

low-risk patients, who will commit many of the future acts of violence?⁵ Second, is there evidence that an overall reduction in violence can be achieved by applying this cost-effective and acceptable intervention to a group who are more likely to offend while denying it to those who as a group are less likely to offend? Will the additional resources spent on preventing violence by high-risk patients be justified in terms of harm reduction?⁶

At the end of the recent paper, Singh *et al* recommend that risk assessments be provided with a qualification explaining their limitations. Here we agree as well. Perhaps it should be 'this risk assessment provides an estimate of an uncertain probability of an unspecified event with no consideration of the consequences'.

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Authors' reply: We thank Large & Singh for their comments. But we would point out that we did not examine positive predictive value, as they say we did. We described the proportion of those classified as high risk who then acted violently. The two are only the same if an ascription of high risk, whether made using a structured risk assessment instrument (SRAI) or arrived at through clinical judgement, is treated as a 'prediction'. Studies of the predictive validity of risk instruments out of necessity handle the data in this way¹ and usually conclude that SRAIs demonstrate a moderate level of accuracy. As those who design SRAIs and others have repeatedly pointed out, however, fallible predictions are of limited value to clinicians.² One thing that should help those clinicians is knowing what a classification of high risk means and, in particular, whether it means the same thing in different settings. We found that after controlling for time at risk, the rate of violence in groups classified as high risk using SRAIs shows substantial variation.

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