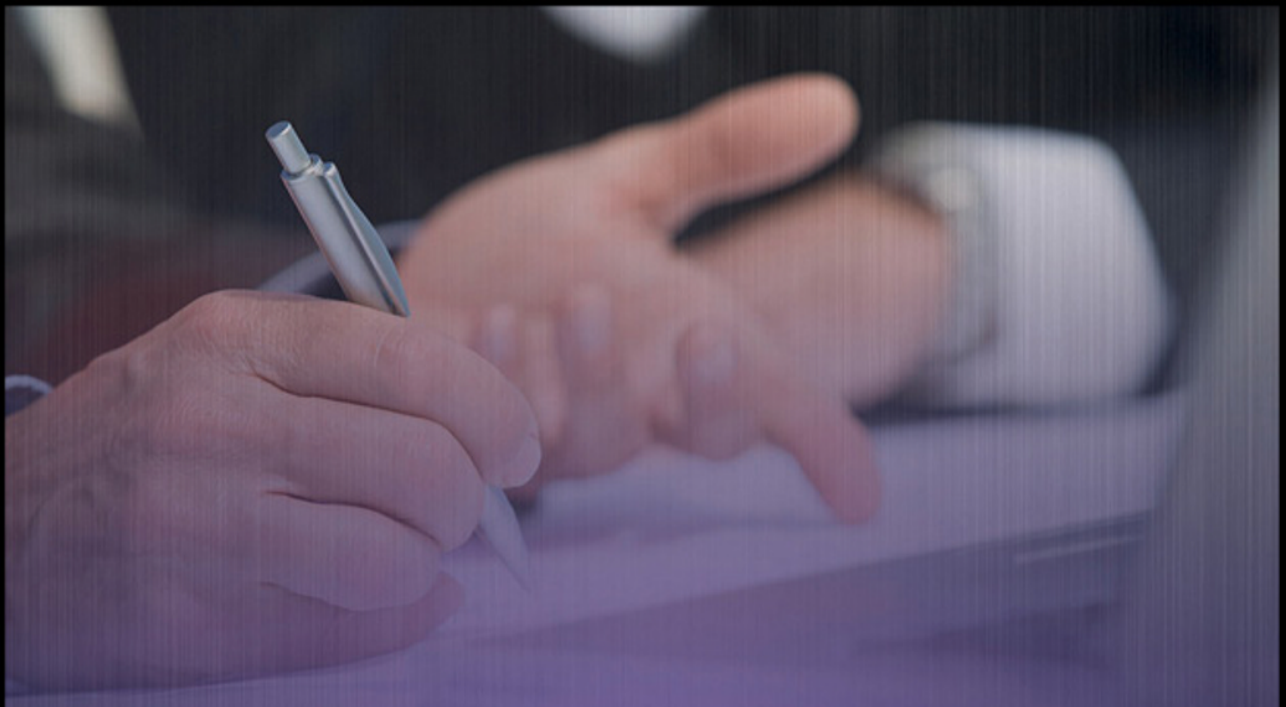

Assessments in Forensic Practice

A HANDBOOK

Edited by
Kevin D. Browne, Anthony R. Beech, Leam A. Craig, and Shihning Chou

WILEY Blackwell

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About the Editors

Kevin D. Browne, PhD, CPsychol (Foren), FSB, EuroPsy is Director of the Centre for Forensic and Family Psychology and Director of Forensic Psychology Programmes in the Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham, UK. As a Registered and Chartered Forensic Psychology Practitioner, he has written books and articles extensively in the areas of family violence, child maltreatment, institutional care, and deinstitutionalization of children and has been working as a consultant to UNICEF and WHO. In the past, he was Head of the World Health Organization Collaborating Centre on Child Care and Protection (2006 to 2009) and the Chief Executive of the High Level Group for Children in Romania (2003 to 2006). He acts as an expert witness to civil and criminal courts in the assessment of parenting, child maltreatment, sexual and violent offenses in the home, and matters concerning child rights, care, and protection.

Anthony R. Beech, DPhil, FBPsS is the Head of the Centre for Forensic and Criminological Psychology at the University of Birmingham, UK. He has authored over 180 peer-reviewed articles, over 50 book chapters, and six books in the area of forensic science/criminal justice. His particular areas of research interests are risk assessment; the neurobiological bases of offending; reducing online exploitation of children; and increasing psychotherapeutic effectiveness of the treatment given to offenders. In 2009 he received the Significant Achievement Award from the Association for the Treatment of Sexual Abusers in Dallas, Texas, and the Senior Award from the Division of Forensic Psychology, British Psychological Society, for recognition of his work in this area.

Leam A. Craig, BA (Hons), MSc, PhD, MAE, CSci, CPsychol, FBPsS, FAcSS, EuroPsy is a consultant forensic and clinical psychologist and partner at Forensic Psychology Practice Ltd. He is Professor (Hon) of Forensic Psychology, the Centre for Forensic and Criminological Psychology, University of Birmingham, and Visiting Professor of Forensic Clinical Psychology, School of Social Sciences, Birmingham City University, UK. He is a Chartered and Registered (Forensic and Clinical) Psychologist, a Chartered Scientist, and holder of the European Certificate in Psychology. He is a Full Member of The Academy of Experts. He is a Fellow of the British Psychological Society, Fellow of the Academy of Social Sciences and recipient of the Senior Academic Award from the Division of Forensic Psychology for distinguished contributions to academic knowledge in forensic psychology. He has previously worked in forensic psychiatric secure services, learning disability hospitals, and consultancy to prison and probation services throughout England, Wales, and Northern Ireland, specializing in high-risk complex cases. He is currently a Consultant to the National Probation Service on working with offenders with personality disorders. He has previously been instructed by the Catholic and Church of England Dioceses, South African Police Service, and the United States Air Force as an expert witness. He acts as an expert witness to civil and criminal courts in the assessment of sexual and violent offenders and in matters of child protection. In 2015 he co-authored a Ministry of Justice research report into the use of expert witnesses in family law. He sits on the editorial boards of several international journals. He has published over 80 articles and chapters in a range of research and professional journals. He has authored and edited 10 books focusing on the assessment and treatment of sexual and violent offenders, offenders with intellectual disabilities, and what works in offender rehabilitation. He is a series editor for the What Works in Offender Rehabilitation book series published by Wiley-Blackwell. His research interests include sexual and violent offenders, personality disorder and forensic risk assessment, and the use of expert witnesses in civil and criminal courts.

Shihning Chou, PhD is an assistant professor and forensic psychologist. She is the Deputy Director of the Centre for Forensic and Family Psychology, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham and has carried out research on international adoption, deinstitutionalization of children, and parenting interventions. Her practice focuses on psychological and risk assessment in parenting, childcare and protection, and family violence. Her current research interests lie in the development of offending/harmful behavior and psychological vulnerability, childhood victimization, child-to-parent violence, psychological sequelae, and recovery and family well-being after political violence. She is also interested in forensic occupational and health issues such as the impact of staff and situational variables on patients/residents.

Contributors

Karen Bailey, CPsychol is a principal forensic psychologist in Birmingham and Solihull Mental Health Foundation Trust and trained to facilitate Safeguarding Children training within the trust. Her practice focuses on psychological and risk assessment in parenting, childcare and protection, family violence, child abuse, and neglect. Her experience also includes risk assessments of sexual and violent offenders via the Prison and Probation Services and preparation of expert witness reports of mandatory and discretionary life-sentenced and indeterminate sentenced prisoners. She has experience of providing oral evidence at lifer Parole Board reviews as well as in Family Courts and has presented research at conferences on child abuse and neglect and the role of criminality in poor parenting.

Taljinder Basra, DClinPsy is a HCPC registered clinical and forensic psychologist employed at Birmingham and Solihull Mental Health Foundation Trust, working in the Severe and Complex Care Directorate. He has several years' experience in assessing risk in parents suspected of neglect and/or abuse, and offenders in a mental health hospital and in the community. He has also been involved in training and teaching risk-related topics to mental health professionals and university graduates in both the UK and India. His research has included investigating the demographic, personality styles, coping strategies, anger, and parental stress differences between abusive and neglectful parents. He is currently interested in exploring the role and prevalence of self-conscious emotions, such as shame in inpatient adult mental health service users who are in forensic settings.

Anthony R. Beech, DPhil, FBPsS is the Head of the Centre for Forensic and Criminological Psychology at the University of Birmingham, UK. He has authored over 180 peer-reviewed articles, over 50 book chapters, and six books, all in the

area of forensic science/criminal justice. His particular areas of research interests are risk assessment; the neurobiological bases of offending; reducing online exploitation of children; and increasing psychotherapeutic effectiveness of the treatment given to offenders. In 2009 he received the Significant Achievement Award from the Association for the Treatment of Sexual Abusers in Dallas, Texas, and the Senior Award from the Division of Forensic Psychology, British Psychological Society, for recognition of his work in this area.

Louise Bowers, ForenPsyD is a chartered and registered forensic psychologist and a director of the Forensic Psychologist Service Ltd. Louise splits her time between giving expert evidence (Crown Court and Parole Board), providing therapy, delivering training, university lecturing, and working for the Health and Care Professions Council (HCPC). She was the first psychologist appointed to the Parole Board (2003–2010), where she was instrumental in developing the role of forensic psychology on the board. Louise's doctorate research was an investigation of offense supportive cognition in young adult sexual offenders. Previous roles have included senior positions within the HM Prison Service, the NHS, and with a range of private providers of forensic services.

Kevin D. Browne, PhD, CPsychol FIBiol is the Head of the Centre for Forensic and Family Psychology at the University of Nottingham, UK. He has written extensively in the areas of family violence, institutional care, and deinstitutionalization of children, and has been working as a consultant to UNICEF. In the past, he has also been a temporary advisor to the World Health Organization on child health and the Chief Executive of the High Level Group for the Children in Romania. He was the Head of the World Health Organization Collaborating Centre for Child Care and Protection from 2006 to its closure in 2009.

Shihning Chou, PhD is an assistant professor and forensic psychologist. She is the Deputy Director of the Centre for Forensic and Family Psychology, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham and has carried out research on international adoption, deinstitutionalization of children, and parenting interventions. Her practice focuses on psychological and risk assessment in parenting, childcare and protection, and family violence. Her current research interests lie in the development of offending/harmful behavior and psychological vulnerability, childhood victimization, child-to-parent violence, psychological sequelae, and recovery and family well-being after political violence. She is also interested in forensic occupational and health issues such as the impact of staff and situational variables on patients/residents.

Franca Cortoni, PhD, CPsych is a clinical and forensic psychologist. She is an associate professor at the School of Criminology of the Université de Montréal and

a research fellow at the International Centre for Comparative Criminology. Since 1989, she has worked with and conducted research on male and female sexual offenders. Dr Cortoni has published extensively and made numerous presentations at national and international conferences on sexual offender issues. Among others, she has co-edited a book on female sexual offenders and a book on criminal violence (published in French). She is also a member of the editorial board of *Sexual Abuse: A Journal of Research and Treatment* and of the *Journal of Sexual Aggression.*

Leam A. Craig, PhD, CPsychol FBPsS, FAcSS is a consultant forensic and clinical psychologist and partner at Forensic Psychology Practice Ltd. He is Professor (Hon) of Forensic Psychology at the Centre for Forensic and Criminological Psychology, University of Birmingham, and Visiting Professor of Forensic Clinical Psychology at the School of Social Sciences, Birmingham City University, UK. He is a Fellow of the British Psychological Society, Fellow of the Academy of Social Sciences and recipient of the Senior Academic Award from the Division of Forensic Psychology for distinguished contributions to academic knowledge in forensic psychology. He is a chartered and registered (forensic and clinical) psychologist, a chartered scientist, holder of the European Certificate in Psychology and a Full Member of the Academy of Experts. He is currently a Consultant to the National Probation Service on working with offenders with personality disorders. He has previously been instructed by the Catholic and Church of England Dioceses, the South African Police Service, and the United States Air Force as an expert witness. He has published over 80 research articles in a range of research and professional journals along with 10 books. He is a series editor for the What Works in Offender Rehabilitation book series published by Wiley-Blackwell. His research interests include sexual and violent offenders, personality disorder and forensic risk assessment, and the use of expert witnesses in civil and criminal courts. He sits on the editorial boards of several international journals.

Louise Dixon, PhD is a forensic psychologist who has specialized in the prevention of and intervention in violent behavior for over a decade, with a particular focus on the family, children, and young people. She is currently a reader at Victoria University at Wellington. She specializes in the prevention of interpersonal aggression and violence. Primarily, her research has centered on the study of intimate partner violence and abuse, and the overlap with child maltreatment in the family. Louise has received funding from prestigious UK research councils such as the Economic and Social Research Council, Higher Education Funding Council for England, and the Police Knowledge fund. She is a series editor for the What Works in Offender Rehabilitation book series published by Wiley-Blackwell.

Simon Duff, PhD is a chartered and registered forensic psychologist working academically at the Centre for Forensic and Family Psychology, Division of Psychiatry and Applied Psychology, School of Medicine, University of Nottingham

and clinically at the Mersey Forensic Psychology Service in Liverpool. He has carried out research concerned with aspects of stalking, sexual offending, working memory, and hypnosis. His practice focuses on working with individuals who have sexually abused children, and individuals with sexual fetishes that have led to prosecution. His current research interests lie in stalking, sexual offending, fetishes, non-offending partners of men who have offended against children, and aspects of denial.

Caroline Friendship, PhD is a chartered and registered forensic psychologist who is a psychologist member of the Parole Board and also works in private practice. Her current roles involve the risk assessment of prisoners and the provision of research consultancy services to criminal justice organizations. Previous posts include Principal Psychologist with Her Majesty's Prison Service and Principal Research Officer for the Home Office (now Ministry of Justice). She has written over 20 peer-reviewed publications relating to the use of reconviction as an outcome measure and evaluating offending behavior programs.

Eleanor M. Gittens, PhD is a recognized teacher in Forensic and Investigative Psychology. She has carried out research on the spatial behavior of offenders, criminal careers, violence, and violent offenders. Her current research interests lie in the development of criminal behavior and the progression of the criminal career; offender and geographical profiling; investigative interviewing; and intelligence-led policing.

Lynsey F. Gozna, PhD is a Chartered Psychologist and Scientist, Associate Fellow of the British Psychological Society and a member of the National Arson Prevention Forum in the UK. She is a Teaching Fellow in Forensic Psychology at the University of Leicester and an Honorary Visiting Fellow at the University of Lincoln, UK. Her research interests relate to interviewing in forensic settings to enhance the effectiveness of practitioners making high stake judgements of risk incorporating consideration of personality, motive, and mind set across a range of offence types. Recently she has been investigating the concept of revenge including how this applies to offending behaviour and accompanying decision-making in the context of forensic mental health. She additionally works in a multi-agency child sexual exploitation team where she has been developing the CAPTIVE psychological formulation model to enhance the intervention, investigation and management of cases.

Ruth M. Hatcher, PhD is a lecturer in Forensic Psychology at the University of Leicester, a chartered forensic psychologist (British Psychological Society), and a registered psychologist (Health and Care Professions Council). She has 15 years' experience conducting forensic psychological research and has managed a number

of research projects including evaluations of offending behavior programs (for the Ministry of Justice and the Northern Ireland Office). In addition, she has been involved in evaluations for bodies such as the Home Office, Ministry of Justice, Leicestershire Probation Area, and the Department for Education and Skills in Ireland. She has published numerous peer-reviewed publications, book chapters, and books.

Clive R. Hollin, PhD is Emeritus Professor at the University of Leicester, UK. He wrote the best-selling textbook *Psychology and Crime: An Introduction to Criminological Psychology* (2nd ed., 2013, Routledge); and also *The Psychology of Interpersonal Violence* (2016, Wiley-Blackwell). In all, he has published 21 books alongside over 300 other academic publications; he was for 20 years lead editor of *Psychology, Crime, & Law*. Alongside various university appointments, he has worked as a psychologist in prisons, the Youth Treatment Service, special hospitals, and regional secure units. In 1998 he received the Senior Award for Distinguished Contribution to the Field of Legal, Criminological, and Forensic Psychology from the British Psychological Society.

Kevin Howells, PhD is Emeritus Professor at the University of Nottingham and a clinical psychologist who has worked both as a practitioner and an academic in the forensic field. He has worked in forensic and mental health services in the United Kingdom, Australia, and the United States. He has been a professor at the Universities of Birmingham, South Australia, and Nottingham and was Head of the Peaks Academic and Research Unit at Rampton Hospital. He has published extensively in the fields of anger and aggression, violent and sexual offending, and mental disorder in relation to offending behavior. He is a Fellow of the British Psychological Society and a chartered clinical and forensic psychologist.

Roger B. Hutchinson, MSc, CPsychol is a consultant psychologist, and a director of Forensic Psychology Practice Ltd. He initially trained as a botanist and worked as a research technician before qualifying as a clinical psychologist in 1981. He has worked within the NHS primarily in developmental pediatrics, neuropsychology, learning disability, and forensic services, becoming the clinical director of a large learning disability service which won national awards for "best patient environment," "best mental health team," and "risk management team of the year." He has an NHS management qualification and also trained as a Master NLP Practitioner. His has specialist interests in profound disability and complex needs, lecturing throughout the world in the area of Snoezelen and multisensory activity. Through his work as an expert witness he continues to try to ensure that people with a disability are afforded equality of choice and opportunity.

Carol A. Ireland, PhD is a chartered psychologist, forensic psychologist, and chartered scientist. She acts as an advisor in crisis/conflict situations and is lead trainer and developer of training for a high-secure psychiatric hospital. Carol currently acts as a consultant for the police as a national advisor for critical incidents. She also works at the University of Central Lancashire, where she is the Director of Studies for the MSc in Forensic Psychology. She is one of the lead trainers for the International Organisation of Forensic Practitioners. She has written over 50 publications, including journal articles, book chapters, and books, mainly on offending, consultancy, and crisis (hostage) negotiation.

Vicki Jackson-Hollis, PhD is an evaluation officer at the National Society for the Prevention of Cruelty to Children (NSPCC). In this role she designs and conducts qualitative and quantitative evaluations exploring the delivery and outcomes of intervention programs to prevent child maltreatment. She has carried out a body of research into the victimization of children and young people in the school and community environments (extrafamilial victimization), exploring its characteristics, impact, and the risk factors for victimization. She is particularly interested in the role of victimization in the development and continuation of offending behavior in young people. While completing a PhD in Applied Forensic Psychology at the University of Nottingham, she was also involved in an EU Daphne funded study of child abandonment involving nine European countries.

Lawrence Jones, CPsychol is the Head of Psychology at Rampton Hospital, Nottinghamshire Health Care Trust and an honorary associate professor at the University of Nottingham. He has worked in community prison and health settings with offenders and is qualified as a clinical and a forensic psychologist. He has published on a range of subjects including therapeutic communities, offense paralleling behavior, case formulation, and working with people with personality disorder diagnoses who have sexually offended, and teaches on the Leicester and Sheffield clinical psychology doctorates and the Nottingham forensic psychology course.

William R. Lindsay, PhD, FBPS, FIASSID, FAcSS is Consultant Clinical and Forensic Psychologist and Clinical Director in Scotland for Danshell Healthcare. He is Professor of Learning Disabilities at the University of Abertay, Dundee and Honorary Professor at Deakin University, Melbourne. He has published over 300 research articles and book chapters, published five books, held around 2 million pounds in research grants, and given many presentations and workshops on cognitive therapy and the assessment and treatment of offenders with intellectual disability. His current research and clinical interests are in dynamic risk assessment, sex offenders, personality disorder, alcohol-related violence, and CBT, all in relation to intellectual disability.

James McGuire, PhD is Professor of Forensic Clinical Psychology at the University of Liverpool, where he was also Director of the Doctorate in Clinical Psychology program 1995–2013. Prior to that he worked in a high-security hospital and has carried out psycho-legal work involving the assessment of individuals for criminal courts for hearings of the Mental Health Review Tribunal and the Parole Board. He has conducted research in prisons, probation services, juvenile justice, and other settings on aspects of psychosocial rehabilitation with offenders, and has published widely on this and related issues. He has acted as a consultant to criminal justice agencies in a number of countries.

Eugene Ostapiuk, MSc, CPsychol is a consultant forensic clinical psychologist (retired) and Honorary Professor at the University of Birmingham School of Psychology and Centre for Forensic and Criminological Psychology. He has worked in the public sector and in private practice, specializing in working with families in crisis, psychological assessment of risk, and evaluation of parenting skills in family proceedings. He has been associated with postgraduate teaching in social learning theory, behavioral interventions with offenders, consultancy, and with professional training courses in forensic and clinical psychology at the Universities of Leicester and Birmingham, and has published in these areas.

Kerry Sheldon, PhD, DClinPsy is a HCPC Registered Principal Clinical Psychologist in an Older People's NHS Integrated Mental Health Service. Her practice currently focuses on older people with organic and/or functional disorders within community and inpatient settings. Her career includes working for the probation service, managing a NHS research department, teaching undergraduate and postgraduate psychology, criminology and forensic psychology as well as consultancy work for Pearson's Education Limited. Dr Sheldon has carried out research on men who download child abuse images from the Internet, personality disorders, the effects of pornography, as well as a number of service evaluations. She has a number of publications including Sheldon, K. (2012). Internet Sex Offences, In B. Winder & P. Banyard (Eds.) In A Psychologist's Casebook of Crime: From Arson to Voyeurism. Palgrave Macmillan; Sheldon, K. Davies, J., Howells, K (Eds.) (2011). Research Methods for Forensic Practitioners, Willan Publishing; Sheldon, K and Howitt, D. (2007). Child Pornography and the Internet. John Wiley & Sons.

Ian Stringer, MSc, CPsychol is a consultant psychologist, and a director of Forensic Psychology Practice Ltd. He is an honorary research fellow in the Centre for Forensic and Criminological Psychology, University of Birmingham. He graduated in Clinical Psychology in 1985. His career has included work in a specialist residential unit for children (up to ten years of age) with severe behavioral problems; a long-stay adult mental health hospital for adults with chronic mental illness; special hospitals; regional secure units, and youth treatment services. His work has

included children with extreme emotional and behavioral problems; adolescent offenders and adolescents with behavioral problems; sex offenders (including risk assessments for clergy of various denominations, screening both while in training and after subsequent offending), and violent and aggressive people across a wide age range (childhood to old age). He is currently a consultant to both the Youth Offender Service and the National Probation Service in the development of a transition framework, and the development of a framework for the assessment of personality disordered offenders, and management programs and treatment frameworks. He has published in the areas of assessing risk in sexual offenders and treating sexual offenders with intellectual disabilities.

Peter Sturmey, PhD is Professor of Psychology at the Graduate Center and Queens College, City University of New York. He has published over 200 journal articles, 50 book chapters, and nearly 20 books mostly related to behavior analysis, staff and parent training, developmental disabilities, case formulation, and severe challenging behavior.

James Vess, PhD has over 30 years of clinical and research experience with offender populations in the United States, New Zealand, and Australia. He served in a variety of clinical, supervision, and program evaluation roles at Atascadero State Hospital, a high-security forensic treatment facility in California, and has held academic positions at Victoria University of Wellington, New Zealand and Deakin University in Australia. His research has focused on assessment, risk management, and public policy relating to violent and sexual offenders. He is currently a senior psychologist specialist with the California Department of Corrections and Rehabilitation.

Tony Ward, **PhD, DipClinPsyc** is Professor of Clinical Psychology at Victoria University of Wellington. He was director of the Kia Marama treatment center for sex in Christchurch, New Zealand and has taught clinical and forensic psychology at the Universities of Canterbury, Victoria, Melbourne, and Deakin. Professor Ward's current research interests include offender rehabilitation and desistance, restorative justice and ethical issues in forensic psychology, and theoretical psychopathology and cognition in offenders. He is the creator of the Good Lives Model of offender rehabilitation and gives numerous workshops, keynote addresses, and consultations around the world on this model. He has published over 350 academic articles and is an adjunct professor at the Universities of Birmingham and Kent.

Kate Whitfield, PhD is a senior lecturer in Forensic Psychology at Sheffield Hallam University. She has carried out research on critical and major incident management, crisis negotiation, and child abandonment in Europe. Her current research interests relate to online offending and victimization, organizational

concerns in forensic settings, preventing violence against children, and leadership during critical incidents.

Phil Willmot, PhD is a consultant forensic and clinical psychologist with the Men's Personality Disorder Service and Mental Health Service, Rampton Hospital and a Senior Fellow of the Institute of Mental Health, University of Nottingham. He has previously worked in a number of public sector prisons where he specialized in the assessment, treatment, and management of high-risk offenders, particularly sexual offenders. His research interests include the mechanisms of change in the treatment of personality disorder, and developing treatment programs for offenders who have committed a combination of sexual, violent, and firesetting offenses.

Pamela M. Yates, PhD has worked as a clinician and researcher in various capacities since 1987. She has worked with adults and youths, including sexual offenders, violent offenders, individuals with substance abuse problems, and victims of violence, and has developed accredited offender treatment programs. Her research and publications include offender rehabilitation, assessment and treatment of sexual offenders, program evaluation, risk assessment, treatment effectiveness, psychopathy, and sexual sadism. She has written extensively on the Self-Regulation and Good Lives Models of sexual offender intervention.

1

Introduction

KEVIN D. BROWNE, ANTHONY R. BEECH, LEAM A. CRAIG AND SHIHNING CHOU

Research and practice in forensic psychology involves a wide range of activities within secure and community settings. Secure settings include Her Majesty's Prison Service, private prisons, Local Authority homes for young people and secure units for adult and young offenders with mental health issues and/or personality disorders run by the National Health Service (NHS) or private organizations. Furthermore, there are similar secure services offered to adults or young people with intellectual disabilities who are also deemed to be a danger to themselves or others. Community settings involve psychologists working with the police, social services, youth offending services, and community health services, especially in the areas of violence in the community, domestic violence, child abandonment, abuse, and neglect.

The aim of psychological interventions in forensic settings is to reduce the possibility of harmful behavior directed toward self or others or that threatens the rights and safety of adults and children. This involves the prevention of violent and antisocial behavior and helps with the detection and identification of those perpetrators who have already committed a violent or antisocial offense. These activities are usually carried out in community settings.

Forensic psychologists working in secure settings are usually working with people who have already committed an act of violence and/or antisocial behavior. The aim of their work is to assess the factors that led to their index offense and ameliorate or reduce the chances of the same behavior being repeated within the secure setting or after release. Risk factors associated with violent and antisocial

Assessments in Forensic Practice: A Handbook, First Edition. Edited by Kevin D. Browne, Anthony R. Beech, Leam A. Craig, and Shihning Chou.

acts include mental health problems, addiction and substance misuse, intellectual disabilities, personality disorders, and adverse experiences in childhood.

Hence, one of the most frequent activities of a forensic psychologist, in both community and secure settings, is to carry out "psychological assessments" in relation to the risk of violent and antisocial behavior (including acquisitive crime) and the formulation of criminogenic needs that direct interventions in terms of treatment and rehabilitation. The formulation balances the assessment of dynamic risk and background static risk factors, with protective factors that may help prevent people in conflict with the law from reoffending.

Furthermore, forensic psychologists advise law enforcement agencies and the criminal justice system on behavioral assessment in the investigation of offenders, eyewitness testimony, psychological influences on jury decision-making, and the preparation of vulnerable children and adults in court.

Similar to clinical psychologists, forensic psychologists must be proficient and competent in skills such as clinical/forensic assessment, interviewing and observation, written and verbal communication, and psychological report writing. Often, they are invited as expert witnesses into court and/or to make case presentations informing courts about an offender's ability to stand trial, about Parole Board hearings, and about the multidisciplinary teams who are making decisions about the future placement of offenders.

With respect to victims of crime, forensic psychologists are involved in the assessment of re-victimization and victim support, child custody evaluations, parenting assessments, counseling services to victims, and the assessment of post-traumatic stress disorder and its relation to the victim to offender concept.

The criminal justice system and the professionals, policymakers, politicians, and the general public often see offenders and victims as a strict dichotomy, that is a person is either a victim or an offender. However, in reality, the distinction is blurred if current and life histories are taken into account. In fact, the majority of offenders have been previously victimized and a significant proportion of victims later develop behavior harmful to themselves or to others. This can be within their family environment only or it can be within the family and the community.

STRUCTURE OF THE BOOK

This book contains four sections, covering the assessment of various client groups in different legal and professional contexts.

Part One covers psychological and risk assessment in investigations and in the criminal justice system:
Risk assessment and formulation
Violent offenders and murderers

Sexual offenders
Firesetters
Parole assessments
Behavioral assessment in investigative psychology.

Part Two focuses on the assessment of clients in mental health and specialist health services:
Assessing risk of violence in mentally disordered offenders
Assessing mental capacity in offenders with intellectual and developmental disabilities
Offenders with personality disorders
Offenders and substance abuse.

Part Three covers the assessment of violence in the family and the community and its relevance to prevention:
Community approaches to the assessment and prevention of intimate partner violence and child maltreatment
Parental assessments in childcare proceedings
Perpetrators of domestic violence.

Part Four engages readers in discussions on policies and practice issues in forensic assessment:
Assessment of hostage situations and their perpetrators
Assessing the sexually abused child as a witness
Working with young offenders
Ethics of risk assessment.

PART ONE

Criminal Justice Assessments

2

Case Formulation and Risk Assessment

PETER STURMEY AND WILLIAM R. LINDSAY

INTRODUCTION

Effective and appropriate assessment is the cornerstone of offender management and treatment.Thus, mental health professionals often assess risk of recidivism and conduct case formulations to identify the most effective intervention for a specific offender. Risk assessment and case formulation are interdependent clinical activities. Case formulations may result in interventions which produce both beneficial changes in offender behavior and may also subsequently impact risk assessment. For example, teaching an offender generalized problem solving and vocational and alcohol management skills that are based on the formulation of their case may well reduce the offender's risk and may result in an increased likelihood of less restrictive placement. Alternatively, an inappropriate, ineffective, or iatrogenic treatment plan may result in increased offender risk and result in an increased likelihood of restrictive placement and continued costs of incarceration and of treatment. For example, an inappropriate cognitive treatment plan might inadvertently teach an offender to minimize his or her problems by teaching that person to describe his or her private verbal behavior in a manner consonant with treatment progress, even though his or her private verbal behavior has not truly changed. Thus, risk assessment and formulation for treatment planning are two central aspects of the assessment of offenders.

This chapter will provide an overview of risk assessment and case formulation within the context of offender services. The first section will describe risk assessment and illustrate the application of the risk assessment of offenders. The second

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section will describe case formulation generally and its application to offenders, and will specifically illustrate its application to persons with personality disorders. The final section will summarize outstanding issues in risk assessment and case formulation when working with offenders.

RISK ASSESSMENT

Risk assessment refers to the evaluation of a risk and the likely cost of such risk. Diverse fields such as economics and public health, and ensuring the safety of food, use risk analysis. Thus, in forensic psychology risk analysis involves the estimation of the costs of reoffending and violence to others, and the costs of such risks to individuals and society. Traditionally, forensic risk assessment involves assessment of static/historical risks and dynamic risks. Static/historical risk assessment contains unchangeable factors in the person's history and, since one cannot change one's history, the value of a static risk assessment for a particular individual will never reduce but will increase if they commit another offense. Dynamic risk assessment refers to the assessment of variables that are more open to change through clinical intervention and other variables.

Static/Historical Risk Assessment

Throughout the 1970s and 1980s, it became clearer that clinical judgment was extremely poor in predicting who would and would not reoffend in cases where there was a judicial or mental health review (Quinsey, Harris, Rice, & Cormier, 1998; Steadman, Fabisiak, Dvoskin, & Holohean, 1987). There were many reports in the literature concerning the poor predictive validity of clinical judgment when clinical judgment is unsupported by any actuarial prediction (Elbogen, 2002; Litwack, 2001; Quinsey et al., 1998). Throughout the 1970s and 1980s, research appeared using statistical prediction instruments applied to forensic issues. In relation to general criminal recidivism, predictive accuracy, based on actuarial prediction, rose to around 60–80% (Andrews & Bonata, 2010). Research on the prediction of violent and sexual recidivism also produced a range of promising variables (Harris, Rice, & Quinsey, 1993; Monahan, 1981). Harris et al. (1993) studied 695 men submitted to a maximum security psychiatric institution for varying lengths of time. These authors followed up all but a few of the participants and compared recidivists (N=191) with non-recidivists (N=427) on a range of variables which might predict future violence. These variables subsequently formed the basis of several of the risk assessment instruments used at present. For example, work on the *Historical/Clinical/Risk Management* (HCR-20) (Webster, Eaves, Douglas, & Wintrup, 1995), cites Harris et al. (1993) as evidence for eight of the ten historical actuarial variables in the HCR-20.

In Harris et al. (1993), several childhood variables emerged as showing highly statistically significant differences between recidivists and non-recidivists, such as childhood aggression and maladjustment in early schooling, being expelled or suspended from school, and being arrested before the age of 16 years. All of these variables can be considered to be indications of violence and disruption in childhood, and this cluster of predictive variables has continued to feature in all subsequent historically based risk assessments. Another childhood predictor was whether or not the individual had been separated from their parents prior to the age of 16 years. All these predictors may perhaps be assessed reliably and accurately, at least under some circumstances; however, these variables may be thought of as proxies for learning experiences. For example, although separation from parents prior to the age of 16 years is a fairly easy item to assess, it probably points to a range of developmental and attachment difficulties which the individual may have experienced associated with parental separation, the subsequent effects of that separation, and pathways to offending.

In relation to adult variables, Harris et al. (1993) found that employment history, previous violence, absconding from institutions, failure of prior conditional release, and whether or not the individual had previously been in a relationship all distinguished recidivists from non-recidivists. Again, these variables were incorporated into subsequent assessments.

In relation to the index offense, perpetrator age distinguished the groups and this variable was retained in subsequent assessments. The Psychopathy Checklist – Revised score (Hare, 1991) was higher and a diagnosis of personality disorder was more common in the recidivist group.

While considering the Harris et al. (1993) study, it is worth noting the somewhat counterintuitive predictors which had not been included in some later risk assessments. For example, victim injury was significantly lower in the recidivist group. The percentages of offenses against women and in which the perpetrator knew the victim were also lower in the recidivist group. In other words, more violent offenses, offenses against strangers, and offenses against women were more frequent in those who did not reoffend. Interestingly, a diagnosis of schizophrenia occurred more than twice as often in the non-recidivist than the recidivist group. Harris et al. (1993) also included two proximal or dynamic variables including pro-criminal values and attitudes unfavorable to convention, which were both more common in the recidivist group.

These authors then combined these variables into a successful predictive instrument that included the following variables: separation from parents when under 16 years, whether or not the person had been married, elementary school maladjustment, failure in prior conditional release, age at index offense, diagnosis of personality disorder, alcohol abuse history, victim injury in the index offense, diagnosis of schizophrenia, whether or not there had been a female victim, and offense history. The *Psychopathy Checklist – Revised* was also included in the item list. This risk

assessment was called the *Violence Risk Appraisal Guide* (VRAG) (Quinsey et al., 1998). Because of its extensive empirical derivation, the VRAG and its accompanying assessment for sexual offenses, the *Sex Offender Risk Appraisal Guide* (SORAG), have become standard instruments against which other risk assessments have been compared for predictive accuracy. Both the VRAG and SORAG have been cross-validated on a variety of forensic psychiatric populations and prisoner samples (Harris, Rice, Quinsey, & Cormier, 2015). These authors found that the VRAG predicted those who would and those who would not perpetrate a future violent offense with significant accuracy and a medium to large effect size, and produced significantly more accurate predictions than unstructured clinical judgment.

Around the same time, *Structured Clinical Judgment* was developed by Webster et al. (1995) in the form of the Historical/Clinical/Risk Management – 20 Items (HCR-20) Assessment. This is the most widely used *Structured Clinical Judgment* and is organized into three sections: historical (ten items), clinical (five items), and risk (five items). The clinician rates each item on a three-point scale: 0, no evidence of the variable; 1, some evidence of the variable; 2, clear evidence of the variable. The total score is the sum of the items. The authors do not generally recommend making decisions on the basis of the total score; rather, they recommended that the items are structured in order to help the consideration of a comprehensive range of variables with a view to arriving at a final judgment. In this way, actuarial, historical variables are combined with an assessment of current clinical status and consideration of future risk variables.

The HCR-20 has been revised more recently to accommodate changes in clinical practice. The HCR-20 V3 (Douglas, Hart, Webster, & Belfrage, 2013) is a much expanded manual that accommodates shifts that have occurred in clinical and forensic practice, and principally incorporates greater attention to formulation and risk management plans. The HCR-20 V3 describes a seven-step process of gathering case information, evaluating the presence of the 20 risk factors, evaluating the relevance of risk factors, developing a risk formulation, developing future scenarios relevant to the person being assessed, considering risk management strategies, and concluding on the seriousness and imminence of the risk. The 20 items have also changed significantly since first published according to clinical experience and new research over the years.

Several groups of researchers have compared the predictive accuracy of both the VRAG and the HCR-20 (original versions) on a range of databases. Generally, studies have used Receiver Operator Characteristics (ROC) to evaluate the significance of risk prevention. A ROC curve is a two-dimensional plot of the true positives on the *y*-axis and false positive on the *x*-axis. Researchers use the Area Under the Curve (AUC) to measure the accuracy of a prediction. An AUC of .7 indicates a significant prediction with a medium effect. For example, Kroner and Mills (2001) followed up 79 male offenders who had been convicted of various violent offenses, excluding sexual offenses. In their comparison of predictive accuracy, they found that the

VRAG achieved an AUC value of .75 and the HCR-20 had an AUC value of .72. Both of these are significantly better than chance with a medium to large effect size, and there was no meaningful difference between the AUCs for each measure. Barbaree, Seto, Langton, and Peacock (2001) compared the predictive accuracy of the VRAG, SORAG, and Static-99 (Hanson & Thornton, 1999). The Static-99 is an actuarial assessment for future sexual offending. These authors employed a Canadian database of 215 sex offenders who had been released from prison for an average of 4.5 years. They found that the VRAG, SORAG, and Static-99 successfully predicted general recidivism and sexual recidivism.

As has been indicated, the HCR-20 has a highly respectable scientific background in common with other risk assessments. *Structured Clinical Judgment*, in the form of the HCR-20, is the most frequently used form of risk assessment. It has now been subject to a considerable quantity of research work in a range of settings for offenders in both correctional and mental health facilities. Since it has a range of clinical scales, it is unsurprising that much of the research has been carried out in forensic psychiatric settings or with mentally disordered offenders. For example, Grann, Belfrage, and Tengstrom (2000) conducted a two-year follow-up of 404 forensic patients who had committed violent offenses. They found that the HCR-20 H scale (historical section) predicted violence significantly for both offenders with a diagnosis of schizophrenia (AUC=.71) and offenders with personality disorder (AUC=.71). In a two-year follow-up of 70 psychiatric patients who had committed violent acts, Dolan and Khawaja (2004) reported that the HCR-20 total score significantly predicted self or collateral reports of violence (AUC=.76) and documented incidents of reoffending (AUC=.71).

Work on the HCR-20 has begun to investigate a range of other variables with mentally disordered offenders. Douglas and Ogloff (2003) investigated the relationship between rater confidence and accuracy of the prediction of risk. They followed up 100 forensic psychiatric patients, 79% of whom had a violent index offense. In addition to completing HCR-20 judgments, raters were asked to indicate their confidence in the judgment on a 10-point scale. They found that the AUC value for the high confidence group was much greater than for the low confidence group for predicting any violence.

The HCR-20 has also been employed with female participants. In a comparison of male and female forensic patients, Strand and Belfrage (2001) found no difference in scale or total scores between the two groups. The only significant gender differences were on individual items: males scored higher on previous violence, violence at a young age, substance use, and negative attitudes, with females scoring higher on personality disorder, impulsivity, and stress. On the other hand, de Vogel and de Ruiter (2005) compared 42 women and 42 men in a forensic psychiatric service and found that the HCR-20 was a better violence predictor for men (AUCs for total scaled score ranged between .75 and .88) than for women (AUCs ranged from .52 to .63). Grevatt, Thomas-Peter, and Hughes (2004) investigated the extent to which

the HCR-20 predicted short-term violence within six months of admission to a forensic unit. Although the H scale and total score were poor predictors of short-term violence, the clinical (C) scale significantly predicted any incidents (AUC = .72) and verbal abuse (AUC = .81). They also found that the C and risk (R) scales reduced significantly in response to treatment in hospital.

In a follow-up to Barbaree et al. (2001), Langton, Barbaree, Seto, Peacock, Harkins, and Hanson (2007) extended the original database to include 468 sexual offenders followed up for an average of 5.9 years. Langton and colleagues found that the VRAG was a significant predictor of serious violent incidents (AUC = .73), while the Static-99 significantly predicted future sexual incidents (AUC = .75). They found that all instruments had predictive validity for the types of incidents for which they were designed. Harris et al. (2015) made a further evaluation of the VRAG and SORAG, predicting serious violent and sexual recidivism in a sample of 396 sexual offenders. For serious violent recidivism, both the VRAG and the SORAG were found to have AUC values of .73, and for sexual recidivism corresponding AUC values were .65 and .66, respectively. Therefore, the various studies are consistent, showing the VRAG and HCR-20 to have predictive values that are significant with a medium to large effect size.

Risk assessment instruments have been found to predict with significant accuracy a range of types of violent incident in different populations, including offenders with Intellectual Disability (ID). For example, Quinsey, Book, and Skilling (2004) investigated the predictive validity of the VRAG in men with ID. Their study employed 58 men with serious histories of antisocial and aggressive behavior, who were followed up for an average of 16 months. Eighty percent of participants had at least one additional diagnosis: 56% had a diagnosis of some type of personality disorder; 36% had been diagnosed with some type of paraphilia; 11% had a diagnosis of psychosis; and 9% were diagnosed with affective disorder. Thirty-nine had at least one incident of antisocial or aggressive behavior over the follow-up period. Quinsey et al. (2004) found that the VRAG showed significant predictive value with a medium effect size (AUC = .69), and that monthly staff ratings of client behavior were significantly related to antisocial incidents.

Two subsequent studies compared the relevant predictive accuracy of a number of risk assessments, including the VRAG. Gray, Fitzgerald, Taylor, MacCulloch, and Snowden (2007) compared the VRAG, PCL-Screening version (Hart, Cox, & Hare, 1995), and the HCR-20 in a group of 145 offenders with ID and 996 offenders without ID, all discharged from four independent sector hospitals and followed up for a minimum of two years. All instruments showed significant predictive validity for all groups and, for the ID group, all the assessments predicted future incidents with a medium to large effect size for both violent and general recidivism. Indeed, all the risk predictors showed greater accuracy with the ID group than with the mainstream non-ID offenders. Lindsay et al. (2008) completed a further evaluation of a number of risk assessments on a sample of 212 offenders with ID from a range

of community and secure settings. They followed participants up for a period of one year and compared the VRAG, HCR-20, Static-99 (Hanson & Thornton, 1999), and Risk Matrix (RM) 2000 (Thornton, Mann, Webster, Blud, Travers, Friendship, & Erikson, 2003), and used two measures of proximal risk assessment (see below). The VRAG and HCR-20 both showed significant predictive accuracy (AUC = .71 and .72, respectively). The RM 2000 had poorer predictive accuracy with a small AUC, but the authors noted that the assessment was promising since the scoring criteria were relatively straightforward. Thus, the results from these various studies suggest that the predictive validity of actuarial risk assessment with offenders with ID was at least as good as other offender groups. These studies attest to the value of actuarial risk assessment and *Structured Clinical Judgment* in the assessment of risk for offenders across cultures and settings.

The more recent iterations of the HCR-20 and the VRAG have also been evaluated. The VRAG-R was evaluated by Rice, Harris, and Lang (2013) with 1,261 sexual and violent offenders released from maximum security establishments. It was found to have very good predictive accuracy with large effect sizes up to 49 years after discharge. The HCR-20 V3 was evaluated in a special issue of the *International Journal of Forensic Mental Health* and studies reported good inter-rater reliability (Douglas & Belfrage, 2014), validity for different aspects of the assessment (Strub, Douglas, & Nicholls, 2014), and violence prediction (Doyle, Archer Power, Coid, Kallis, Ullrich, & Shaw, 2014).

Dynamic/Proximal Risk Assessment

As mentioned earlier, Harris et al. (1993) found that two dynamic variables – attitudes unfavorable to convention and pro-criminal values – showed highly significant differences between recidivists and non-recidivists. Thornton (2002) also incorporated antisocial attitudes into his framework for assessing dynamic risk in sex offenders, and demonstrated the difference between sex offenders and non-sex offenders on attitudes supportive of sexual offending.

Hanson and colleagues (Hanson & Harris 2000; Hanson & Morton-Bourgon, 2004) developed an important approach to the understanding and assessment of dynamic risk. They separated such factors into "stable" and "acute" factors. Stable dynamic factors include dispositions, such as a propensity to anger, and states that may have been learned through a person's life, such as alcohol dependence. These stable dynamics are amenable to treatment. In this way the risk can be reduced through learning a range of personal skills or controlled through environmental manipulation. Acute dynamic factors are events that are closest in time to the behavior to be predicted; for example, a person may be drunk and/or provoked to anger when a family member insults them, both acute factors sharply increasing the dynamic risk. (Note that acute dynamic factors overlap with the controlling variables, such as establishing operations, discriminative stimuli, and current contingencies used in applied behavior analysis.)

An example of this approach comes from Hanson and Harris (2000) who studied a sample of offenders in probation settings. They found that dynamic factors were indeed predictive of supervision breakdown caused by the person reoffending. Both Hanson and Harris (2000) and Hanson and Morton-Bourgon (2004) have reported that dynamic factors had additional predictive value over static risk assessment in relation to both violent and sexual incidents. It is with these factors that clinicians would start when considering appropriate intervention. Thus, acute dynamic risk assessment informs forensic case formulation by identifying significant target behaviors that pose risk, and also by identifying manipulable variables that may be part of the case formulation and be the basis of the treatment plan. Note, however, that the relationships between acute dynamic risk factors observed in group studies may have little or no relevance to the case formulation of individual cases. For example, a group study might find a correlation of .3 between an acute dynamic predictor such as drunkenness with a group of participants. For one offender there may be a very strong positive correlation between drunkenness and offending; for a second person there may be a weak relationship that is only strongly predictive of violence when other variables, such as insults from family members, are present; and, finally, for a third person being drunk may have a large negative correlation with offending, for example, when someone drinks to reduce arousal and arousal is related to offending. Thus, clinicians should consider the relationship between group studies of acute dynamic risk factors cautiously when formulating individual cases.

Monahan (1981), while acknowledging the crucial value of static risk factors, also stressed the importance of understanding contextual dynamic factors as antecedents to crime or indeed as protective factors preventing individuals from committing crime. If a person has a long-standing love of the Rolling Stones, has all their albums, and has a ticket for their concert tonight, it is reasonable to predict that this person will go to a Rolling Stones concert tonight; however, if that person breaks their leg seriously on the morning of the concert, this will significantly alter the event prediction. In this way, it is clear that even with the strongest predictive factors, proximal variables can intervene to make significant changes. (In this case, proximal variables increased the likelihood of competing responses negatively reinforced by pain reduction and increased the response cost of engaging in activities reinforced by the Rolling Stones.) Short-term fluctuations in mood, substance abuse, or victim access can sharply change the risk of onset of offending. Controlling these factors through self-regulation or environmental manipulation can be correspondingly protective against the onset of antisocial behavior or criminal acts.

Lindsay et al. (2004) and Steptoe, Lindsay, Murphy, and Young (2008) have demonstrated the importance of dynamic risk factors in two separate reports on offenders with intellectual disabilities in maximum security hospitals. They developed the *Dynamic Risk Assessment and Management System* (DRAMS), which employed variables from previous studies, including mood, antisocial behavior, abhorrent thoughts, psychotic symptoms, self-regulation, therapeutic alliance, substance

abuse, compliance, emotional relationships, and victim access. Since their participants were drawn from a high-security setting, there were no opportunities for substance abuse or victim access. By gathering daily ratings of participant behavior, they related them into independently collected incident data. They found that for individual participants, ratings taken on the day before an incident were significantly higher than ratings taken at least seven days distant from any incident. The significant predictors were mood, antisocial behavior, abhorrent thoughts, and total score. In a subsequent larger-scale study, Steptoe et al. (2008) found that sections of the DRAMS on mood, antisocial behavior, and intolerance/agreeableness had significant predictive values with future incidents (AUC > .70). There were also highly significant differences with large effect sizes between assessments taken one or two days prior to an incident and the control assessments conducted at least seven days distant from an incident. This study confirms the importance of dynamic variables and in particular dynamic antisociality in relation to future incidents for offenders with ID.

Conclusions

There have been significant developments in the evaluation of risk assessments for sex offenders and violent offenders. The available evidence suggests that risk assessments based on actuarial variables predict significantly better than chance and significantly better than unstructured clinical judgment. Dynamic variables are also important considerations and, as Hanson and Harris (2000) have shown, provide additional predictive value over static risk assessment. Consideration of these proximal factors is likely to be the point at which clinical intervention will begin. This now leads us to consideration of that very task.

CASE FORMULATION

General Features of Case Formulation

Eells (2007a) offered a generic definition of case formulation as "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems … A case formulation also serves as a blueprint guiding treatment and as a marker for change. It should help the therapist experience greater empathy for the patent and anticipate possible ruptures in the therapy alliance …" (p. 4). For example, psychodynamic approaches may place substantial emphasis on uncovering the alleged developmental roots of a problem, since within this theoretical framework uncovering these apparent causes is not merely a part of the formulation, but also part of the treatment. Cognitive behavioral approaches vary in the weight they place on history. Some Cognitive Behavior

Therapy (CBT) approaches de-emphasize history, as it may add little of substance to the formulation and the subsequent development of a treatment plan (Kuyken, Padesky, & Dudley, 2009), whereas other CBT approaches place some weight on understanding where a client's schema might have come from and developed. Various behavioral approaches to case formulation also differ on the emphasis given to history. For example, some transcripts of Wolpe interviewing clients show him searching for a conditioning event that a client has not yet identified. Other approaches, such as the Functional Analytic Clinical Case Model, only place emphasis on the current controlling variables that have a large causal impact on target behaviors and that the client and therapist can readily manipulate to produce the largest, most meaningful benefits to clients (Haynes & O'Brien, 2000; Lapaalainen, Timonen, & Haynes, 2009). Thus, there is general agreement that case formulations should be brief, should abstract out key features of the case, should integrate diverse aspects of the case, perhaps including history, and should guide idiographic treatment.

Despite this agreement on these general features of case formulation, there is significant disagreement on key questions (Sturmey, 2009b). For example, approaches to case formulation differ on the nature of the target behaviors that formulations should address, the status of cognitions and emotions as causes of behavior or behavior to be changed, and the reality of inferred constructs, such as alleged cognitive structures, and the desirability of mono-theoretical versus integrated case formulations, and so on.

There is general agreement that the main function of case formulation is to predict the most effective treatment beyond treatment implied by diagnosis and treatment as usual. Case formulation may unify diverse information, such as different target behaviors that serve the same function, repeated patterns of interactions, social relationships, and reactions to different stressors or events. Case formulation can be a tool to use with the clients. For example, clients may participate in varying degrees in developing and using the formulation. In so doing, it is possible that case formulation may be more respectful of client autonomy and dignity. Involving a client in developing their own formulation may also begin the process of behavior change by gradually teaching the client discriminations about their own behavior and its relationship to the environment. This may subtly begin the process of behavior change before initiating a formal treatment plan and thereby make client behavior change more likely (Skinner, 1953). It may assist the client in understanding their problems and the rationale for their treatment better than if the formulation is delivered cold without client participation. Finally, a formulation may enhance the therapeutic alliance and help the therapist understand and repair disruptions to the therapeutic alliance (Eells, 2007a).

There are many approaches to case formulation. Approaches differ both in terms of theoretical orientation and in terms of the specific technology used to make a formulation. Thus, formulations may be made from cognitive behavioral, behavior

analytic, psychodynamic, eclectic, and other approaches (Eells, 2007b; Sturmey, 2009b). Case formulation may use interviews, questionnaires, observations, and specific guidelines on how to conduct an assessment to make a formulation, and may use written summaries, letters to clients (Dunn, 2009), or diagrams to summarize the current variables related to current problems, and may or may not also diagram the development of the presenting problems (Lapaalainen et al., 2009). Different approaches to case formulation also vary in the extent and manner in which clients participate in making the formulation.

Despite the current popularity of client participation in developing formulations, there is very little evidence to support the ideologically seductive views of client participation. There are two related problems. First, no studies to date have operationally defined client participation. Thus, it is difficult to know exactly what participants do when they participate in formulation and whether different studies and advocates of case formulation are referring to different things. Second, the only study to date that has reported data on client reaction to formulations produced mixed results. Chadwick, Williams, and MacKenzie (2003) found that although some clients with psychosis reacted positively to their formulations, others viewed their formulations negatively, perhaps because their formulations traced their current problems back to early in their history and thus appeared to present their problems as fixed in their history and overwhelming. This latter point may be particularly relevant to formulation with offenders, many of whom have long forensic histories and extensive histories of abuse and deprivation. Due to the limited quantity of data on this point no firm generalization can be made on the role of client participation in case formulation, but it is clearly an area that is ripe for empirical investigation.

Forensic Case Formulation

Forensic Case Formulation (FCF) is but one form of case formulation, so it shares many features with other forms of formulation, but also faces additional special challenges. Offenders often present with many of the same problems as general clinical populations, such as anxiety, depression, and social skills deficits and excesses, and also present with higher rates of other problems, such as personality disorders, substance abuse, and violence than clinicians encounter in other contexts. Thus, clinicians working in forensic settings must have generic case formulation skills, as well as specialist skills in formulating problems more commonly encountered in forensic settings.

FCF also presents at least three specific challenges to clinicians: offenders often have extensive histories, may live in settings that are very different from the place where clinically significant problems occurred, and their clinical problems are intricately bound up with the justice system. Offenders often have forensic histories that date back to childhood and adolescence; some have histories of abuse, deprivation, and unusual experiences dating back even earlier. In addition, many

offenders – especially those who are incarcerated – have extensive histories with the justice system. Thus, clinicians attempting to formulate forensic cases have to digest, analyze, and synthesize an unusually large quantity of client history. Further, clinicians have to evaluate histories that may be incomplete and presented with many forms of biases from the offender, family members and significant others, other clinicians, and members of the justice system.

A second challenge for FCF is that index offenses and other forensically and clinically relevant behavior often cannot occur in restricted forensic settings. For example, if an offender is incarcerated they may have no access to alcohol, illicit substances, or minors. Thus, if substance use is a key element in an FCF it may be difficult or there may be no opportunity to observe the clinically relevant behavior and in the context in which it occurred prior to incarceration. One potential solution to this problem comes from the recent development of the notion of offense paralleling behavior (OPB), which refers to the possibility that behavior observed in a restrictive forensic setting may be functionally similar to offending behavior even if it is topographically different from the offending behavior. For example, an offender with a history of violent, acquisitive offenses might show a pattern of coercive or threatening behavior in order to obtain items that are valuable to him or her. Likewise, an offender who retreats into violent fantasy when alone prior to an offense might also engage in this behavior in a forensic setting. If these behaviors do indeed parallel the functions of index offenses they may afford the clinician the opportunity to formulate a case and, indeed, to implement a treatment plan based on a formulation (Daffern et al., 2007).

Finally, clinicians in forensic services have to interact with the justice system, which significantly impacts treatment delivery and disposal of the offender. For example, a clinicians' evaluation of risk and treatment progress might lead them to recommend discharge. In contrast, a facility board, sensitive to the politics and community reaction to discharging violent sexual offenders, may be reluctant to concur with clinicians' judgments. Similarly, the behavior of staff in a residential setting might maintain or exacerbate clinically relevant behavior. For example, Shepherd and Lavender (1999) reported that aggressive episodes in a juvenile setting were more often directed toward non-professional staff than to professional staff. This observation suggests that some aspect of non-professional staff behavior might precipitate or reinforce offender aggression and that some form of staff training might be appropriate, especially for non-professional staff.

Understanding the Development of Offending Behavior

Many authors have proposed that a case formulation should both account for the development of the presenting problem and integrate the development with the presenting problem, and that this should be one of the criteria for a good formulation and should be part of professional training in case formulation (Eells, 2007a).

For example, many forensic case formulations note the absence of appropriate social behavior and compensatory inappropriate social behavior in offenders; often forensic case formulations attempt to describe how appropriate social behavior was not learned and how socially inappropriate behavior came to take its place and serve the same purpose as the absent appropriate social behavior (Gresswell & Hollin, 1994). Many FCF also note the unusual family histories of many offenders. These histories might include the absence of models for appropriate behavior, the presence of models for socially inappropriate behavior, punishment for appropriate behavior, and reinforcement of behavior that subsequently develops into offending behavior. Thus, an offender's history might reveal that as a child his or her family members routinely engaged in violence, presented few models and opportunities to learn problem solving, and punished delaying of gratification. If as an adolescent, the future offender subsequently becomes part of a subculture that punishes typical social behavior and reinforces deviant behavior socially and through the material benefits of offendings, such as through acquisitive offenses, then the clinician might link this history to the current presenting problems of violence, acquisitive offenses, lack of problem-solving skills, and intolerance for delay of gratification. Of course, an offender may present with the same main problems, but through a different learning history. These differences in learning histories might make a significant difference in treatment, for example, if a second person presented with the same problems – aggression and acquisitive offenses – but learned these behaviors with a history of anxiety, avoidance of criticism.

A second potential benefit of FCF is that it may make sense of apparently senseless behavior, such as offending behavior that is harmful to the person or that, at least at first blush, appears to be a random and bizarre act of violence that occurred out of the blue. A good example of how a history-based FCF can account for a seemingly meaningless highly violent offense and guide a treatment plan comes from Gresswell and Hollin (1994), who reported a case formulation of the development of offending behavior in a murderer.

Understanding the development of offending behavior and how this relates to the current problems and their maintaining factors may also be helpful to the clinician in developing an integrated FCF and a better treatment plan. For example, if a history consistently identifies deficits in certain social or problem-solving skills that are repeatedly related to offending or clinically important behavior, then this aspect of the history may point the clinician toward an appropriate and powerful intervention strategy that addresses many of the offender's significant problems. The potential benefit of incorporating history into a case formulation when it relates to current important variables comes from Wolpe's annotated case formulations (Wolpe & Turkat, 1985). These reveal Wolpe conducting detailed clinical interviews to search for potential conditioning events that can be important for some clinical problems. Wolpe then uses the results of these history-based

interviews to identify variables in the *present* environment that can be manipulated to conduct treatment. For example, Wolpe and Turkat (1985, pp. 13–22) reported a case study of a woman with a fear of passing out. Only after extensive interviewing did Wolpe find a possible conditioning event that might have accounted for the onset of the problem. She finally revealed that when she was five years old she was taken to hospital without her parents and told that she would have an unannounced eye operation which she experienced as "total terror" (p. 16). Thus, Wolpe could now formulate the case as a fear of passing out and losing control based on this early conditioning event. This formulation also accounted for other specific fears, such as a fear of begin in deep water where she also feared passing out. Kuyken et al. (2009, pp. 225–228) used a similar process when they linked a client's core beliefs of being "a waste of space" and "useless" to specific historical traumatic events. Again, though, they use history to inform an understanding of current behavior and its relationship to the environment to develop a treatment plan based on current variables that can be changed. In the end we are not Time Lords: history is not a variable that we can manipulate; current environmental variables and behavior can be changed and sometimes client history helps us to identify what those current environmental variables might be.

Case Formulation of Current Problems: Personality Disorders

Offenders present with a very wide range of current problems which often include more severe mental health issues, including personality disorders, psychoses, aggressive behavior, concurrent substance abuse problems, and sexual disorders. Additionally, they may present with skill deficits, such as unassertiveness and lack of sexual knowledge and behavior, and excessive behaviors, such as bullying and lying. These current problems are often the focus of clinical interest, including case formulation. These problems are too diverse for this chapter to review comprehensively, and the reader is referred to generic volumes on case formulation (Eells, 2007a; Hersen & Rosqvist, 2009; Sturmey, 2007, 2008, 2009a). This section will illustrate the applications of case formulation to two common forensic problems: personality disorders and aggression.

Personality disorders seem an unlikely candidate for case formulation; many people see them as ingrained structural characteristics of a person reflecting the person's underlying, unchanging, and perhaps unchangeable biology. Yet the classic psychology literature on personality is replete with the well-established finding that personality and environment interact with one another, resulting in considerable variability in behavior within and across people. Sometimes environment swamps personality and all people behave in the same manner; sometimes extraverts behave in a timid fashion and very anxious people are sometimes brave in the face of extreme threats. Thus, whatever the status of the construct of personality, one must allow for environmental variables to influence behavior.

Diagnostic labels such as personality disorders serve a number of useful purposes, such as shorthand ways of communicating something about clients, service planning, and legal functions; however, the use of constructs such as personality disorders as explanations of observed behavior is illogical, since behavior is used to infer the presence of the alleged construct and then the alleged, unobserved construct is used to explain the observed behavior used to infer the construct itself. Skinner (1953: 284) writes that: "The personality, like the self, is said to be responsible for features of behavior. For example, delinquent behavior is sometimes attributed to a psychopathic personality … We may quarrel with any analysis which appeals to a self or personality as an inner determiner of action, but the facts which have been represented with such devices cannot be ignored." Skinner went on to discuss which observations of behavior lead to the inference of personality. He noted that responses can be organized by environmental variables such as reinforcer deprivation. For example, a person who is hungry adjourns a meeting and eats, but a sated person no longer speaks or behaves as the hungry person he formally was. The timid person made angry shows all the characteristic behavior of a person whose behavior is reinforced by observing other people suffer: they watch aggressive movies, yell at others, and see the other people cower. Skinner went on to suggest that a single personality is not a useful construct, but rather that the environmental variables related to reinforcement organize our responses. Thus, the pious personality of a Sunday Christian religious congregation is replaced by the angry and aggressive business person on Monday morning at work. These two so-called personalities perhaps inhabit the same skin, but they come and go with available contingencies.

There have been several interesting applications of case formulation to personality disorder. For example, Turkat's (1985) important volume on behavioral case formulation includes case descriptions of antisocial (Sutker & King, 1985), paranoid (Turkat, 1985), and histrionic personality disorders (Bantley & Callon, 1985). All three of these functional assessments of personality disorders share several things in common. They operationalize the patterns of behavior denoted by the shorthand of "personality disorder," and identify the reinforcers that hold those patterns of behavior together. Intervention, where possible, involves addressing each cluster of behavior and its associated reinforcer by teaching new ways of obtaining these reinforcers or devaluing them. The most pertinent example for this chapter is the example of antisocial personality disorder (ASPD), and this chapter will discuss this example in some detail.

Sutker and King (1985) offered a behavioral case formulation of Mr V, a 28-year-old man who met DSM-III criteria for ASPD. Mr V's primary physician referred him for assessment after he had a car accident. He subsequently reported lower back pain without any known organic origin and requested medication for his lower back pain. The authors conducted a behavioral assessment using a clinical interview, a review of medication charts, interviews with significant others in Mr V's life, including his wife, and an extensive psychometric assessment.

During the initial interview Mr V was cooperative, verbally facile, emotionally responsive, and uninhibited. He was unclear about the direction of his life and concerned about his marriage and some apparently minor legal problems. Although he admitted a history of legal problems and drug abuse in the past, he asserted that he had grown out of these problems. Based on this and two weeks of self-monitoring, Sutker and King developed four main domains of problems, including back pain, depression, marital discord, and legal difficulties and their associated situational factors. For example, legal difficulties included driving while drunk, speeding tickets, and the injury litigation. These problems were influenced by situations such as alcohol and drug use, and increased idle time.

Subsequent assessment with his wife and reviews of his medical records revealed an extensive history of legal and illegal drug and alcohol abuse, marital problems related to repeated flagrant sexual infidelity, and changing jobs without warning with subsequent financial problems. The psychometric assessment and a further interview with Mr V revealed yet further problems throughout his development. Intelligence tests results were scattered and suggested someone who was able, but was easily distracted and had failed to maximize his intellectual abilities. Other assessment information revealed that his family home had lacked supervision and his parents frequently fought in relation to his father's drinking and staying out late at night. His parents divorced when he was 11 years old. During adolescence he engaged in extraverted, sensation seeking behaviors, including drug use, sexual behavior, and criminal behavior. He avoided the academic aspects of school and his home because his mother was too critical for him. After marrying a young woman because she was pregnant by him he obtained employment. He led a relatively settled life for two years, but became bored of his wife and this lifestyle and returned to his former habits. After joining the marines for two years this pattern continued and he had further easy access to illegal drugs. He enjoyed being in the marines because of the physical aspects of the job, a culture condoning sexual promiscuity, and its camaraderie. After his recent drunk driving offense his wife, who had threatened divorce previously on many occasions, then filed for divorce for the first time. This precipitated his most depressed episode and he reflected that his drug use caused more problems that it solved.

Sutker and King's case formulation noted that this man had several significant strengths, including intelligence, responsiveness to structured environments, such as the marines, and some motivation to escape the negative emotions he experienced. During the development of his problems he experienced few negative consequences for deviant behavior. His drug abuse was initially effective in reducing negative emotions, but eventually was ineffective in achieving happiness and a personally satisfying life.

The formulation of his current problem identified four problem areas. These included (i) antisocial psychopathology, such as alcohol and substance abuse, and impulsive reckless behavior, such as promiscuity and drunk driving; (ii) depression,

such as complaints of boredom, reduced activity, and exaggeration of pain; (iii) cognitive and behavioral dyscontrol, such as little impulse control and poor self-discipline in many areas of his life; and (iv) social immaturity and dependence, such as being both demanding of significant others and simultaneously not investing in personal relationships. This case formulation suggested several treatment goals, such as maintaining an alcohol and drug-abuse-free life, finding exciting alternatives to drug-abuse and promiscuity, learning skills to manage his negative emotions, acquiring some self-discipline in his life, and improving relationships with his wife or divorcing and gaining clear goals for work and education. Based on this formulation, Sutker and King derived several elements of a possible treatment plan. These included (i) forming a good therapeutic relationship that avoided any appearance of superficiality or manipulation to which Mr V might be especially sensitive; (ii) reduction of alcohol and substance abuse, and subsequent possible relapses, perhaps through in-patient treatment; (iii) use of positive reinforcement, rather than punishment during the therapeutic relationship; (iv) maximizing personal strengths, such as social facility and physical prowess; and (v) removal of antecedent stimuli associated with drug abuse and antisocial behavior. As mentioned earlier, behavioral case formulation and assessment of acute dynamic risk factors overlap, and this case illustrates this. For example, a risk assessment might identify alcohol and substance abuse antecedent stimuli related to drug use and antisocial behavior as acute, dynamic risk factors that are modifiable and that could be the basis for a treatment plan, such as Sutker and King suggested.

This approach to formulation of ASPD emphasizes breaking down the global construct of "personality" into a matrix of response classes and their controlling environmental variables, such as situations that influence each response class. The problem of distortion and lying from clients who may have a lifetime of deceit and minimization of personal problems is addressed by using multiple informants and sources of information. Treatment is potentially difficult because the construct of "personality" in part denotes that the problems to be addressed are pervasive throughout many of the person's life domains and hence treatment may include many independent and/or interdependent problems to be addressed. For example, in Sutker and King's treatment plan they gave preeminence to treatment of drug and alcohol abuse as an essential area for change which, if not addressed, was likely to undermine treatment of other domains. Nevertheless, effective treatment of this problem domain may have some benefit to other domains, but would be unlikely to change all four problem domains, which would probably require other interventions.

Outstanding Issues in Case Formulation

There is now an extensive literature – if not, indeed, book industry – on case formulation, which provides many models for clinicians to use in case formulation, including FCF (Sturmey & McMurran, 2011). Yet, despite the surfeit of case