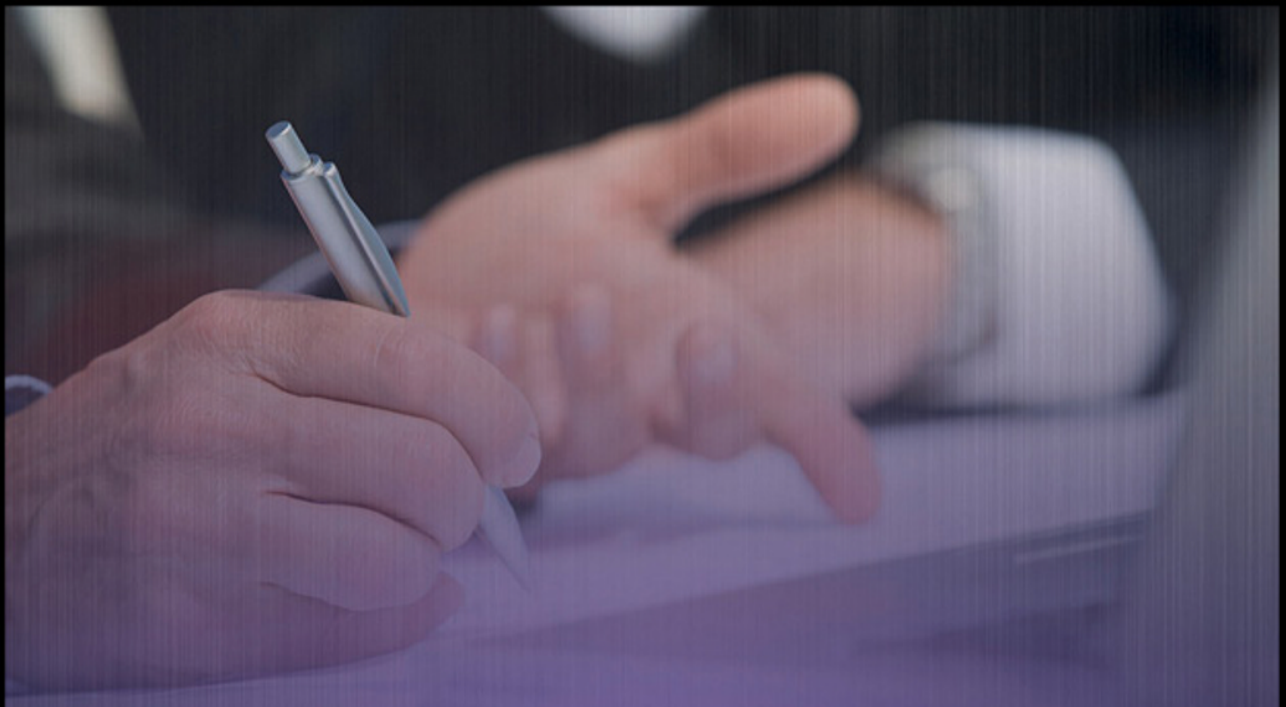

Assessments in Forensic Practice

A HANDBOOK

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

WILEY Blackwell

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The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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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

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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