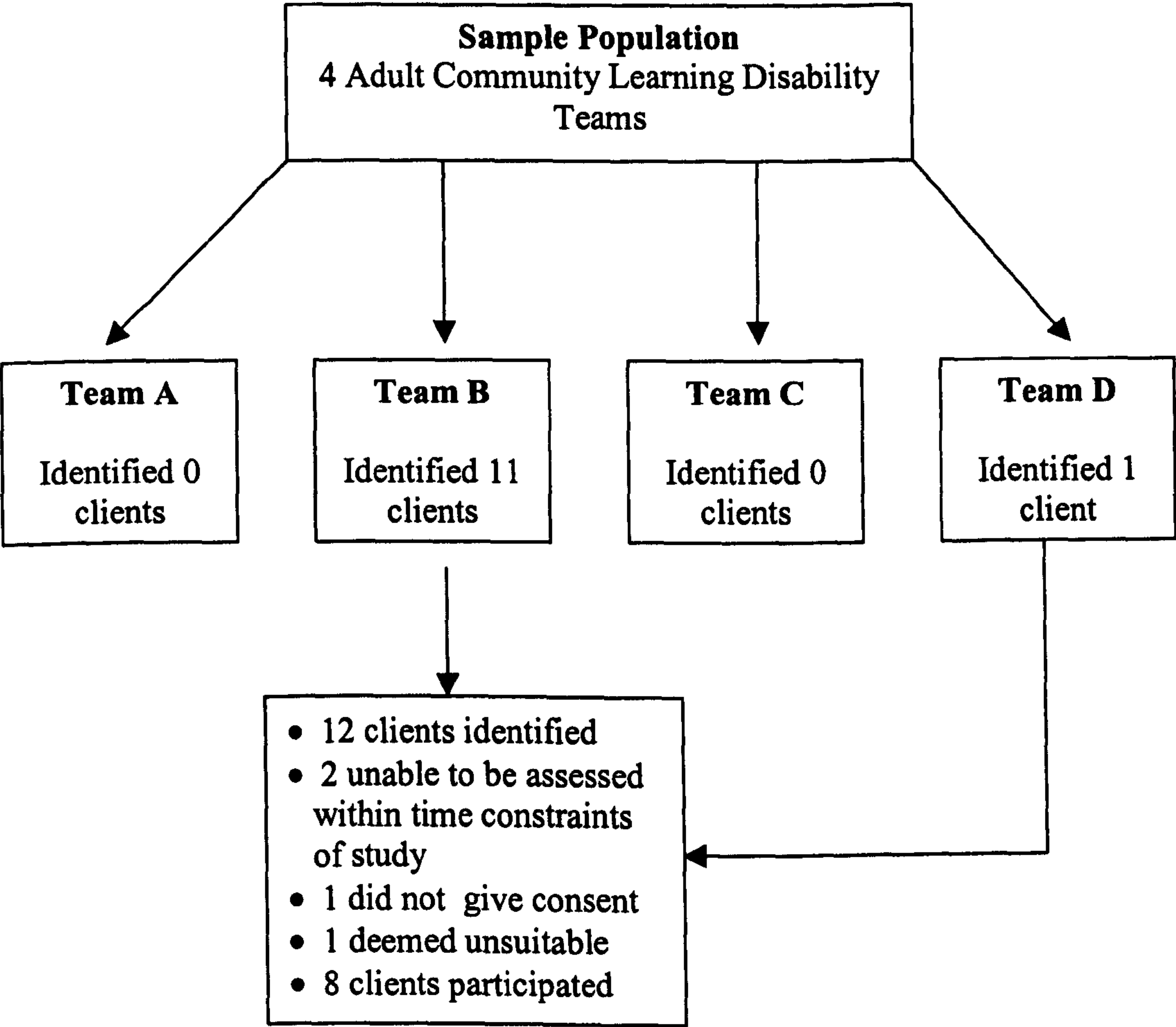
Once the data had been collected it was transposed onto a computer database. This was then analysed using the Statistical Package for the Social Sciences (SPSS 12.0). The data was checked and cleaned. Data was recorded as missing for 1 participant as their verbal IQ, performance IQ and full scale IQ were not known by the clinician.

5. Quantitative Results

5.1.1 Clients

A total of 12 clients were sampled to take part in the present study across four Adult Community Intellectual Disability Teams. The sample and recruitment figures for the clients are shown in Figure 2 below.

Figure 2. Sampling and recruitment figures for clients.



5.1.2 Client Demographics

Of the sample of 8 clients, 7 (87.5%) were male and 1 was female. The ages of the sample ranged from 20 years to 58 years, the average age being 36 years old. The clients' verbal IQ scores ranged from 48 to 72, the average score being 61. In addition, the clients'

performance IQ scores ranged from 49- 72, the average score being 65. The full scale IQ scores ranged from 45 to 72, the average of which, was a score of 60. The entire sample was of White/British ethnic origin. These demographics are detailed in the table below.

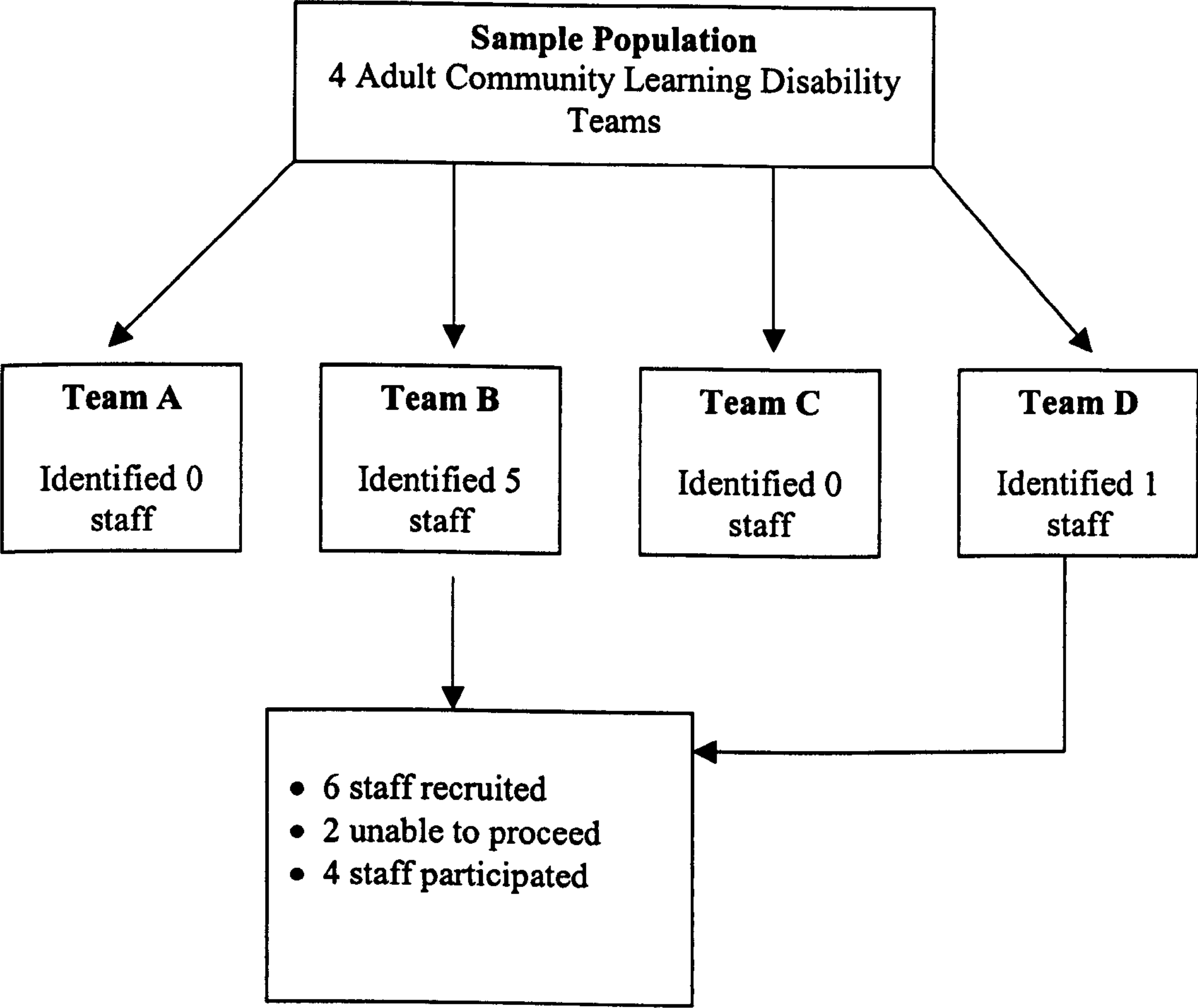
Table 2. The range, mean and standard deviations of Verbal IQ, Performance IQ and Full Scale IQ for the client sample.

| Variable | Range | Mean (S.D) |
|----------------|-------|------------|
| Age | 20-58 | 36 (14.11) |
| Verbal IQ | 48-72 | 61 (8.90) |
| Performance IQ | 49-74 | 65 (8.23) |
| Full scale IQ | 45-72 | 60 (8.53) |

5.1.3 Staff

Initially, 6 staff members were recruited to take part in the present study across four Adult Community Intellectual Disability Teams. However, 2 of these were unable to proceed as the clients whom they had identified for inclusion were either: deemed unsuitable; did not give consent; or could not be assessed within the time constraints of this project. As a result of this, 4 members of staff were included in the final sample. The sample and recruitment number for the staff are shown in Figure 3 below.

Figure 3. Sampling and recruitment figures for staff.



5.1.4 Staff Demographics

All of the 4 participating staff members were female and came from a psychological professional background. In total, 2 of the sample were Consultant Clinical Psychologists, 1 was a Trainee Clinical Psychologist and (25%) was an Assistant Psychologist. The number of years experience working with people with intellectual disabilities ranged from 2 to 26 years, the median being 13.75. Table 3 shows the number of clients recruited to the current study by each clinician.

Table 3. The number of clients recruited to the current study by each clinician.

| Clinician | No. of clients recruited to the current study |
|-----------|---|
| 1 | 1 |
| 2 | 3 |
| 3 | 3 |
| 4 | 1 |

5.2 Initial Analysis

The data was collected and transposed onto a statistical software package (Statistical Package for the Social Sciences 12.0; SPSS). Demographic data was recorded as missing for 1 participant as their verbal IQ, performance IQ and full scale IQ were not known by the clinician.

5.2.1 Homogeneity and Normality

Prior to analysis, the data was examined to establish the appropriate application of statistical tests. Parametric tests are considered to be more powerful and therefore, a first choice if the criteria for their application are fulfilled: variance of scores around the mean should be homogenous and scores should display a normal distribution (Clark-Carter, 1997).

The Levene test (Levene, 1960) was carried out on the data to check for homogeneity of variance. This indicated that the scores on the Clinician Feedback Questionnaires for both the DRAMS and the FACE Risk Profile were not significantly different; that is the two variances were approximately equal, therefore meeting the first assumption of homogeneity (see Appendix K).

In addition to this, the Kolmogorov-Smirnov test (Chakravart, Laha, & Roy, 1967) was carried out to test for distributional adequacy of the data. This indicated that the data was normally distributed, thus satisfying the second assumption of normality (see Appendix L).

As the assumptions of homogeneity and normality were verified, parametric testing was deemed to be the most appropriate method of statistical analysis. Further, in keeping with psychological research convention, statistical significance was tested at the 5% level (Clark-Carter, 1997).

5.3 Analysis

In total, 4 clinicians administered 4 DRAMS and 4 FACE Risk Profiles to the 8 clients. The clinicians' scores on the Clinician Feedback Questionnaires were compared for the DRAMS and the FACE Risk Profile. These scores are shown in table 4 alongside the order in which the measures were administered and by which clinician.

Table 4. Each clinician’s score on the Clinician Feedback Questionnaires for the DRAMS and FACE Risk Profile and order in which the tools were administered to the client.

| Clinician | Client | Order of measure administered (FACE/DRAMS,DRAMS/FACE) | Score on Clinician Feedback Questionnaire (DRAMS) | Score on Clinician Feedback Questionnaire (FACE) |
|-----------|--------|---|---|--|
| 1 | 1 | DRAMS/FACE | 21 | 18 |
| 2 | 2 | DRAMS/FACE | 20 | 15 |
| 3 | 3 | FACE/DRAMS | 18 | 17 |
| 2 | 4 | FACE/DRAMS | 20 | 12 |
| 2 | 5 | FACE/DRAMS | 22 | 17 |
| 3 | 6 | DRAMS/FACE | 26 | 19 |
| 3 | 7 | DRAMS/FACE | 29 | 22 |
| 4 | 8 | FACE/DRAMS | 24 | 19 |

5.3.1 Treatment Effect

In cross-over trials, treatment effects are compared by combining the difference between A and B from within each group (Senn, 1993). In the current study therefore, the mean scores on the Clinician Feedback Questionnaires were compared for both the DRAMS and the FACE Risk Profile. These are displayed in Table 5 below.

Table 5. The mean and standard deviations and range of clinicians’ scores on the Clinician Feedback Questionnaires.

| Measure | Mean | Std. Deviation | Range |
|---------|------|----------------|-------|
| DRAMS | 26 | 3.62 | 18-29 |
| FACE | 17 | 2.97 | 12-22 |

The clinicians’ scores on the Clinician Feedback Questionnaires for the DRAMS and the FACE were compared using a paired *t*-test. This comparison was within subjects and indicated that the Clinicians’ rated the DRAMS statistically significantly higher than the FACE Risk Profile ($t= 6.316, df= 7, p<0.0004$).

5.3.2 Order Effect

Order effects refer to trends which can affect the experiment as a whole as a result of the order in which the treatments are received by participants (Senn, 1993). In the current study the data was analysed to investigate whether the statistically significant difference observed between the Clinician Feedback Questionnaires in relation to the DRAMS and the FACE was due to the order in which the clients’ were administered the measures i.e. DRAMS/FACE or FACE/DRAMS).

The mean and standard deviations of the difference in Clinician Feedback Questionnaire scores in the DRAMS/FACE and FACE/DRAMS periods were calculated. The results are shown in Table 6.

Table 6. The mean and standard deviations of the clinicians’ differences in scores on the Clinician Feedback Questionnaires in DRAMS/FACE condition and FACE/DRAMS condition.

| Group | <i>n</i> | Mean | Std. Deviation |
|------------|----------|------|----------------|
| DRAMS/FACE | 4 | 5.50 | 1.91 |
| FACE/DRAMS | 4 | 4.75 | 2.87 |

An independent *t*-test was carried out which indicated that there was no statistically significant difference between the scores obtained by the clinicians in the 2 conditions. Therefore, the scores on the Clinician Feedback questionnaires for those clients who received

DRAMS/FACE were not significantly different to the scores for those clients who received FACE/DRAMS ($t= 0.453$, $df= 6$, $p=0.679$).

5.3.3 Effects of IQ

A subsidiary analysis was carried out to investigate if there was a correlation between the differences in scores on the Clinician Feedback Questionnaires and the clients' levels of intellectual functioning. It was hypothesised that the higher a client's IQ score, the more useful the clinicians would deem the DRAMS would be, indicated by higher scores on the Clinician Feedback Questionnaires. In order to test this hypothesis, a nonparametric measure of correlation, Spearman's rho was carried out. A significant strong positive correlation was found between IQ and size of difference in scores on the Clinician Feedback Questionnaires ($r= 0.86$, $n=7$, $p= 0.013$), indicating that the higher a clients full scale IQ, the more useful the clinician rated the DRAMS when compared the FACE. Furthermore, clients' verbal IQ scores were found to be more highly correlated ($r= 0.889$, $n=7$, $p= 0.007$) with size of difference in scores on the Clinician Feedback Questionnaires than performance IQ scores ($r= 0.748$, $p= 0.053$).

6. Qualitative Results

The qualitative data resulting from the comments⁵ on the Clinician Feedback Questionnaires were collected and explored by the Principal Investigator using a method of template analysis (King, 2004). This refers to a particular way of thematically analysing qualitative data whereby the researcher identifies and summarises themes as important in a data set, and organises them in a meaningful and useful manner (School of Human & Health Sciences, University of Huddersfield, n.d.).

6.1 Methodology

A number of specific steps (as identified by King, 2004) were involved in the template analysis technique adopted in the current study. These are summarised below:

1. Definition of a priori themes
2. Transcription and initial coding
3. Development of template

6.1.1 Definition of a priori themes

When using template analysis, it is common to identify a number of themes in advance. Often this is because a research project has begun with an assumption that certain aspects of the phenomena under investigation should be focused on, or the topic being researched is so well-established that certain themes can be expected to arise ((School of Human & Health Sciences, University of Huddersfield, n.d.).

⁵ The qualitative data was based only on the additional comments made by the clinicians on the Clinician Feedback Questionnaires.

Murphy *et al.* (2005) in their prior evaluation of staff's attitudes towards the DRAMS in an inpatient setting, highlighted a number of themes in their data. These were: (1) Focus; the staff's ability to focus their care increased as a result of using the DRAMS; (2) Collaboration; the DRAMS facilitated collaborative working and joint decision making; (3) Opportunities; the opportunities created by the DRAMS e.g. a weekly point of contact, justification of decisions and time to discuss issues; (4) Challenges of using the DRAMS; (5) Appearance of the tool; (6) Ethical dilemmas; and (7) Additional training. It was anticipated by the Principal Investigator that these themes may arise from the clinician's feedback comments in the current study and therefore, these were identified as a priori themes. As noted by King (2004) however, these themes may be modified or dispensed with altogether if they do not prove to be useful or appropriate to the data examined. Furthermore, it is crucial to recognise a priori themes as tentative-equally subject to redefinition or removal as any other theme (School of Human & Health Sciences, University of Huddersfield, n.d.). It was also pertinent to note that the research in the area was not well-established as the DRAMS was a relatively new measure.

6.1.2 Transcription and initial coding

Template analysis does not require highly detailed transcription as other forms of qualitative analysis (King, 2004) but as the clinician's feedback comments were in the main brief, these were transcribed by the Principal Investigator in full. After the data had been examined in full, themes of relevance to the research question were marked and those corresponding to the a priori themes were coded as such. New themes were defined to include the relevant material and arranged into an initial template.

6.1.3 Development of template

The initial template was produced once the coding produced no new themes distinctly different from those identified previously, as recommended by King (2004). This initial template was then applied to the whole data set and modified according to each transcript. Where significant changes were made to the template, those sections coded prior were adjusted accordingly. For example, where themes were identified that were not covered by an existing code, these were defined as new themes and coded. In addition, where a priori themes were found not to be relevant they were removed. There were also instances whereby the Principal Investigator deemed the a priori themes to be either too narrowly or broadly defined to be useful and so these were redefined accordingly. Once the final version of the template was defined and all transcripts coded to it, this served the basis for the interpretation.

6.2 The DRAMS

The above process of template analysis of the comments made on the Clinician Feedback Questionnaires relating to the DRAMS identified the following seven themes which are described in full below:

- i. Collaborative usage
- ii. Clinical utility
- iii. Appearance of the tool
- iv. Administration guidance
- v. Community sample
- vi. Client understanding
- vii. Specific items

6.2.1 Collaborative Usage

The major theme which emerged from the clinician feedback was related to the DRAMS promoting a collaborative discussion between the clinician and client. Moreover, five comments were recorded about this issue. For example, one clinician commented: *'I liked the idea of using the DRAMS as a guide to conversation. When used in this manner, it was collaborative and did not appear too challenging or directive for the client.'* Other comments concluded that: the DRAMS was easier to administer collaboratively than the FACE Risk Profile; that it was a good prompt for conversation, particularly when discussing a difficult topic such as risk; and that it initiated an open discussion about general feelings but also specific incidents.

In addition, further comments were made about collaborative usage but in reference to instances whereby the clinician and client were not in agreement about the level of risk on any one item. The guidance for the DRAMS (see Appendix M) stated clearly that 'it is the clinician's opinion that is documented' in instances of disagreement. One comment received in the current study suggested that it may be useful to include a further column on the DRAMS so that the clinician and client's view could both be recorded. Further, that where clinician and client disagreed, this provided valuable information about cognitive distortions, denial and minimisation on behalf of the client.

Moreover, an additional comment also referred to the usefulness of recording differences in opinions between the clinician and client and noted that the DRAMS allowed this to be done in a non-confrontational manner. This clinician further noted that, *'it is advantageous that the clinician has the final say on the level of risk given the likelihood that people with intellectual disabilities often acquiesce on such measures.'*

Notwithstanding these comments, references were also made to some difficulties associated with the intended collaborative usage of the DRAMS on specific items. Moreover,

two comments referred to difficulties in addressing the 'Sexual self-regulation' section with clients who were not referred for issues around sexual offending. In addition, a further comment stated that: *'some of the items were difficult to complete collaboratively with the client and were more appropriate for staff to complete such as the section on 'opportunity for victim access.'*

6.2.2 Clinical Utility

A number of comments were made by clinicians about the potential clinical utility and the relevance of the DRAMS for assessing risk in people with intellectual disabilities. For example, one clinician commented that *'the areas covered by the DRAMS are good for a general risk assessment.'* Moreover, a further remark stated that the DRAMS was 'very relevant' to the client's area of risk.

However, two comments stated that the DRAMS was not relevant to the areas of risk posed by their clients. In spite of this, one of the clinicians was able to acknowledge that: *'it was useful however, to consider these (areas of risk) as I may not have asked these questions without the DRAMS.'*

In addition to this, one clinician made reference to the DRAMS providing a risk assessment at a single point in time and noted that due to the client 'doing well' at the point of assessment, this could have led to an underestimation of risk.

A further recurrent theme in the feedback received from clinicians was in relation to the potential usefulness of repeatedly administering the DRAMS to clients over a period of time. Moreover, it was commented on three occasions that it was felt that this would be a useful way of measuring treatment efficacy and comparing changes in thoughts, feelings and behaviour. For example, one clinician commented that: *'the DRAMS will be helpful in monitoring change over time.'* In addition, it was felt by one clinician that the DRAMS would

be a useful tool for measuring change over longer periods of time for example, for those clients who may be referred back to a service after being discharged. This was evidenced by the quote: *'I would definitely use the DRAMS again as a measure of treatment effectiveness and it would be extremely useful for clients who are re referred to the service.'*

6.2.3 Appearance of the Tool

In total, four positive comments were made about the appearance of the DRAMS and the appeal of this to people with intellectual disabilities. For example, *'the layout of the DRAMS is excellent. I especially liked the graduated sizes of the tick boxes as these added a further visual aid to understanding for the clients.'* Other comments referred to the DRAMS being 'well laid out', 'clear', 'relatively simple to use' and the 'pictorial symbols helpful.'

However, seven comments raised concerns about the appearance of the tool and/or offered suggestions for improvement. For example, one clinician noted: *'the happy/neutral/sad face visual aids were quite useful although these are quite value-laden and did not directly correspond to some of the items. For example, if the client agreed that they felt a 'wee bit' sad, this still came under the happy face column.'* Further, two comments suggested that it would be useful to have space on the DRAMS for the clinician and client to record any extra comments or notes and two comments were made about the regional language differences used within the Likert scale. For example: *'the Likert scale on the DRAMS may need adapting for use outside Scotland as clients may not understand the 'wee bit' category.'*

Lastly, one comment referred to the stop signs on the DRAMS which indicated the highest level of risk. This clinician commented that: *'the stop sign may prevent the client from disclosing information through fear of negative outcomes.'*

6.2.4 Administration Guidance

A further common theme arising from the clinician feedback was related to the lack of guidance in how to administer the DRAMS. This was evidenced by a total of four clinician comments. These described the guidance as ‘vague’ and suggested that further guidance was needed. For example, one such comment included: *‘the DRAMS would be easier to administer if there was detailed guidance.’* In addition, two comments were received regarding the ‘Problem with recent renewal of emotional relationships’ item in particular, and these clinicians felt unsure about what this referred to.

6.2.5 Community Sample

The clinicians made a number of comments about the use of the DRAMS with people who lived in the community as opposed to those living in residential care and one clinician remarked that the current tool may need adapting for this purpose. Moreover, one clinician noted that the ‘Agreement with routine’ section was ‘difficult’ to complete with clients living in the community due to the lack of access to collaborative information from staff. Furthermore, a comment was also received about the ‘Complaining about staff’ section on the DRAMS, with this clinician arguing that this section was ‘not always relevant’ for clients living within the community. However, this clinician suggested that this item could be broadened to include ‘complaining about family.’

6.2.6 Client Understanding

In total, two general comments were made by clinicians regarding the ability of clients with intellectual disabilities to understand the information contained within the DRAMS. Indeed, one of these clinicians made a suggestion for improving clients’ understanding by stating that: *‘it would be useful to have an explanation or instructions for the DRAMS on a*

card to give to the client at the beginning in a language which they could understand.’ In addition, one clinician suggested that the DRAMS may be more helpful with individuals who were more intellectual able and commented that *‘the client I used the DRAMS with had a severe learning disability and therefore found it quite difficult to understand. It may need a cut-off point for use with clients of a certain intellectual ability.’*

Some comments were also made about specific items which clinicians found difficult to explain to certain clients. For example, one clinician commented that ‘suspicious thoughts’ item was difficult to explain to the client. However, in spite of these difficulties, one clinician pointed out the benefits of being able to modify the language used when administering the DRAMS so that it was appropriate to the individual’s level of understanding: *‘the main advantage of the DRAMS is that it is not too prescriptive. You are able to adapt the language for clients of different abilities.’*

6.2.7 Specific Items

A further common theme identified by the thematic analysis of clinicians’ comments was related to specific items on the DRAMS. For example, two comments were made about the ‘agreement with routine’ section. These included:

‘I thought that the section on ‘agreement with routine’ was particularly clear and helpful’ and ‘it would be useful to have a question within the ‘agreement with routine’ section about whether or not the individual had abided by rules, as often this is part of the treatment plan for offenders in this client group.’

In addition to this, one clinician commented that the item, ‘Spending time on own’ under the ‘self-esteem/social isolation’ section was viewed as a risk increasing factor on the DRAMS when in fact, this can sometimes be an important part of a client’s management plan. Further, this clinician noted for example, how having ‘time-out’ can often be used as a

positive coping strategy and therefore, is not necessarily a sign of increasing risk. Moreover, one clinician remarked that they found the ‘anti-social behaviour’ section of particular use with their client.

6.3 The FACE Risk Profile

The same process of template analysis carried out on clinician feedback relating to the DRAMS was applied to the data obtained from the Clinician Feedback Questionnaires relating to the FACE Risk Profile. It was anticipated that the a priori themes identified before analysing the clinician feedback from the DRAMS would be similar to those expected to arise in the feedback from the FACE Risk Profile as the clinicians were being asked the same questions about each measure and therefore may raise similar issues about each and make related comparisons between the DRAMS and the FACE Risk Profile. It was however, deemed important not to overlook material that did not fit into the a priori themes and as asserted by King (2004) recognise a priori themes as tentative rather than definite, especially in view of the feedback being about two disparate measures.

In total, four main themes were identified and these are described in full below:

- i. Relevance
- ii. Perceived usefulness and scope
- iii. Collaborative usage
- iv. Limitations

6.3.1 Relevance

The predominant theme identified from the clinician feedback about the FACE Risk Profile was around the issue of relevance. Moreover, nine comments were made suggesting that the FACE Risk Profile was not a relevant risk assessment tool to be used with people with intellectual disabilities. Furthermore, clinicians commented that they were forced to ‘miss out’ and ‘fill in the gaps’ on a number of areas of the FACE Risk Profile which had no relevance to their clients. In addition, one clinician commented that it would have been *‘very time consuming to cover everything as many areas were not relevant.’*

One clinician argued that, *‘people with learning disabilities may have different issues to the general population and therefore some items on the FACE may need adapting.’* On this theme, a further comment suggested that the FACE Risk Profile was *‘very mental health services orientated’* and questioned how these issues referred to people with intellectual disabilities.

6.3.2 Perceived usefulness and scope of the FACE Risk Profile

Notwithstanding the comments about relevancy, the perceived usefulness and scope of the FACE Risk Profile formed a further common theme from the clinician feedback. This was evidenced by a total of five statements relating to the thoroughness of the measure such as: *‘I found the FACE to be very inclusive and wide-ranging.’* Similarly, one clinician argued that with ‘further adaptation’ the FACE Risk Profile would be a more useful tool for people with intellectual disabilities.

6.3.3 Collaborative Usage

A further major theme highlighted by the clinicians’ in relation to the FACE Risk Profile was around the complexity of the language used in the measure and the ability of

people with intellectual disabilities to understand this. For example, one clinician commented that *'the language used in the FACE is quite complex so it is difficult to use it 100% collaboratively with the client.'* This issue seemed to impact on the clinicians' abilities to use the tool collaboratively with some clients. Specifically, three clinicians commented that the FACE Risk Profile was difficult to use collaboratively. For example, one clinician commented that *'the FACE does not lend itself to being carried out collaboratively with clients.'*

6.3.4 Limitations of the FACE Risk Profile

Clinicians made four comments about the limitations of using the FACE Risk Profile as a risk assessment tool for people with intellectual disabilities. These referred to the lack of *'user-friendliness,' 'lack of room to expand upon things,'* the *'subjective nature'* and a concern that it would *'remind people of their past behaviours.'*

The following section will discuss the implications of these results.

7. Discussion

7.1 Summary of Results

The aim of this study was to investigate the clinical utility, as opposed to the predictive accuracy of the Dynamic Risk Assessment and Management System (DRAMS) as a measure of risk within a community sample of offenders with intellectual disabilities. Furthermore, to explore the experiences of clinicians in using the DRAMS, in comparison to their experiences of using the FACE Risk Profile (as per local Trust policy) to assess risk in this client group. It was hypothesised that clinicians would find the DRAMS to be a more clinically useful tool and would therefore; score it more highly than the FACE Risk Profile on 5-point scaled Clinician Feedback Questionnaires (devised by the Principal Investigator).

Statistical analyses of the quantitative data provided by the Clinician Feedback Questionnaires revealed that clinicians did rate the DRAMS more highly on this measure, therefore demonstrating that they found it to be more clinically useful than the FACE Risk Profile. Further, there was found to be no significant order effects on the results, in that the Clinician Feedback Questionnaires obtained the same results regardless of the order that the risk assessment measures were administered to the client by the clinicians (e.g. DRAMS/FACE or FACE/DRAMS).

A subsidiary analysis revealed a significant strong correlation between the IQ of clients and difference in scores on the Clinician Feedback Questionnaires. Moreover, the higher a client's full scale IQ score, the more useful clinicians rated the DRAMS compared with the FACE Risk Profile. In addition, verbal IQ was found to be more highly correlated with this difference in scores than performance IQ.

7.2 Discussion of Results

The significant finding that clinicians using the DRAMS to assess risk in a community sample of offenders with intellectual disabilities, rated it more highly in terms of clinical utility than the FACE Risk Profile (the risk assessment tool implemented by the local Trust to be used as standard with all clients) offers some support to the study reported by Murphy *et al.* (2005). Indeed, Murphy *et al.* (2005) stated that staff reports of using the DRAMS were ‘favourable’ (p. 37) and highlighted a number of themes raised by staff which were replicated by the current study, outlined below.

7.2.1 Replicated Themes

To begin with, the major theme highlighted by clinicians in the present study in relation to the DRAMS, was the collaborative nature of the tool and the usefulness of this in working with offenders with intellectual disabilities. Collaboration between clinician and client is deemed to be an important facet of the risk assessment process for a number of reasons, including that it allows an open discussion and reflection on behaviour (Murphy *et al.*, 2005). Collaboration was also identified as a key theme in the Murphy *et al.* (2005) study where staff reported that the collaborative nature of the DRAMS encouraged amongst other issues, a willingness in clients to ‘make joint decisions and accept responsibility,’ in addition to allowing the opportunity for them ‘to think of alternatives to their usual reactions or inaction’ (p.37).

A further theme identified by Murphy *et al.* (2005) and replicated by the current study related to the usefulness of the DRAMS in focusing the clinician’s attention. Murphy (2005) reported that this allowed concentration on the ‘real issues’ (p. 36). This theme can be said to overlap with the ‘clinical utility’ theme in the current study where references were made to the

‘relevance’ of the DRAMS and its use in focusing the clinician on issues which they may have not have considered.

The ‘appearance of the tool’ was an additional staff feedback theme reported by Murphy *et al.* (2005) and replicated by the present study. However, the suggestions made for improvements in the visual appearance of the DRAMS by clinicians’ in the current study were not reported by Murphy *et al.* (2005).

The theme relating to ‘administration guidance’ in the current study had some overlap with the ‘additional training’ theme reported in Murphy *et al.* (2005) study. Moreover, Murphy *et al.* (2005) stated that staff in their sample had highlighted the need for a manual or a handbook in administering the DRAMS. In the current study, six clinicians commented on this issue and emphasised the lack of detailed guidance.

Although the current study replicated a number of previous findings in the limited knowledge base about staff evaluations of the DRAMS (e.g. Murphy *et al.*, 2005), a number of novel findings can also be reported.

7.2.2 The Effect of IQ

The strong correlation observed between IQ of the client and clinician’s rating of the DRAMS is a very interesting finding which suggests that the DRAMS may be a more clinically useful tool, the more intellectually able a client is. This proposal is supported by a comment drawn out by the thematic analysis whereby a clinician stated that in their experience, the DRAMS had been difficult to use with a client with severe intellectual disability. Although, this finding is seemingly to be expected, it is not one previously reported in the literature relating to the DRAMS. Indeed, according to the report provided by Lindsay *et al.* (2004a), the DRAMS had not been previously used on a client with a severe intellectual disability (i.e. IQ < 55).

This finding has important implications for the clinical efficacy of the DRAMS with less intellectually able individuals. Moreover, the DRAMS may demand a level of self-monitoring and self-awareness which is not accessible to individuals with severe intellectual impairments. Furthermore, clinicians deeming the DRAMS to be particularly more useful with verbally able individuals may indicate that it is actually a more useful tool for people without intellectual impairments, or at least those with milder intellectual impairments.

7.2.3 Application of the DRAMS in a Community Setting

The present study offers the first attempt to report findings related to using the DRAMS in a community sample of offenders with intellectual disabilities and so contributes to the research in a previously unexplored area. Moreover, the comments received from the clinicians' in relation to using the DRAMS with a community sample suggested that the measure may require further adaptation for this purpose. For example, some of the items on the DRAMS were deemed as difficult to complete by the clinicians for clients living in the community, where there was often no staff with which to corroborate information.

7.3 Further Issues

In addition to the issues outlined in the preceding discussion, there are a number of further issues and implications that have been raised as a result of the current study which warrant further consideration. These are discussed below:

7.3.1 Potential Halo Effect

In the service where the current study was conducted, the FACE Risk Profile had been introduced as a Trust policy and therefore it was a requirement that it was carried out with every client at various points in their care pathway. The thematic analysis of clinician's

comments about the FACE Risk Profile however, indicated very strongly that the tool was not well liked, evidence by nine comments suggesting that it was not a relevant risk assessment tool to be used with people with intellectual disabilities. As an enforced measure, the staff may have viewed the FACE Risk Profile as an imposition and therefore their comparably positive comments about the DRAMS could have been due to a halo effect (Reber, 1985) as the DRAMS has been specifically designed for people with intellectual disabilities (Lindsay *et al.*, 2004a).

Linked to the issue of the DRAMS being designed specifically for people with intellectual disabilities, is the authors assertions that it is a 'collaborative tool...best used idiomatically with individual participants' (Lindsay *et al.*, 2004a). Indeed, the physical appearance of the DRAMS, designed to be accessible to people with intellectual disabilities may have been a further factor which could add to any potential halo effect.

7.3.2 Conceptual Difficulties and Construct Validity

A number of conceptual difficulties are apparent within the Dynamic Risk Variables contained within the DRAMS. Moreover, Lindsay *et al.* (2004a) as outlined earlier (see p. 74) identified a series of major variables which they extracted from the literature on proximal/dynamic risk which were then 'subdivided into specific items' (Lindsay *et al.*, 2004a, p. 269) in order to form the DRAMS. It would seem however, that in transposing these variables into the DRAMS format, some of the items have been modified or moved to different variables. For example, In the Lindsay *et al.* (2004a) paper both 'suspicious thoughts' and 'criminal thoughts' were contained within a separate 'Thoughts' variable. The 'suspicious thoughts' item as it appears on the DRAMS however, is contained within the 'Mood/Emotion' variable despite this not being an emotion and similarly, the 'criminal

thoughts' item is contained within the 'Antisocial Behaviour' variable in spite of these being thoughts, rather than behaviours.

In addition to the conceptual difficulties, there are a number of potential construct limitations evident within the DRAMS. For example, the 'blaming others' item is contained within the Intolerance/Agreeableness variable. This however, can be questioned in that blaming others is a factor of locus of control (Reber, 1995), rather than how intolerant or agreeable an individual is. Likewise, it may also be queried whether an individual's 'agreement with routine' (derived from the major variable of 'Compliance') is actually a reliable measure of their compliance. Further, the item within this variable 'looking after self' is clearly related to many other factors than compliance alone.

A similar issue arises from the 'refusing medication' item which Lindsay *et al.*, (2004a) placed within the 'clinical interest' variable. It could be argued that refusing medication is directly linked to compliance and therefore, this item may be better placed within the 'agreement with routine' variable.

Equally, the item 'winding others up' is also contained within the variable of 'clinical interest' on the DRAMS. Lindsay *et al.* (2004a) however, stated in their paper originally, that 'winding others up' was in fact contained within the 'antisocial behaviour' variable, derived from the literature on proximal/dynamic risk. It seems questionable therefore, why this item has been placed within the 'clinical interest' variable on the DRAMS.

7.3.3 Statistical Issues

The authors of the DRAMS (Lindsay *et al.*, 2004a) do not provide sufficient analysis or comment about the statistical properties of the measure in their paper. They acknowledge this shortfall by stating that 'the psychometric properties of the instrument are as yet unclear' (p. 273). Furthermore, although the authors provide some information about the reliability of

the DRAMS, they make no such assertions about the ⁶sensitivity or specificity of the measure. Therefore, it is unclear as to the predictive accuracy of the DRAMS and indeed, if it is able to predict future offending at a level significantly better than chance. Lindsay *et al.*, (2004a) recognise this omission but assert that, 'at a research level this may be important but at a clinical level it is less so.' Moreover, they state that the 'DRAMS is not designed to be a coherent, unified dynamic risk assessment. It simply takes the available variable and sets them out in a usable fashion' (p. 273).

In view of the above assertions, there is no strong evidence to suggest that the DRAMS is measuring a single concept, nor that the subscales are actually measuring what they purport to measure. This may undermine the concept of predictive power, i.e. the proportion of individuals predicted by the DRAMS to be at risk of reoffending who indeed turn out to reoffend. Further, internal consistency of the items within each subscale of the DRAMS should be determined, along with the measure's predictive and discriminative reliability. Until such psychometric properties of the DRAMS are investigated, the efficacy of it as a measure of dynamic risk is difficult to quantify.

7.4 Limitations of the Study

7.4.1 Sample size

A clear limitation of this study is the small number of participants. The study did not reach the intended sample size and therefore was statistically underpowered. However, difficulties in recruiting research participants with intellectual disabilities is well documented within the literature (Department of Health, 2005; Williams, 2003) alongside the implications of this on statistical power and generalisation (Oliver *et al.*, 2002; Willner, 2005).

⁶ This can be interpreted as the probability that a randomly selected recidivist would have a more deviant score (i.e., the sensitivity of the measure) than a randomly selected non-recidivist (i.e., the specificity of the measure; Beech & Ward, 2004).

The Lindsay *et al.* (2004) paper which introduced the DRAMS as a risk assessment tool and was published in the 'Journal of Applied Research in Intellectual Disabilities,' assessed only ten participants with the DRAMS for reliability purposes and five participants over a three-month period. When compared with these small numbers of participants, a sample of eight participants in the current study is arguably valid. Similarly, difficulties have also been observed in recruiting staff to take part in research on offenders with intellectual disabilities. Indeed, the Green *et al.* (2003), Murphy *et al.* 2005 and Robertson and Clegg (2002) studies sampled nineteen, ten and six staff respectively.

Intellectual disabilities is historically an under-privileged area in research activity, especially when compared with mental health populations. The need to develop research in this area has recently been recognised by the Department of Health (Department of Health, 2005). In particular, there is a need to increase the evidence base on community samples of offenders with intellectual disabilities. The review of the current literature in the field, carried out for the purposes of this study found only two studies reporting on community samples of offenders with intellectual disabilities (e.g. Harris & Tough, 2004; Quinsey *et al.*, 2004). All of the participants in these samples however, were originally recruited whilst residing in institutions and were then later followed-up in the community. Additionally, both of these studies were carried out in Canada and there is a pressing need for similar work to be carried out within the UK. Indeed, the current study is the first attempt to investigate the clinical utility of the DRAMS in a community sample of offenders with intellectual disabilities. In view of this, and due to the paucity of literature in the area, any knowledge which may extend the evidence base is surely worthy of further consideration although, due to the small sample size, generalisations should be made with caution.

7.4.2 Participant Characteristics

The sample can be further criticised in that the staff participants who carried out the risk assessments varied greatly in terms of their experience (i.e. 2 being Consultant Clinical Psychologists, 1 being an Assistant Psychologist and 1 being a Trainee Clinical Psychologist). Although all were from a psychological background and had undergone specific training in relation to administering the DRAMS and the FACE Risk Profile, there was a clear imbalance in wider previous experience (i.e. the range of previous experience being 2-26 years) which would have undoubtedly impacted on the individuals' proficiency and confidence in conducting assessments of risk. Indeed, Robertson and Clegg (2002) cited staff's past experience of risk and offending as a factor which increased their confidence in making risk assessments. Further, in a study with a larger sample size, the inclusion of qualified and unqualified staff may allow for useful comparisons to be made between different levels of staff, amount of experience and confidence in carrying out risk assessments.

Out of the six staff originally recruited, one was male and both were Social Workers within a Community Intellectual Disability Team. However, difficulties with the clients which they planned to recruit for the study meant that unfortunately, neither were included in the final sample. If these staff had been included, it may have allowed for a comparison to be made between different professional groups' experiences of using the DRAMS and FACE Risk Profile with offenders with intellectual disabilities.

If the suggestion of Robertson and Clegg (2002) is valid, that characteristics of such samples reflect the allocation of work being studied, then it may be argued that in the case of the current study, the majority of community risk assessment work is carried out by Clinical Psychologists.

The sample can be further criticised in that all of the staff who carried out the risk assessments were female. These characteristics do not replicate the findings of Robertson and

Clegg (2002) who reported in their study that almost all of the staff members who agreed to take part were men. Robertson and Clegg (2002) suggested that 'risk work with people with intellectual disabilities largely falls to male workers' (p. 175). In the current study, the predominance of female staff can be seen to reflect the ratio of female:male workers within the Community Intellectual Disability Teams sampled, although this was not formally recorded.

7.4.3 Methodological Limitations

A number of compromises in the study design led to methodological limitations. For example, two of the psychologists carried out risk assessments with three clients, compared to the other two psychologists who only carried out the assessments with one client each. The decision was made to carry out the experiment in this way in order to get a reasonable (albeit still very small) sample size. Although this may violate the assumption of independence (Senn, 1993), it can be argued that it was the experience of carrying out the FACE and DRAMS with *different* clients that was the important unit of measurement. However, future studies could satisfy the assumption of independence by featuring each member of staff once and only once.

A further criticism can be made about the design of the Clinician Feedback Questionnaires, in particular the questions relating to ease of use and time taken to complete the DRAMS and FACE. Although ratings indicating that the measures were easy to use and not time consuming were deemed to be positive, it has to be argued that this serves to oversimplify the complex issue of risk prediction. Indeed, it is clearly not the case that a measure which is quick and easy to use will prove to be a superior risk assessment tool. In spite of this criticism, the aim of present study was to evaluate clinicians' evaluations of the clinical utility of the DRAMS and therefore issues of ease of use and time taken to complete a measure were

deemed to be relevant issues. If however, a future study was concerned with the predictive accuracy of a risk assessment tool, then questions relating to ease of use and time taken may not be pertinent.

7.5 Clinical Implications

The current study was one of face validity, rather than construct validity, in that the aim was not to evaluate the DRAMS or FACE Risk Profile on their ability to predict future offending behaviour but rather to evaluate clinicians' experiences of the 'usability' of the measures. Indeed, the findings of the current study indicated that when comparing the DRAMS and FACE Risk Profile in terms of their general usability, clinicians' rated the DRAMS more favourably. This raises important clinical issues. For example, although it is difficult to make generalisations from such small sample sizes, would it be ethical to *not* continue to use the DRAMS if it was found to be a more clinically useful tool with offenders with intellectual disabilities than the FACE Risk Profile? As the current study did not however, compare the two measures in terms of their predictive accuracy, the finding that clinicians rated the DRAMS to be more clinically useful is less relevant if it is not in fact, a more accurate predictor of risk than the FACE Risk Profile. Clearly, this is an area that warrants further research.

7.6 Conclusions

Although the sample of clinicians in the current study appeared to rate the DRAMS as a more clinically useful risk assessment tool than the FACE Risk Profile and in doing so, replicated a number of previous findings (Murphy *et al.*, 2005), the present study has also raised a number of unanswered questions and identified numerous avenues for further exploration. In addition to this, several limitations of the research have also been

acknowledged. Notwithstanding these, if research on the DRAMS is to progress, then the current study can offer a number of specific points, highlighted by clinicians, which may improve the clinical utility of the measure. These are as follows:

- Clinician and clients' views about each dynamic risk item could be recorded on the DRAMS. Differences in such views would provide valuable information about cognitive distortions, minimisations etc.
- The Likert scale may need adapting. In particular, 'wee bit' may need substituting for 'a little bit.'
- Consideration could be given to removing the 'stop' signs on the DRAMS as these may discourage the client from disclosing information about risk.
- Further administration guidance from the authors of the DRAMS would be useful, as would written information for the client about the DRAMS.
- Some items could be broadened to include clients living within the community. For example, items like 'complaining about staff' including 'complaining about family.'

7.7 Future Research

It is clear that further study in the field is required. As asserted by Lindsay *et al.* (2004a), the evidence base in relation to the DRAMS thus far, is a reflection of pilot work and as such, it has considerable limitations which need to be addressed by future research. Areas of potential investigation include the following:

7.7.1 Alternative Study Designs

The current study was concerned with the clinical utility of the DRAMS, as opposed to the predictive accuracy of the measure. Therefore, the ability of the DRAMS to predict future offending behaviour in a community sample of individuals with intellectual disabilities remains unknown. This is clearly an area that warrants further research.

Furthermore, as the current study has been concerned with the comparison of the DRAMS to the FACE Risk Profile, an avenue of future study would be the evaluation of the DRAMS with other risk assessment measures, for example those ordinarily utilised by the participating clinicians. This would have the advantage of avoiding comparison of the DRAMS with an enforced measure, such as the FACE Risk Profile and thus, would potentially eliminate the halo effect which may have been a factor in the present study.

7.7.2 Alternative Samples

A major limitation of the current research was the size of the sample which led to the study being statistically underpowered. Moreover, it would be useful if further investigation included the recruitment of larger numbers of clinicians. In addition to this, as previously discussed it would also be interesting to include staff from different professional backgrounds such as nursing or social work. This would allow for between-subject comparisons to be made about the DRAMS.

A further limitation of the current study was that the sample of clinicians was drawn from one NHS Trust and indeed, from one psychology department. Recruitment across a wider geographical area may allow for more breadth of experience between clinicians and differences in departmental and professional cultures could be drawn on. In addition to this, as asserted earlier, the sample in the current study was restricted to female staff members. It would be preferable if future research in the area contained a more representative gender mix.

It would also be useful to investigate in more detail the applications of the DRAMS within various community settings and to consider the effectiveness of the measure in predicting risk in different types of offenders (e.g. sexual offenders compared with violent offenders). As asserted by Lindsay *et al.* (2004a) these differences may be reflected in the individual DRAMS profiles.

7.7.3 Level of Intellectual Functioning

The finding in the present study that the DRAMS may be more clinically useful with individuals who are intellectually more able is certainly an avenue which requires further investigation. Moreover, if additional evidence is found to support the suggestion here that the DRAMS is not suitable for people with severe impairments of intellectual functioning, then surely the efficacy of the measure as a tool for this client group should be questioned.

7.7.4 Psychometric Properties

As outlined earlier, there is much to be learnt about the psychometric properties of the DRAMS and the accuracy of the measure in predicting future offending behaviour. Indeed, it is necessary for the internal consistency of the measure to be established, along with the construct and discriminative validity. Only once these factors have been investigated can the sensitivity and specificity of the measure be determined and ultimately, the utility of the DRAMS as a risk assessment measure for people with intellectual disabilities be confirmed.

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SECTION 3

CRITICAL APPRAISAL

1. Critical Appraisal

1.1 Origins

The idea for the current study arose from my experiences of working in a Community Learning Disability Team as an Assistant Psychologist. The service frequently received referrals for individuals who had offended or exhibited risky behaviour, yet there seemed to be a lack of guidance in the literature on how to work with this client group. In addition, the non-existence of a standardised risk assessment tool made quantifying the level of risk posed by an individual extremely problematic.

The uncertainty around how best to meet the needs of people with intellectual disabilities who offended had implications on a number of levels. Firstly, the offenders themselves who were vulnerable people with intellectual disabilities had a right to the best possible assessment and treatment. As there was not clear guidance, even with the best intentions, their needs were not being met. Secondly, there was potential for the rights of potential victims to be overlooked; there was a danger of losing sight of the need to protect possible victims while attempting to provide suitable care for a potential offender. Finally, as a result of the latter two implications, there was pressure placed on the professional responsible for carrying out a risk assessment to ‘get it right,’ particularly within a health and social care culture increasingly concerned with minimising the ‘costs’ of risk.

It was against this background that I became interested in carrying out further research in the area of risk assessment and particularly in evaluating a risk assessment tool that had been specifically designed for people with intellectual disabilities. It was my experience that due to a lack of specialist tools, psychometric or psychological measures standardised on other populations were often adapted for use with people with intellectual disabilities, rather than designed to specifically meet their needs. Consequently, it was impossible to interpret scores

in relation to non-offending populations, other similar offenders or other types of offenders (Lindsay, 2002).

A number of reflections emerge from the process of conducting the current study. These will be discussed below:

1.2 Devising the methodology

The process of designing the methodology for the current study was prolonged and complicated. As a requirement of the Trust where I planned to conduct the research, the FACE was to be completed with every client and it was clear that these would still have to be completed alongside the DRAMS. In addition, it was extremely difficult to balance what would be potentially clinically useful research with the academic requirements of the course and at the same time ensuring statistical feasibility. For example, an initial meeting with a statistician revealed a difficulty with the proposed method of data collection. As I was concerned with exploring staffs' experiences of administering the DRAMS, I had to control for members of staff carrying out significantly more (or less) risk assessments than each other as this would obviously skew the results. In practice this meant that each member of participating staff could not carry out more than two risk assessments. As the participant group was already notoriously difficult to recruit, this was a major setback.

1.3 Recruitment of participants

Recruitment of people with intellectual disabilities who had offended or who were at risk of offending was the source of most concern throughout the project. People with intellectual disabilities are a notoriously difficult to recruit population and I realised from the onset that this would present a challenge. Most of the research that I had read in the area was derived from studies with very small sample sizes (e.g. $n=5$) or where there were larger

samples, these were conducted in captive populations, such as inpatient units or institutions. However, the literature lacked research carried out in a community setting, where arguably the risk posed by this client group is higher with increased costs to the community. In addition, it was whilst working in this setting that I had initially encountered the difficulties that prompted the current study.

After discussion with my field supervisor who worked within the Community Intellectual Disabilities Team where the research was to be conducted and consultation with a medical statistician, it was deemed that the study would be extremely clinically useful, even though a small sample size would reduce statistical power. However, I failed to take into account participants who met the eligibility criteria but declined to take part in the study. With hindsight, this seems quite a likely scenario, particularly in view of the participants being encouraged to talk about the level of risk they posed, but it was something that I had not given adequate consideration to. In addition to this, some of the participants were difficult to locate and were not reliable attendees at appointments. For the majority, engagement with the service was not part of any probation or court conditions and therefore was not mandatory.

The recruitment of sufficient numbers of staff to carry out the risk assessments also presented as problematic. Theoretically, some staff could have completed the DRAMS on their entire caseload of upwards of twenty individuals. This however, may have violated the assumption of independence (Senn, 1993) if for example, any particular clinician carried out proportionately more DRAMS assessments. Conversely, assessments carried out by a wider group of clinicians would provide a broader range of feedback; a fundamental aim of the current study.

In spite of these difficulties in recruitment, it feels like quite an achievement to have been able to recruit those participants who agreed to take part, particularly as my sample is drawn from the community and larger than many reported in the literature. Moreover, I was

surprised that the majority of the sample had been involved at some point with the Criminal Justice System as I had anticipated that much of the 'risky' behaviour for which people were referred to services would involve 'challenging' behaviour or behaviour that was being managed within intellectual disability services.

I was also keen to obtain a sample of varied abilities in that: the IQ (intelligence quotients) scores of participants spanned the range associated with an intellectual impairment (≤ 75). Indeed, much of the published research in the area is concerned with people at the more intellectually able end of the spectrum. In addition, inclusion of a female participant in the current study seemed to be novel as there appears to be no reference to female offenders with intellectual disabilities within the literature.

From the process of conducting this study, I have learnt to my expense that the recruitment of staff and participants can be considerably more time-consuming than anticipated and I now realise the importance of thoroughly examining the feasibility of sampling from specific clinical populations during the planning stage of research. For future projects, I would be encouraged to carry out a pilot study to address these issues.

1.4 Difficulties in obtaining informed consent

My previous research experience was limited to studies that had already been granted ethical approval so the process of this was completely new to me. Consequently, I spent a lot of time considering how to overcome the difficulties of obtaining informed consent from people with intellectual disabilities.

Initially, I misunderstood the ethical guidance on consent forms, believing that these had to follow a standard format. However, the ethics committee agreed that I could use pictures and symbols to make my consent forms and information sheets more accessible for people with intellectual disabilities. Although time consuming, I feel that this process has

made me more aware of how to adapt information so that it is understandable to someone with an intellectual disability and I feel more confident about doing this in the future.

1.5 Project management

A further reflection is around the difficulties I experienced in carrying out the research whilst simultaneously managing the demands of clinical training. My previous experience was as an Assistant Psychologist, employed to carry out research and therefore there was protected time to do this. However, my experience during the current study was somewhat different.

To begin with, during my third year I was travelling a considerable distance to my clinical placement, which was in a different county to the service where my research was being conducted. This made liaison with the staff collecting data more difficult and time consuming. I also felt more removed from the research than I would have liked and less able to control the data collection.

1.6 Lack of control

I found lack of control particularly difficult in terms of being reliant on other people to collect the data on my behalf. Again, in my previous experiences of conducting research, I had sole responsibility for collecting data. Although on the whole I found staff extremely willing to assist, they also had to manage their own overstretched workloads and asking them to take part in my research was obviously supplementary to their existing work. In addition to this, I also found it awkward to pursue staff who had kindly agreed to collect data, as it already felt like an imposition to ask them in the first place.

Carrying out future research as a qualified Clinical Psychologist may help to overcome these difficulties as being employed within the service where the data is collected would be an

obvious advantage. Moreover, this would enable increased control over the data collection, the research process as a whole and improve liaison with colleagues.

1.7 Conducting research alongside clinical commitments

The experience of conducting this study has allowed me to realise the difference between conducting research full time and conducting research alongside clinical commitments. If the opportunity should arise for me to carry out research post-qualification, I shall be mindful of these experiences and ensure that protected time is given solely for research pursuits. In addition, clinical departments could further utilise the input of trainees who are keen to carry out research for doctoral training.

Moreover, my experience of receiving research supervision from my field supervisor has given me the opportunity to see how Clinical Psychologists can use their research skills to supervise others in carrying out research and oversee and advise in the execution of such projects. This process has also made me aware of the practical difficulties of carrying out research in a clinical setting e.g. obtaining a sufficient sample size but also the rewards of seeing a research proposal come to fruition.

1.8 Participant contact

In the current study, I was not responsible for interviewing the participants with intellectual disabilities but rather for interviewing staff about their experiences of interviewing the participants. This felt quite different from research that I have done in the past and in some sense, less rewarding. I felt that I lacked the first-hand experience of actually administering the DRAMS and assessing the participants' reactions to this. Again, this led to me feeling quite removed from the study and less in control. However, it was encouraging

when staff reported positive outcomes from their interviews with clients and when clients were particularly pleased at being asked to take part.

In the planning stages of the current study, I had explored the possibility of also interviewing the participants with intellectual disabilities about their experiences of being administered the DRAMS but I felt that this was impractical within the time restraints of the research project. Although some of the staff passed on anecdotal observations and comments about participants' reactions, actual interviews with participants may have provided extremely useful information and is a possible avenue for future study.

1.9 General reflections

The experience of developing a research proposal and conducting the research project has been an extremely valuable learning experience. I have become more appreciative of the practical difficulties of putting research methodology into practice and have realised the importance of making compromises which may ultimately weaken the methodology. Moreover, I have found that I was readily able to critique other research during the process of the literature review but now with the experience of conducting my own research, I appreciate just how difficult it is to produce a methodologically sound study.

A recent change to the format requirements of the thesis has called for the production of three shorter self-contained pieces of work as opposed to the longer old-style thesis. Although I do not have the experience of writing up research in the manner specified by the previous guidelines, I have found the new requirements to be quite containing and less daunting than I imagined the old-style guidelines to be. In addition to this, I feel that the new format, including adherence to a specific journal's notes to authors will increase the likelihood of submissions for publication and make the process of doing this much more straightforward and significantly less time consuming.

Finally on a personal level, I have become more aware of my reactions to stress and the pressures of working to deadlines. Moreover, I have found that my coping strategies are not always the most helpful! From this experience, I feel that I will be better-equipped to manage similar situations in the future as a qualified clinician by recognising my own limitations and seeking support where required.

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APPENDIX A

Journal of Applied Research in Intellectual Disabilities Author Guidelines



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Journal of Applied Research in Intellectual Disabilities

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Manuscripts should be sent by email attachment to

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Please scan the attachment with a virus check before sending by email.

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Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

Preparation of the Manuscript

Manuscripts should be formatted with a wide margin and double spaced. Include all parts of the text of the paper in a single file, but do not embed figures. Please note the following points which will help us to process your manuscript successfully:

- Include all figure legends, and tables with their legends if available.
- Do not use the carriage return (enter) at the end of lines within a paragraph.
- Turn the hyphenation option off.
- In the cover email, specify any special characters used to represent non-keyboard characters.
- Take care not to use l (ell) for 1 (one), O (capital o) for 0 (zero) or ß (German esszett) for (beta).
- Use a tab, not spaces, to separate data points in tables.
- If you use a table editor function, ensure that each data point is contained within a unique cell, i.e. do not use carriage returns within cells.

Cover Page

A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address. A suggested running title of not more than fifty characters, including spaces; and up to six key words to aid indexing should also be provided.

Main Text

All papers should be divided into a structured summary (150 words) and the



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main text with appropriate sub headings. A structured summary should be given at the beginning of each article, incorporating the following headings: Background, Materials and Methods, Results, Conclusions. These should outline the questions investigated, the design, essential findings and main conclusions of the study.

The text should proceed through sections of Abstract, Introduction, Materials and Methods, Results and Discussion, and finally Tables. Figures should be submitted as a separate file. The reference list should be in alphabetic order thus:

Emerson E. (1995) *Challenging Behaviour: Analysis and Intervention in People with Learning Disabilities*. Cambridge University Press, Cambridge.
 McGill P. & Toogood A. (1993) Organising community placements. In: *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services* (Eds E. Emerson, P. McGill & J. Mansell), pp. 232-259. Chapman and Hall, London.
 Qureshi H. & Alborz A. (1992) Epidemiology of challenging behaviour. *Mental Handicap Research* 5, 130-145

Journal titles should be in full. References in text with more than two authors should be abbreviated to (Brown *et al.* 1977). Authors are responsible for the accuracy of their references.

We recommend the use of a tool such as EndNote or Reference Manager for reference management and formatting.

EndNote reference styles can be searched for here:

<http://www.endnote.com/support/enstyles.asp>

Reference Manager reference styles can be searched for here:

<http://www.refman.com/support/rmstyles.asp>

Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

● Illustrations and Tables

These should be referred to in the text as Figures using Arabic numbers, e.g. Fig. 1, Fig. 2, etc, in order of appearance. Figures should be clearly labelled with the name of the first author, and the appropriate number.

Each figure should have a separate legend; these should be grouped on a separate page at the end of the manuscript. All symbols and abbreviations should be clearly explained. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure.

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, and given a short caption.

Please save vector graphics (e.g. line artwork) in Encapsulated Postscript Format (EPS), and bitmap files (e.g. half-tones) in Tagged Image File Format (TIFF). Ideally, vector graphics that have been saved in metafile (.WMF) or pict (.PCT) format should be embedded within the body of the text file. Detailed information on our digital illustration standards is available on the Blackwell web site at <http://www.blackwellpublishing.com/authors/digill.asp>.

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APPENDIX B

Thesis Structure Guidelines

21 PRESENTATION/STRUCTURE OF THE THESIS

21.1 General Points

The thesis should not exceed 30,000 words of text (excluding references, appendices and for qualitative theses, transcripts).

In general you should follow the standard journal conventions on structure, formatting and style (APA Publication Manual, the BPS Style Guide).

The following are points taken with some minor modification from a BPS document on Guidelines for Assessment of the Ph.D. by J. Sloboda and S. Newstead.

21.2 Presentation and Clarity

- (1) The reader should be able to read the text without difficulty.
- (2) The text should be clear and "tell a story".
- (3) The submission should be "user friendly". The reader should be able to find his or her way around the thesis, locating figures and tables, and being able to cross-reference easily.
- (4) Number sections but, if appropriate, appendices and even paragraphs as well.
- (5) The style should be economical without unnecessary duplication or repetition.
- (6) The bibliography/reference list should be complete, accurate, and presented consistently in one of the standard styles (e.g. that used by BPS and APA journals).

21.3 Originality and Creativity

The research and the written submission should be the candidate's own work. Some trainees may work on studies whose nature is determined by the fact that they are part of a larger research endeavour being conducted by a local sponsor or academic supervisor. This is quite acceptable providing that the candidate can demonstrate his/her independent contribution and is responsible for the detailed design and execution of the investigation(s) reported.

21.4 Structure of Thesis

In dividing your dissertation into chapters and subheadings, you can choose any structure which seems most suited to your study. Have a look at past theses just to give you an idea about structure/presentation. While it is unwise to be too prescriptive, all dissertations should include the following sections:

(i.) Title Page

Your title should be a clear, precise and 'eye-catching' statement of your research area. Avoid very long titles that consist of a long sentence with many clauses. Use a full colon followed by a subtitle if necessary. Include, on this page, your name, the year of submission, and the degree for which you are submitting (i.e. Doctorate in Clinical Psychology).

(ii.) Contents Page

There is no need to detail every single sub-heading or Appendix. If you are using 'automatic section numbering' within your word processing package (as in this booklet) then a contents page can be created within a few seconds (and the advantage of this method is that your page

numbers/section numbers will automatically update if you change things in the body of your thesis). A list of Appendices and any Addenda (see below) should be presented on the same page as your contents page. A rough guide is that your contents page should be no longer than two sides of A4 (single spaced).

(iii.) List of Tables

This should be on a separate page following your contents page. Ensure that Table numbers and titles are consistent with those presented in the main body of your thesis. Again, if you are familiar with 'automatic caption numbering' this can be done in a matter of seconds and, as above, can be automatically updated.

(iv.) List of Figures

As above - on a separate page.

(v.) Abstract

You should, by now, be familiar with the nature and function of an abstract (i.e. a very concise account that gives the reader a clear idea about the background to your research, what you looked at, how you went about this, what you found, and what the implications are; often the reader can only decide from the abstract whether or not it is worth reading your work in any detail).

Abstracts of theses and dissertations are deemed to be an integral part of the work to be examined, and must be produced in accordance with the following requirements:

One copy of the abstract to be bound with each dissertation and two loose copies of the abstract are to be submitted for examination at the same time as the thesis.

The abstract must not exceed 300 words, and must be produced with single-spacing on one side of A4 paper and must be suitable for photographic reproduction.

The abstract must show the author and thesis title in the form of a heading.

(vi.) Self-Contained Review of Relevant Literature

Candidates should show that they have a thorough knowledge of the field based on familiarity with original sources. Undue dependence on secondary sources is to be avoided.

The self-contained review of literature should adhere to the requirements of a specified peer-reviewed psychology journal, included in the Science or Social Science Citation Index. The word count for such reviews for the journal chosen must fall within a minimum of 5,000 and a maximum of 8,000 words. Suitable target journals might include the British Journal of Clinical Psychology, the Journal of Consulting and Clinical Psychology or the Journal of Health Psychology.

A literature review is more than a catalogue of published work. It should offer a distillation of the current state of knowledge in the field, demonstrating a critical and analytic approach with an awareness of theoretical and methodological issues. It should avoid the inclusion of irrelevant or non-essential literature and avoid digressions. A good review does not necessarily cite every existing reference of potential relevance, especially for an area where there is a very large background literature. Some judicious selection is often appropriate. On the other hand, it should demonstrate a familiarity with work recognised as important for the field of enquiry.

(vii.) Self-Contained Research Report

The self-contained research report can be presented in one of two ways:

1 - In the general style of the British Journal of Clinical Psychology but with allowance for full reporting of the work completed, together with a detailed presentation of results and full and critical discussion (a minimum of 8,000 words, a maximum of 12,000 words, excluding references)

2 - A shorter report, which complies with guidelines for a specified journal (minimum 5,000 words, maximum 8,000 words, excluding references unless specified by the journal as including references). The journal selected should be peer-reviewed and included in the listings for the Science or Social Science Citation Index.

The literature review should reveal some questions or issues which require further investigation. The problem to be tackled should lead naturally from this review.

A clear and succinct statement of the research problem to be explored should be provided together with a set of specific hypotheses, predictions or questions, which the research is then designed to address. Even if there are no specific predictions or hypotheses, the question(s) to be addressed should have some clear focus. The whole exercise should not be presented as a rather vague "fishing trip".

There should be some indication that the problem to be tackled is worthwhile and that it could have some potential bearing on clinical psychological practice either directly or indirectly (in practice much clinically relevant research is not immediately applicable but can be seen as a step on the way to something that might eventually be applicable).

(viii.) Methods of Enquiry Adopted

It is the research questions that drive the methodology and not vice versa. Consequently, the main criterion for judging the appropriateness of the methods adopted is whether they are well suited to addressing the questions, hypotheses or predictions identified. Since selection of methodology is not always a simple and straightforward matter, candidates should indicate the rationale for their choice. A study may legitimately use different methodologies for different stages or aspects.

There should be a sense of planning with the methods having been chosen through a conscious process of deliberation with the criteria for, and advantages and disadvantages of, particular choices of methods being well specified.

The methods section should be broken up into a number of logical sub-sections. The following is often a good framework to aim for:

Design:

What is the overall framework? Is it correlational, repeated measures, independent groups, qualitative, a mixture of these? What are the main independent/dependent variables? How many levels or conditions in each variable? You do not need to say anything about procedure here - that comes in a later sub-heading.

Participants:

How they were selected and demographic information. If the study is an attempt to draw conclusions about a wider population then the Discussion should include consideration of whether the study included a representative sample.

Measures/Questionnaires used:

What questionnaires etc. were used? What do these measure in the context of your research? How did you operationally define your variables (e.g. 'trainee stress level' was operationally defined as: 'number of visits to the pub in a week'). Include the validity and reliability data available from the authors of any standardised measures used.

Procedure:

A description of who did what, when and where in enough detail to allow readers to attempt a replication if they wish.

(ix.) Analysis of Data

- (1) It is often a good idea to structure your Results section around your Research questions or hypotheses, rather than, for example, presenting data in the order in which it appeared in the Questionnaire.
- (2) The data set should be reported in sufficient detail for the reader to get a complete, unbiased picture.
- (3) Qualitative studies need to give a complete account of the data reduction techniques used (i.e. categories, themes, etc., should be listed, and the categorisation process described). Verbatim transcripts of interviews have to be submitted as a separate Appendix to the thesis.
- (4) At all times there should be a clear attempt to distinguish between reporting and interpretation, with most interpretation reserved until the Discussion section.
- (5) The analytic methods used need to be justified and shown to be suitable for the tasks.
- (6) Any problems arising in the analysis should be recognised and tackled appropriately.
- (7) Candidates should show sensitivity to problems of reliability, error of measurement, sources of bias, and the like.
- (8) Understanding should be shown of the assumptions behind the methods of analysis used.
- (9) Where appropriate, candidates should demonstrate imagination and creativity in identifying and analysing emergent properties of data which may not have been foreseen.
- (10) The analyses should be linked to the hypotheses, predictions or questions that formed the basis for the work.
- (11) Candidates should be able to demonstrate judgement in the presentation of key summary data within the body of the text. Primary data, where appropriate, and secondary data should be placed in Appendices.
- (12) The data should be presented in a well structured way so that a clear presentational sequence is achieved.
- (13) Overall, candidates should be able to demonstrate WHY each particular analysis was conducted, HOW the analysis was done and WHAT the analysis reveals about the data.
- (14) There should be some attempt to check the validity of the results, and some discussion of the possible effects of the investigator's opinions and biases. Inter-rater checks and "triangulation" by comparing different methods are all encouraged.

(x.) Discussion

- (1) The Discussion should summarise without undue repetition and in plain language, what has been achieved.
- (2) It should evaluate the study's contribution to the research area.
- (3) The main findings should be interpreted and related to both theory and practice. (The relationship to clinical practice will often not be direct, in the sense that the results can immediately be applied. For example, work that increases the understanding of the nature or processes underlying a particular problem or symptom may eventually and when combined with other work, have an impact on therapy.) Another way of looking at this point is to ask why

should another clinical psychologist bother to read this work?

- (4) There should be a reflection on the research process as a whole. This reveals what the candidate has learned during the Course of the work.
- (5) In many cases it will be appropriate to include a section which discusses the limitations of the research design and methodology in the light of knowledge and experience gained whilst undertaking the work, and outlines alternative or additional approaches that might be followed.
- (6) There should be some pointers to future work, either by the candidate or others.
- (7) An attempt should be made to identify issues which require further clarification.

(xi.) Critique of Research

Critical appraisal of the research process founded on the keeping of a research diary. If Option ii. has been chosen this section of the thesis should comprise a detailed critique of research methodology with careful specification of the research limitations. This should be written in conjunction with discussion of future research strands and opportunities (minimum 2,000 words, maximum 5,000 words).

(xii.) Appendices/Addenda

- (1) Appendices are bound with your thesis and come after the References. Addenda are any materials that are separately presented or bound (e.g. the transcripts from a qualitative study should be separately bound and presented as an Addendum). Any addenda should be clearly listed in your contents page.
- (2) It is difficult to be prescriptive about what should go in the Appendices but things such as copies of questionnaires, detailed scoring procedures, summarised raw data, information sheets/consent forms, and so on are often put here. Include only as much material as is usefully relevant - otherwise the main body of your thesis could end up looking like a slim initial section attached at the front of scores of pages taken up by your Appendices.
- (3) Appendices must include letters of approval from the relevant Ethics Committees, copies of any measurements utilised, together with guidelines for submission to journals identified by the literature review and the main research report (where Option ii. has been chosen). Additionally, where Option ii. has been chosen Appendices should include detailed descriptive data and any information about hypotheses tested or analyses completed which have not been presented in the paper format. In all cases of qualitative theses clear evidence trails should be included.

Balance should be sought so that the total word length of the thesis is not exceeded. Please note that there should be no duplication or cross-referencing of pages or sections between the research report and the literature review that precedes it.

(xiii.) References

These should be in APA or BPsS as described. Ensure that you have included every reference that you have referred to in the body of the thesis and within the Appendices.

Note that for secondary citations the APA convention is as follows: If Jones (1996) is your source and Jones has cited Smith (1934) then in the body of text you should say Smith (1934, cited in Jones, 1996). In the references you only need to give the reference for Jones (1996) - i.e. the source you have accessed. There is no need to give the original reference as well, but you will not be penalised in any way if you prefer to give both references in full. Also, please bear in mind, that secondary citations in your thesis should be kept to a minimum; you may get penalised if you have relied too heavily on these.

APPENDIX C

The Dynamic Risk Assessment and Management System (DRAMS)


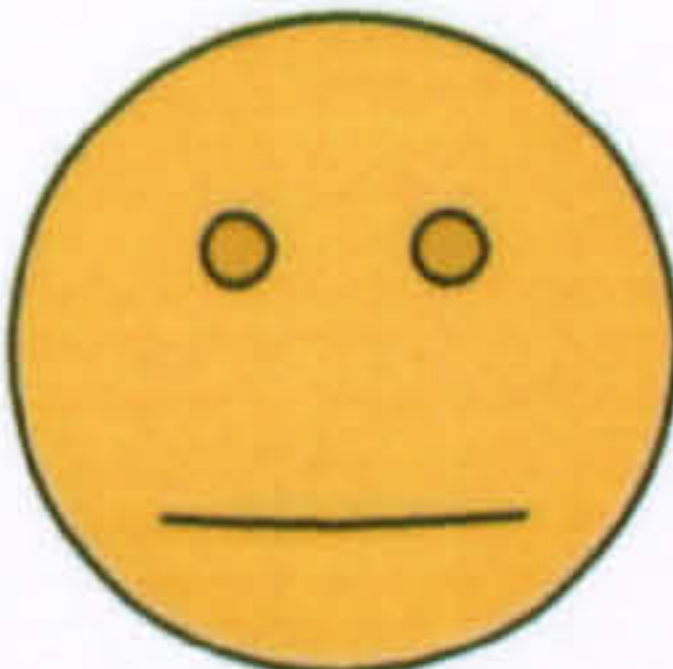

**Dynamic Risk Assessment and Management System
(DRAMS)**


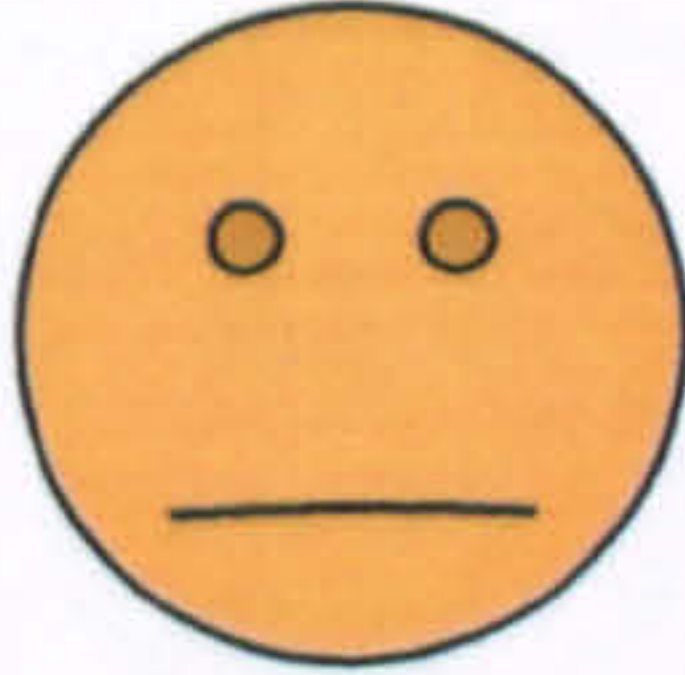
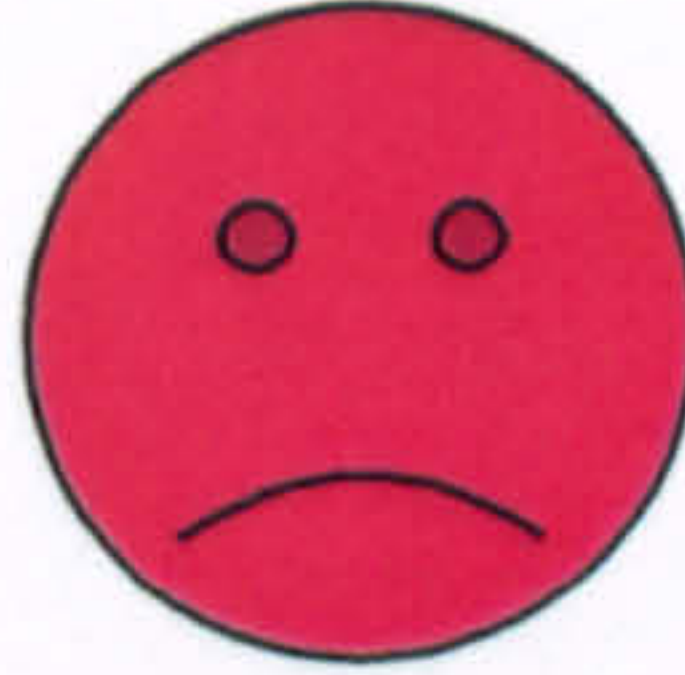
Name:



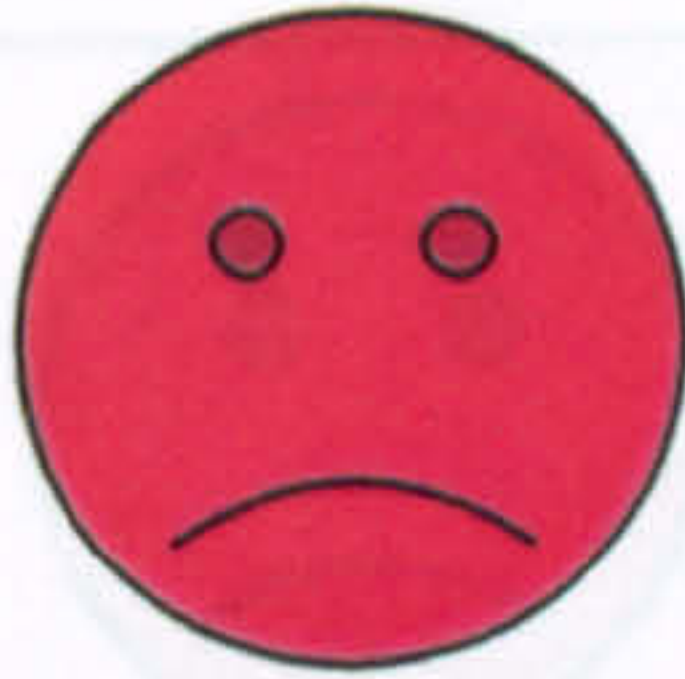
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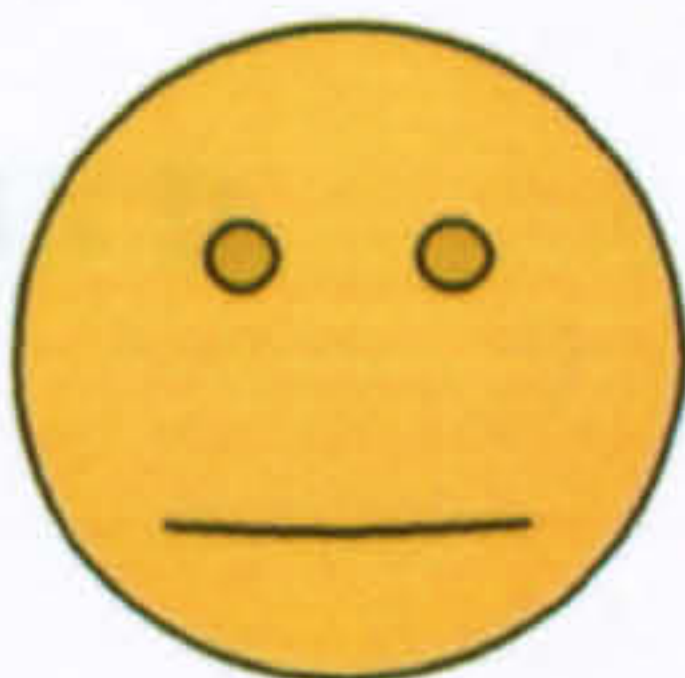

























Time:

| Dynamic Risk Variable |  |  |  | |
|--|---|---|---|---|
| Mood/Emotion | | | | |
| Anxiety (worry or uptight) | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Sadness | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Mania (high or excited) | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Suspicious thoughts | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Problem with recent renewal of emotional relationships | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |

| Dynamic Risk Variable |  |  |  | |
|---|---|---|---|---|
| <u>Anti- Social Behaviour</u> | | | | |
| Criminal thoughts | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Impulsive | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Refusing to engage in therapy | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Verbal threats | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Non-verbal threats | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| <u>Intolerance/Agreeableness</u> | | | | |
| Inappropriate anger | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |
| Complaining about staff | <div><div></div><div>none</div></div> | <div><div></div><div>wee bit</div></div> | <div><div></div><div>lots</div></div> | <div><div></div><div>all the time</div></div> |

| Dynamic Risk Variable |  |  |  | |
|----------------------------------|---|---|---|--|
| Blaming others | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| Lack of consideration for others | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| <u>Sexual self-regulation</u> | | | | |
| Sexually impulsive | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| Sexually inappropriate behaviour | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| Aberrant sexual thoughts | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| <u>Violent self-regulation</u> | | | | |
| Violence to self | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |
| Violence to others | <div><div></div></div> <div>none</div> | <div><div></div></div> <div>wee bit</div> | <div><div></div></div> <div>lots</div> | <div><div></div></div> <div>all the time</div> |

| | | | | |
|-------------------------------|--|--|---|--|
| Dynamic Risk Variable |  | |  |  |
| Violence to property |  none |  wee bit |  lots |  all the time |
| <u>Agreement with routine</u> | | | | |
| Looking after room |  very tidy |  tidy |  untidy |  disagree with routine |
| Looking after self |  very tidy |  tidy |  untidy |  disagree with routine |
| Daily routine |  trying hard |  trying |  trying very little |  disagree with routine |
| <u>Substance abuse</u> | | | | |
| Alcohol abuse |  none |  wee bit |  lots |  all the time |
| Drugs/solvents abuse |  none |  wee bit |  lots |  all the time |

| | | | | |
|--------------------------------------|--|---|--|--|
| Dynamic Risk Variable |  |  |  | |
| <u>Opportunity for victim access</u> |  no chance |  wee chance |  good chance |  constant chance |
| <u>Self-esteem/social isolation</u> | | | | |
| Feel bad about myself |  none |  wee bit |  lots |  all the time |
| Spending time on my own |  none |  wee bit |  lots |  all the time |
| <u>Clinical interest</u> | | | | |
| Psychotic symptoms |  none |  wee bit |  lots |  all the time |
| Winding others up |  none |  wee bit |  lots |  all the time |
| Refusing medication |  none |  wee bit |  lots |  all the time |

Patient/client signature.....

Staff signature.....

APPENDIX D

The Functional Analysis of Care Environment (FACE) Risk Profile

FACE Risk Profile

Learning Disabilities

Confidential

RLD

This form is to be completed following the assessment and/or review of risk, in accordance with local Clinical Risk Management Standards. Written details of current and past risks/behaviour should be provided on p.2/3. **This form must be photocopied onto gold coloured paper.**

ASSESSMENT SUMMARY

| | | | | | | | | | | | |
|---|----------|----------------|------------------------|---|----|--|--|-----|--|-----------|----|
| Surname: | | | | Risk history | | | | | | | |
| First name: | | | | Is there any evidence of a history of significant risk (tick) | | | | Yes | | No | |
| Sex: | | | | Is there a history of conviction for violent or sexual offences | | | | | | | |
| NHS number: | | | | Involvement in serious incident in past 3 months? | | | | | | | |
| Title: | | Date of Birth: | | No | | Near miss | | SUI | | Not known | |
| Lead contact name: | | | | Current risk status (rate using the following scale): | | | | | | | |
| Lead contact tel. No: | | | | <div>0= No apparent risk. No history/warning signs indicative of risk.</div> <div>1= Low apparent risk. No current indication of risk, but person's history and/or warning signs indicate possible risk. Required precautions covered by standard care plan i.e. no special risk prevention measures or plan required.</div> <div>2= Significant risk. Person's history and condition indicate the presence of risk and this is considered to be a significant issue at present. Requires a contingency risk management plan.</div> <div>3= Serious risk. Substantial current risk. Circumstances are such that a risk management plan should be / has been drawn up <i>and</i> implemented.</div> <div>4= Serious and imminent risk. Person's history and/or warning signs indicate the presence of risk and this is considered imminent. Highest priority to be given to risk prevention.</div> | | | | | | | |
| CPA Level (circle) | Standard | Enhanced | N/A | | | | | | | | |
| Care co-ordinator name: (if applicable) | | | | | | | | | | | |
| Tel: | | Base: | | | | | | | | | |
| Agencies involved: (tick) | | | | | | | | | | | |
| Primary Care | | | Secondary Care | | | | | | | | |
| Social Services | | | Mental Health Services | | | | | | | | |
| Voluntary / independent sector | | | Probation Services | | | | | | | | |
| Education services | | | Police | | | | | | | | |
| Legal status upon assessment: (tick) | | | | Domestic risk (e.g. dangerous use of appliances) | | | | | | | |
| None | | | On leave | | | Risk of suicide | | | | | |
| Informal | | | Supervised discharge | | | Risk of self-injury | | | | | |
| Detained | | | Guardianship | | | Risk of abuse by others | | | | | |
| Assessed by: (print name) | | | | Risk related to physical health | | | | | | | |
| Designation: | | | | Risk of violence / harm to others | | | | | | | |
| Date of assessment: | | | | Risk to child / vulnerable others | | | | | | | |
| Location of assessment: | | | | High Risk of relapse (if a mental illness involved) | | | | Yes | | No | |
| Assessment type (tick): | | | | Potential risk to staff members? | | | | Yes | | No | |
| Initial | | | Review | | | Risk management plan developed? | | | | Yes | No |
| Discharge | | | Follow-up | | | Further action(s) recommended / required: (tick) | | | | | |
| Assessed in crisis situation? | | | Yes | | No | No further action at this stage | | | | | |
| Signed: | | | | Further risk assessment | | | | | | | |
| | | | | Discussion with RMO / team members | | | | | | | |
| Date: | | | | Date of next review: | | | | | | | |

Comments:

RISK FACTORS AND WARNING SIGNS

Time frame for all Current warning signs = past 3 months. For all sections if NO to History and Current leave boxes in that section blank. Otherwise place a ✓ in all boxes which apply a X in boxes that do not apply. Enter 9 if not known or unable to assess (Where risk is indicated in any section, do not leave any boxes blank). Under Notes give brief details of recency, severity, frequency, pattern, ideation and intent.

| Personal Circumstances indicative of risk | History | | Current | | Notes |
|--|---------|--|---------|--|-------|
| | No | | No | | |
| Bereavement (esp. of main carer) | | | | | |
| Breakdown, loss or lack of carer support | | | | | |
| Breakdown / withdrawal or lack of residential placement | | | | | |
| Breakdown / withdrawal or lack of day services | | | | | |
| Concern expressed by others (relatives, carers) | | | | | |
| Social isolation | | | | | |
| Physical abuse / victimisation by others | | | | | |
| Sexual vulnerability | | | | | |
| Emotional abuse / victimisation by others | | | | | |
| Financial abuse / victimisation by others | | | | | |
| Ill-suited home environment | | | | | |
| No stable living environment | | | | | |
| Recurrence of circumstances associated with risk behaviours | | | | | |
| | | | | | |
| Physical Problems indicative of risk | History | | Current | | |
| | No | | No | | |
| Life-threatening illness / procedure (e.g. cardiac problems) | | | | | |
| Mobility problems (e.g. cannot manage stairs) | | | | | |
| Sensory impairment (please specify) | | | | | |
| Seizures | | | | | |
| Pressure sores | | | | | |
| Susceptibility to infection (e.g. in poor home environment) | | | | | |
| Swallowing difficulties | | | | | |
| | | | | | |
| Mental Health Problems indicative of risk | History | | Current | | |
| | No | | No | | |
| Reduced ability to communicate or engage in daily activities | | | | | |
| Severely depressed mood | | | | | |
| Evidence of self-harm / suicidal ideation | | | | | |
| Symptoms of severe mental illness (e.g. delusions) | | | | | |
| Ideas of harming others | | | | | |
| | | | | | |
| Behaviour indicative of risk | History | | Current | | |
| | No | | | | |
| Self-neglect | | | | | |
| Neglect of dependent others | | | | | |
| Domestic risk (e.g. unsafe use of appliances) | | | | | |
| Failure to respond to emergencies | | | | | |
| Drug / alcohol use | | | | | |
| Suicide attempts | | | | | |
| Threats / intimidation of others | | | | | |
| Physical harm to others | | | | | |
| Harm to property | | | | | |
| Deliberate fire setting | | | | | |
| Self-injury | | | | | |
| Aroused or overactive behaviour | | | | | |
| Sexually inappropriate or deviant behaviour | | | | | |
| | | | | | |
| Treatment – related indicators | History | | Current | | |
| | No | | No | | |
| Difficulties in management of medication / treatment | | | | | |
| Non-adherence to therapy programme | | | | | |
| Unplanned disengagement from services | | | | | |
| Failure to respond to behaviour management programme | | | | | |
| Difficulties with / failure to engage with services | | | | | |
| Compulsory admission | | | | | |

Service user name: jlowry@lon10-01-01.odmum.ac.uk

NHS Number (D-o-B if not known) : 00000000000000000000

Persons potentially at risk (tick as appropriate and detail below)

| | | | | | | | |
|---------------|--|----------------|--|-------------------------|--|--------------------------|--|
| None | | Self | | Informal carer / parent | | Co-residents | |
| Staff members | | General public | | Child | | Other (<i>specify</i>) | |

Details:

Summary of main risks identified

Have actions been taken in the past to reduce risk?*(Detail, including effectiveness)*

Yes

No

Unclear

Service user's view of risk (Give details, including person's view of what is needed to reduce risk)

Is the service user aware of possible risks?

Yes

No

Unclear

Protective factors

© 2000-3 FACE Recording & Measurement Systems FACE Risk Profile Learning Disabilities July 2006

Relapse and Risk Management Plan

| | | | | | | | | | |
|--------------------------------------|--|--|---|--|------------|--------------------|---------------|--------------|--|
| Risk Alert Applied (state IT system) | | | | | Agreed by: | | Date applied: | | |
| Service user informed: | | | Y | | N | If not, state why: | | Review date: | |

Trigger signs, symptoms, behaviour suggestive of possible risk/relapse to be addressed by plan

| | | | | | | | | | |
|--|--|--|----------------------|--|--|--|-------------------------|--|--|
| Steps to be taken if service user fails to attend or meet other commitments (tick, detail below) | | | | | | | None | | |
| Send further appointment | | | Discuss with RMO | | | | Contact GP | | |
| Contact care co-ordinator | | | Contact care manager | | | | Contact nominated carer | | |
| Telephone | | | Visit home | | | | Other (specify) | | |

Action to be taken in the event of risk behaviour/relapse

Information sources available / accessed in completing risk profile (Tick all sources used)

| | | | | | | | | | | | |
|------------------------------|--|--|------------|--|--|------------------------|--|--|-----------------|--|--|
| Service user | | | Case notes | | | Carer / relative | | | Other (specify) | | |
| Copies sent to: (tick) | | | Date | | | Copies sent to: (tick) | | | Date | | |
| File | | | | | | GP | | | | | |
| Care Coordinator (if on CPA) | | | | | | Social Services | | | | | |
| Service user | | | | | | Health Services | | | | | |
| Carer | | | | | | Other | | | | | |
| Plan completed by: | | | | | | Signed: | | | | | |
| Designation: | | | | | | Date: | | | | | |
| Signature of service user: | | | | | | Date: | | | | | |

APPENDIX E

Client Demographic Information

Table 1. Gender, age, IQ scores and offence/offending behaviour for each client.

| Client | Sex | Age | Verbal IQ | Performance IQ | Full Scale IQ | Offence |
|--------|--------|-----|--------------|----------------|---------------|--|
| 1 | Female | 31 | 54 | 61 | 56 | Assault, making threats to kill |
| 2 | Male | 42 | 55 | 70 | 60 | Sexual assault on a child |
| 3 | Male | 26 | 48 | 49 | 45 | Physical assault on vulnerable female. Charged not convicted |
| 4 | Male | 20 | 72 | 74 | 72 | Assault |
| 5 | Male | 23 | 68 | 67 | 65 | Fire setting, alleged sexual assault on children |
| 6 | Male | 58 | 67 | 65 | 64 | Sexual assault on child |
| 7 | Male | 54 | missing data | missing data | missing data | Sexual assaults on children. Not convicted but admitted offences |
| 8 | Male | 37 | 65 | 70 | 64 | Assault |

APPENDIX F

Confirmation of Ethical Approval



[REDACTED] Research Ethics Committee

Telephone: [REDACTED]

Facsimile: [REDACTED]

[REDACTED]

Miss Kelly M Gaskin
Trainee Clinical Psychologist
University of Leicester
Dept. of Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Miss Gaskin

Full title of study: An investigation into the validity of the Dynamic Risk Assessment and Management System (DRAMS) and participants' experience of using it to assess risk in a learning disability sample.

REC reference number: 06/Q2405/4

Thank you for your letter of 24 February 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites


The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

APPENDIX G

Trust Research & Development Approval


E mail: 
Department of Clinical Psychology
University of Leicester
104 Regent Road
Leicester
LE1 7LT

Dear Kelly

RE: An Investigation into the Validity of the Dynamic Risk Assessment and Management System (DRAMS) and Participants' Experiences of using it to Assess Risk in a Learning Disability Sample.

I am writing to inform you that the  Mental Health Trust Clinical Research Committee has reviewed and approved the above research protocol.

There was some concern that only Clinical Psychologists and Approved Social Workers were being included, it was felt that it could have been appropriate to also include nursing staff and other health professionals who are also involved in the assessment of risk. However, as this study had received Ethical Approval, and any changes would delay the commencement of the study, it was agreed that this was acceptable as long as reference was made to this limitation.

As part of the dissemination process within the Trust, please can you provide a short summary of your research findings once the study is complete.

If you require any further information please do not hesitate to contact me.

Yours sincerely


Acting Research Coordinator

APPENDIX H

Participant Information Sheet

Patient Information Sheet



You are invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve.

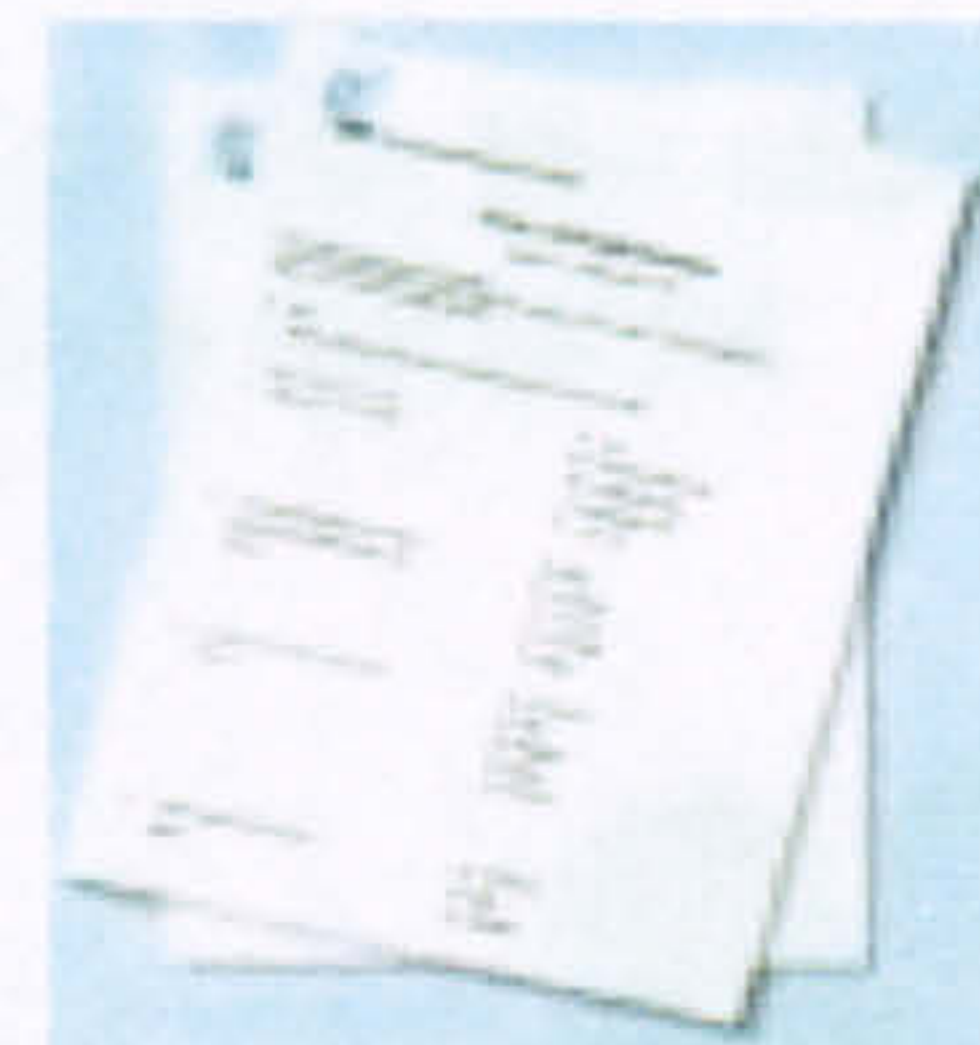
Please take time to read or have read to you the following information carefully.



Please ask us anything that is not clear or if you would like more information.

Then take time to decide whether or not you wish to take part.

This study is to investigate how useful a questionnaire called the DRAMS is when talking about risk in people with a learning disability.



It is being carried out by somebody called Kelly Gaskin who is training to be a psychologist at the University of Leicester

The results of this study may lead to better ways of understanding behaviour in people with learning disabilities which could worry others.

The results could also lead to a new questionnaire, specially designed for using with people with learning disabilities.

Approximately 20 people who are seeing a psychologist or social worker from the Learning Disability Service will be asked to take part.



It is up to you to decide whether or not to take part. If you do decide you would like to take part you can change your mind at any time without giving a reason. This will not stop you from seeing your psychologist or social worker in the future.

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|-----|-----|-----|-----|-----|-----|-----|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | |

You will be given a week to decide whether or not you want to take part in the research.

During this time you can discuss the research with a friend or relative and show them this sheet to help you decide.



If you do decide to take part in the study you will be asked to sign a consent form.

Then the next time you see your psychologist or social worker they will show you a questionnaire called the DRAMS and you will fill this in together.



The questions are about your feelings, mood and behaviour. It may take around an hour to answer them all.

It is possible that thinking and talking about your feelings, mood and behaviour may make you feel upset. If so



please tell the person helping you to answer the questions or another member of staff so that we can help.

This study aims to find better ways of working with people with learning disabilities. Filling in the questionnaire may also give you the chance to think and talk about how you feel about your feelings, mood and behaviour, which some people may find helpful.



If you take part, all your details will be kept private.

The results of this study might be published in a journal so that other people can learn better ways of working with people with learning disabilities.



If you wish to make a complaint about anything to do with this study please ask your psychologist or social worker to contact:

Dr Marilyn Christie
School of Psychology- Clinical Section
University of Leicester
104 Regent Road
Leicester, LE1 7LT

Telephone: 0116 223 1639

Thank you for your time.

APPENDIX I

Participant Consent Form

Patient Consent Form

This form should be read in conjunction with the Patient Information Sheet (version 1.2)

Title of study: An investigation into the validity of the Dynamic Risk Assessment and Management System (DRAMS) and participants' experience of using it to assess risk in a learning disability sample.

Chief Investigator: Miss Kelly Gaskin – Trainee Clinical Psychologist

Supervisor: Dr Marilyn Christie – Consultant Clinical Psychologist

1. My psychologist or social worker has told me about the research study.

Please initial box

☐
2. I have agreed that I would like to take part.

☐
3. It is OK for the person doing the research to look at my notes.

☐

To be completed by the Patient

Name (Block Capitals)

Signature..... **Date**.....

Thank you

To be completed by Researcher

Name of Person taking consent

Signature..... **Date**.....

APPENDIX J

Clinician Feedback Questionnaires

Questionnaire 1: Clinician’s Perceptions of the Usefulness of the Functional Analysis of Care
Environments (FACE) Risk Profile in Assessing Risk in a Learning Disability Sample

1. To what extent has FACE informed your treatment plan for this client?

| | | | | |
|------------|---|---|---|---------------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Significantly |

2. How relevant was FACE to your risk assessment for this client?

| | | | | |
|--------------|---|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| No relevance | | | | High relevance |

3. On completion of FACE, how able do you feel to predict risk for this client?

| | | | | |
|------------|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Very able |

4. How confident do you feel in the level of risk predicted by FACE for this client?

| | | | | |
|----------------------|---|---|----------------|---|
| 1 | 2 | 3 | 4 | 5 |
| Not at all confident | | | Very confident | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

5. How easy was FACE to complete with this client?

| | | | | |
|-------|---|---|-----------|---|
| 1 | 2 | 3 | 4 | 5 |
| Easy | | | Difficult | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

6. How time consuming did you find FACE with this client?

| | | | | |
|------------|---|---|-----------|---|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | Extremely | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

7. Did you think that FACE was a useful risk assessment tool for this client?

Yes

No

8. What do you consider to be the main advantages of using FACE with this client?

9. What do you consider to be the main disadvantages of using FACE with this client?

10. Have you any further comments?

Questionnaire 2: Clinician’s Perceptions of the Usefulness of the Dynamic Risk Assessment and Management System (DRAMS) in Assessing Risk in a Learning Disability Sample

1. To what extent has the DRAMS informed your treatment plan with this client?

| | | | | |
|------------|---|---|---|---------------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Significantly |

2. How relevant was the DRAMS to your risk assessment for this client?

| | | | | |
|--------------|---|---|---|----------------|
| 1 | 2 | 3 | 4 | 5 |
| No relevance | | | | High relevance |

3. On completion of the DRAMS, how able do you feel to predict risk for this client?

| | | | | |
|------------|---|---|---|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | | Very able |

4. How confident do you feel in the level of risk predicted by the DRAMS for this client?

| | | | | |
|----------------------|---|---|----------------|---|
| 1 | 2 | 3 | 4 | 5 |
| Not at all confident | | | Very confident | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

5. How easy was the DRAMS to complete with this client?

| | | | | |
|-------|---|---|-----------|---|
| 1 | 2 | 3 | 4 | 5 |
| Easy | | | Difficult | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

6. How time consuming did you find the DRAMS with this client?

| | | | | |
|------------|---|---|-----------|---|
| 1 | 2 | 3 | 4 | 5 |
| Not at all | | | Extremely | |
| <hr/> | | | | |
| <hr/> | | | | |
| <hr/> | | | | |

7. Do you think that the DRAMS was a useful risk assessment tool with this client?

| Yes | No |
|-------|----|
| <hr/> | |
| <hr/> | |
| <hr/> | |

8. What do you consider to be the main advantages of using the DRAMS with this client?

| |
|-------|
| <hr/> |
| <hr/> |
| <hr/> |

9. What do you consider to be the main disadvantages of using the DRAMS with this client?

| |
|-------|
| <hr/> |
| <hr/> |
| <hr/> |

10. Have you any further comments?

| |
|-------|
| <hr/> |
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Thank you for your time

APPENDIX K

Levene Test for Equality of Variance

Independent Samples Test

| | | t-test for Equality of Means | | |
|------------|-----------------------------|------------------------------|---|---------|
| | | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | Lower | Upper |
| Cross_diff | Equal variances assumed | 1.72603 | -3.47343 | 4.97343 |
| | Equal variances not assumed | 1.72603 | -3.62960 | 5.12960 |

T-Test

Group Statistics

| | Group | N | Mean | Std. Deviation | Std. Error Mean |
|------|-------|---|---------|----------------|-----------------|
| Diff | df | 4 | 5.5000 | 1.91485 | .95743 |
| | fd | 4 | -4.7500 | 2.87228 | 1.43614 |

Independent Samples Test

| | | Levene's Test for Equality of Variances | |
|------|-----------------------------|---|------|
| | | F | Sig. |
| Diff | Equal variances assumed | .133 | .728 |
| | Equal variances not assumed | | |

Independent Samples Test

| | | t-test for Equality of Means | | |
|------|--------------------------------|------------------------------|--|----------|
| | | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | Lower | Upper |
| Diff | Equal variances assumed | 1.72603 | 6.02657 | 14.47343 |
| | Equal variances not assumed | 1.72603 | 5.87040 | 14.62960 |

T-Test

Group Statistics

| | Group | N | Mean | Std. Deviation | Std. Error Mean |
|-------|-------|---|---------|----------------|--------------------|
| Total | df | 4 | 42.5000 | 7.00000 | 3.50000 |
| | fd | 4 | 37.2500 | 4.78714 | 2.39357 |

Independent Samples Test

| | | Levene's Test for Equality of Variances | |
|-------|--------------------------------|--|------|
| | | F | Sig. |
| Total | Equal variances assumed | .955 | .366 |
| | Equal variances not assumed | | |

APPENDIX L

Kolmogorov-Smirnov Test for Distributional Adequacy

NPARTESTS

/k-s (NORMAL) = VAR00001 VAR00002
/MISSING ANALYSIS.

NPARTests

[DataSet01]

One Sample Kolmogorov- Smirnov Test

| | VAR00001 | VAR00002 |
|-----------------------|----------|----------|
| N | 8 | 8 |
| Normal Parameters a,b | | |
| Mean | 22,5000 | 17.3750 |
| Std. Deviation | 3,62531 | 2.97309 |
| Most Extreme Absolute | .180 | .200 |
| Differences Positive | .180 | .167 |
| Negative | -.120 | -.200 |
| Kolmogorov-Smirnov Z | .509 | .565 |
| Asymp. Sig (2-tailed) | .958 | .907 |

- a. Test Distribution is Normal
- b. Calculated from data

APPENDIX M

Guidance for Administering the DRAMS

DYNAMIC RISK ASSESSMENT and MANAGEMENT SYSTEM (D.R.A.M.S.)

Information and Guidance for staff completing DRAMS

Risk assessment

Risk assessment is increasingly seen as an important aspect of care and treatment for all client groups, including those with Intellectual Disability. It can be used to tell us about the current presentation of an individual, or to inform a variety of decisions

such as; appropriate placements, levels of supervision and staffing, and appropriate

treatment programmes. Risk assessment is generally considered under the two broad categories of static/historical/actuarial risk factors and dynamic/proximal risk factors.

Static/historical/actuarial risk factors differ markedly from dynamic/proximal risk factors. The former will never change except perhaps to increase, while the latter vary constantly by the month, week, or even the day. Hanson (2002) has separated dynamic factors into stable dynamic and acute dynamic. Stable dynamic factors refer to variables which may be relatively unchanging although they may be amenable to treatment, e.g. poor anger control. Acute dynamic factors refer to variables which may change by the day or even by the hour, e.g. in a rage, level of provocation and so on.

While a great deal is known and a large amount of research is currently being conducted on the use of historical, actuarial risk assessment, much less is understood about dynamic/proximal risk. Although less is known about dynamic risk, it nevertheless accounts for up to 50% of the probability variance in terms of

estimating violent and sexual incidents (Hanson & Harris, 2000). Both Quinsey *et al.*, (1998) and Hanson & Harris, (2000) have outlined some of the main variables to emerge from studies of proximal risk. The two most significant factors are antisocial attitude and non-compliance with therapeutic or management regimes. Additional items include impulsiveness, mental illness, substance abuse and access to victims. Lindsay *et al.*, (2004) on a study of 52 sex offenders with intellectual disability, have found that, in general, these variables are also correlated with re-offending with these clients.

Rationale for the development of Dynamic Risk Assessment and Management System (DRAMS)

DRAMS was developed in response to a clinical problem faced by the staff and clinical team in the IDD unit in the State Hospital. There was a need for an assessment and management system that focussed on the dynamic factors that influence risk. Whilst developing and implementing positive behavioural programmes with the client group, it was found that acute dynamic risk situations frequently arose, sometimes resulting in serious incidents. This made it difficult to maintain the internal function of the positive programme. Rather than introducing penalties that would prevent individuals from accessing positive outcomes, it was thought that the implementation of a parallel dynamic risk assessment could enable temporary suspension of the positive programme, until the level of dynamic risk had decreased. In effect, individuals would not lose rewards gained, but would not be able to access them or gain further rewards until safe to do so.

It was thought that if a simple enough system could be developed, it could be used collaboratively with patients to explain why the positive programme was temporarily suspended. This might also help to convey to individuals why certain procedures were being followed and decisions made. The use of a simple assessment tool might also encourage individuals to consider their own behaviour, through support, to reflect on their current level of risk. In this way, it would serve as a method of positive feedback for individuals, as dynamic risk levels decrease. Additionally, staff often use intuitive knowledge of individuals

to identify and manage dynamic risk, if this knowledge could be made more clear and accessible, it might ease sharing this with other staff groups working with patients who have IDD. Another advantage might be to engage patients with difficult discussions.

Description of DRAMS

From the literature on dynamic risk, several major variables were extracted and these were in turn subdivided into specific items making up the general variable.

Each of these items is arranged along a continuum from no problem to severe problem. The continuum is worded so that it can be understood by the patient. A traffic light analogy is used to promote the understanding, usability and collaboration of patients. Green traffic lights cover the two least problematic categories, amber traffic lights cover the intermediate categories and red traffic lights cover the most risky categories. In addition, with certain items such as violence to others, drug and solvent abuse and excessive opportunities for victim access (in the case of sex offenders), a stop sign has been introduced (to continue to the Highway Code metaphor). In these cases, once the client has moved back into the less risky categories, they may still not have access to their daily routines until the staff group are satisfied that the level of risk has indeed subsided to acceptable levels.

The DRAMS can be scored by item, by category and as a total score. However, it should be remembered that the DRAMS has been developed as a collaborative tool and it is best used with individual participants.

Reformulation of the DRAMS

Based on the field trial and further research on DRAMS the individual variables have been reformulated as follows:

Mood/Emotion – Anxiety, sadness, mania, suspicious thoughts, problems with recent renewal of emotional relationships

Anti-social behaviour – criminal thoughts, impulsive, refusing to engage in therapy, verbal threats, and non-verbal threats

Intolerance/Agreeableness – Inappropriate anger, complaining about staff, blaming others, lack of consideration for others

Sexual self-regulation – sexually impulsive, sexually inappropriate behaviour, aberrant sexual thoughts

Violent self-regulation – violence to self, violence to others, violence to property

Agreement with routine – looking after room, looking after self, daily routine

Substance abuse – alcohol abuse, drugs/solvents abuse

Opportunity for victim access (in the case of sex offenders)

Self-esteem/social isolation – feel bad about myself, spending time on my own

Clinical interest – psychotic symptoms, winding others up, refusing medication

Potential uses

- ◆ In conjunction with a behavioural programme e.g.
 - So that identified rewards can be safely and consistently accessed
 - Avoiding the use of large points deficits
 - Individuals do not lose rewards gained but cannot use them until safe to do so
- ◆ As a stand alone tool e.g.
 - As a component part of any treatment plan
 - As a way to explain reasons why things are done and decisions made
- ◆ To direct an individual's pathway through their stay on the unit e.g.
 - To help explain decisions about progress
 - To inform decisions about an individual's progress
- ◆ To direct care and treatment e.g.
 - As a component part of ongoing assessment

It identifies areas of risk for individuals, which require to be addressed

◆ **As a reflective tool e.g.**

Encouraging individuals to look at their own behaviour by reflecting on their current level of risk

The reflective and collaborative nature of the system encouraging individuals to take responsibility for themselves

How is DRAMS used

Who carries out the assessment?

Any clinically experienced member of staff who has been orientated to the DRAMS. Although it is designed as a collaborative system, there have been times when individuals refuse to participate e.g. immediately before, during and after a significant aggressive incident, in these cases staff can complete the assessment independently and use DRAMS to reflect on the time period with the individual when he/she is more amenable to discussion.

Individuals may refuse to participate with DRAMS at all. In such cases DRAMS can be completed independently by staff with the aim to continue encouraging the individual to participate. Refusing to engage in therapy is one of the dynamic risk factors included in DRAMS.

Individuals may be considered so unwell that participating in DRAMS may be unhelpful at a given time. In such cases DRAMS can be completed independently to help assess and manage dynamic risk with the aim of encouraging participation as the individual becomes more well.

How often is the assessment carried out?

Once an individual is introduced to DRAMS the frequency of assessment is determined by the key worker in conjunction with the Clinical Team. DRAMS may be

carried out as often as two or three times each day depending on the individual and the circumstances. It may be carried out weekly, fortnightly or even monthly. Frequency can increase or decrease as deemed necessary.

Ideally, following its introduction, DRAMS is carried out on a weekly basis as this maintains a regular point of contact, enables identification and discussion of problems as they arise and ensures regular positive feedback when things are going well. It also enables the individual and staff to become very familiar with the system.

The recommended minimum frequency of DRAMS is monthly. Quite often, when staff are busy dealing with intense and difficult situations on a daily basis, positive feedback for the individuals who are doing well can easily be missed. If DRAMS is carried out at least monthly it ensures that individuals remain familiar with the system, progress is documented, and an opportunity for individual time and positive feedback is maintained. Frequency can be increased quite easily from here, if required, without the individual feeling penalised or having to be familiarised with DRAMS again.

How is DRAMS carried out?

Once staff are familiar with the system they develop their own style for introducing and carrying out DRAMS. This is based on their knowledge of each individual, their therapeutic relationship and the individual needs of each client.

Below are some tried and tested techniques which others have found helpful:

Introducing DRAMS

DRAMS can be introduced to individuals as a way of looking at and talking about their progress and problems. The traffic light analogy can be explained by encouraging them to think about what each signal means i.e. green means go, amber is a warning sign, red means stop.

From time to time, individuals complain about the appearance of the tool being childish. This issue can be addressed by supporting the individual to see beyond the pictorial representation by explaining why the analogy is used, or simply use the DRAMS version without smiley faces.

Each item is explained in very simple terms whilst going through the assessment with them.

In order to help individuals understand and to promote collaboration it is often easier to introduce it to individuals for the first time during a good day/week.

Individuals can be asked to consider whether they sometimes had problems in any of the items – most recognise that they have. For those who do not recognise problems in the items staff encourage talking and thinking about particular incidents/attitudes etc which would be considered problematic/unsafe for their programme to carry on as usual.

It is explained simply that the system could help us look at risk/safety and progress/positive behaviour and make the right decisions together.

Carrying out DRAMS

DRAMS is carried out by spending a short time with the individual reflecting on his recent behaviour to provide an accurate account of how things are.

It is carried out with individuals using a supportive, encouraging, non-judgmental approach.

The staff member carrying out the assessment makes him/her self aware of any progress/problems/issues that have arisen so that an accurate picture is known. This is usually achieved by reading the notes since the previous DRAMS and talking to other staff on duty.

Discussion takes place in an appropriate place away from noise and distractions. Clients are asked for their view on how things have been going and discussion follows. When clients move into the high risk categories they often do not want to discuss the difficult issues so although aiming to reach collaboration and joint decisions on the assessment (and how to manage the risk), **It is the clinicians**

opinion that is documented (the client may have the opinion that everything is great, he has no problems, has done nothing wrong and his attitudes are acceptable....if this is not an accurate picture and that is what is documented then the assessment becomes worthless).

Some helpful introductions include:

Have you felt angry, how much, were you right to feel angry?

You seem to have had a hard day, what kinds of things have been happening?

What have you been thinking about?

You look a bit upset/angry to me, how are you feeling/thinking?

I read in your notes that there was a problem with you touching staff; can you tell me about it?

There are many ways to put the questions and people develop their own style according to the needs of the individual client. Keep it simple

What do the traffic lights/stop signs mean?

GREEN – GO - There are no restrictions to the patient's usual routine or progress.

AMBER - WARNING - The patient moves to an amber light because there are some signals we are worried about. Usual routine and progress are not restricted but the warning signs are highlighted.

RED – STOP - Usual routine and progress is restricted until risk is reduced. In some cases that may be later on the same day, for others it may be the next day or a few days later, it depends on the individual concerned.

STOP – Stop signs cover the most risky categories. If a STOP sign is encountered, usual routine and progress is stopped until it is discussed with the clinical team AND

risk is reduced. This can either be discussed at the clinical team meeting or team members can be contacted for their views in the event that the meeting is several days away and the risk level is reducing.

Ethical Dilemma

An important ethical dilemma has arisen as a result of DRAMS. It arose because individuals are encouraged to be open and honest about their thoughts. The concern is that if an individual reveals risky thoughts and has restrictions placed as a result, then it could be viewed as punitive, since he has not acted on these. If no restrictions are placed and he goes on to act on his thoughts then this could be viewed as negligence. It does beg the question: is it better to know or not to know?

It is important to avoid individuals feeling penalised for being open and honest. If such ethical dilemma arise this should be highlighted discussed with the clinical team.

Scoring DRAMS

DRAMS can be scored by individual item, by category or as a total score. Remember that it has developed as a collaborative tool and is best used idiomatically with individual participants i.e. what is risky for one may not be risky for another. As a general rule of thumb the lower the score the lower the risk.

References

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Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (1998). *Violent offenders: appraising and managing risk*. Washington DC: American Psychological Association.

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