The Criminogenic Needs of Offenders with Intellectual Disability and Personality Disorder

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Abstract

The criminogenic needs of offenders have increasingly come to the attention of those providing services and treatment interventions for this particular population. However, while the mainstream offender literature has advanced in the last few years, the evidence for effective treatments for offenders with an intellectual disability and personality disorder is limited. This thesis aims to contribute to the emerging evidence base by identifying those psychological factors that are shown to benefit from treatment intervention for offenders with ID and PD. In order to do this the thesis is presented in three distinct phases. First, in chapter two, a framework for identifying needs in offenders with PD is critiqued and the strengths and weaknesses of this particular framework is then used to inform the development of a similar approach to the identification of criminogenic needs for offenders with ID and PD (The Treatment Need Matrix; TNM). Chapter three provides a systematic review that was undertaken to establish the relevant areas of need for these offenders, and establish definitions of the areas identified. Research into the reliability of this framework is described in chapter four. Results suggest that the properties of the TNM compare favorably to similar structured clinical judgment tools and on the basis of the current evidence the items included are valid for offenders with ID and PD. Chapter five concludes the thesis by discussing the overall findings of the various studies undertaken and concludes that the TNM provides a useful and unique framework for the identification of treatment needs in offenders with ID and PD.

Acknowledgements

A number of people have contributed to the development of the Treatment Need Matrix and the research undertaken to establish the reliability of the tool.

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Staff members working in a number of forensic intellectual disability services participated in training and agreed for their scores on the case studies to be used in this research. This included staff working in two therapeutic communities for prisoners with intellectual disability hosted at HMP Dovegate and HMP Gartree. Staff working within a medium secure service for offenders with an intellectual disability at St. Andrews Healthcare (Nottinghamshire) similarly agreed to participate in the research, as did nursing staff working in a therapeutic community for offenders with intellectual disability and severe personality disorder at the National High Secure Learning Disability Service at Rampton Hospital. I would name them all but I promised anonymity.

Finally, some gratitude should be expressed to all of those men who have helped me to learn about the complexity of their lives, the difficulties they experience in their relationships, the entrenched nature of their core values, their struggle to manage their emotions and their interrupted and often traumatized development of self and self-management.

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- CHAPTER ONE -

Introduction

The care and rehabilitation of offenders has been a prominent social debate throughout modern times. The politics of imprisonment can become a central debate within elections with different parties seeking to gain popular approval by tapping into current public sentiment, the recent rise and fall of the programme for those with *Dangerous and Severe Personality Disorder* being a striking illustration of the political context surrounding the rehabilitation ethos.

Enthusiasm for the effective treatment of those who engage in criminal activity was subdued by the pessimism enshrined in the "What Works?" debate. In a paper that became synonymous with the *what works* debate, Martinson (1974) analysed a significant number of studies investigating the effects of a variety of offender rehabilitation programmes and concluded that intervention programmes were largely ineffective at achieving significant change in criminal activity. Recognising the relationship between social conscience, politics and the ideology of rehabilitation, Hollin (2001) suggests that the sentiments of Martinson's work were rapidly embraced by the political parties who were prevalent in both the United Kingdom and United States of America and saw government funding shift away from rehabilitation and treatment and towards policing strategies and punishment.

From the pessimism of the nothing works dialogue, however, came a renewed effort to investigate the efficacy of forensic treatments. Perhaps initiated by Palmer (1975) who critiqued the methodology of the original Martinson studies, though supported by Gendreau and Ross (1979) and Ross and Gendreau (1980), research began to suggest that the philosophy of

rehabilitation was worthy of more endeavour. Most notable in the development of offender treatment has been the work of Andrews and Bonta (1996). Meta-analytic studies (for example Andrews et al., 1990) provided the empirical basis for the development of core principles that have come to inform treatment programmes, and the assimilation of this information lead to the development of one of the most influential paradigms in forensic practice, the Risk-Need-Responsivity model.

Briefly, the ***Risk principle*** is concerned with the match between the level of service to the offender's risk of re-offending, with increasing need for treatment services as the risk increases. The ***Need principle*** emphasises the direct significance of criminogenic needs and their relevance as treatment targets. Finally, the ***Responsivity principle*** aims to increases the potential for individuals to learn from a rehabilitative intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender (see table 1.1).

The responsivity principle can be further considered in terms of two aspects, general and specific responsivity. General responsivity advocates the use of cognitive-behavioural methods to both develop new skills and challenge existing anti-social repertoires. Practices such as prosocial modelling, the appropriate use of reinforcement and disapproval, and problem solving (Dowden & Andrews, 2004) spell out the specific skills represented in a cognitive social learning approach.

Andrews and Bonta refer to the specific responsivity as "fine tuning" of the programme to accommodate the individual needs of the offender, including their strengths, learning style, personality, motivation, and bio-social (e.g., gender, race) characteristics of the individual.

Essentially, specific responsivity promotes a comprehensive formulation approach to rehabilitation by matching the style of programme delivery to the individual.

Risk	• Higher risk offenders have greater criminogenic needs • Risk should be assessed using a valid/reliable method • Target higher risk offenders
Need	• Target offender characteristics most predictive of recidivism • Dynamic factors, or criminogenic needs, are appropriate treatment targets • Robust predictors of recidivism include anti-social values and attitudes, pro-criminal associates, impulsivity • Poor predictors of recidivism include self-esteem, depression, anxiety • Target the more criminogenic needs
Responsivity	• Cognitive-behavioural strategies should be used • Promote adaptive cognitive/social skills not anti-social skills • Consider specific responsivity issues
Other	• Consider treatment context • Employ interpersonally sensitive staff, clinically trained and supervised • Offer structured relapse prevention • Include significant others.

Table 1.1: Principles of effective correctional programming

The Risk-Need-Responsivity (RNR) model has arguably become the most influential approach to the assessment and treatment of offenders (Ward, Mesler & Yates, 2007). Despite the clear impetus that the development of the RNR model provided for treatment developers and programme providers, the RNR has nevertheless has its critics. Ward and Maruna (2007) identify a number of key concerns with the both the model, and perhaps more specifically with the nature of programmes developed on the basis of the core principles. In particular they raise concerns about the motivational impact of the model, the reductionist view of human nature implied by the model and the lack of specific responsivity that has been apparent in the majority of RNR

based programmes. Essentially, the quality of the therapeutic alliance between the programme facilitators and the programme participants is questioned.

However, the model has systematically been developed since into a comprehensive and holistic approach to offender rehabilitation (Andrews & Bonta, 2006). Over the years, a number of elements have been added to the core theoretical principles to enhance and strengthen the design and implementation of effective offending behaviour programmes. These additional principles describe, for example, the importance of staff establishing collaborative and respectful working relationships with clients and correctional agencies and managers providing policies and leadership that facilitate and enable effective interventions (Andrews, 2001; Andrews & Bonta, 2006). As such, the RNR therefore encourages programme developers to consider not only the content of the programme, but also the process of delivery and the agency context.

The RNR model, although clearly not without critics has nevertheless been demonstrated to be a significant consideration in the design and delivery of forensic services. Perhaps on the back of renewed enthusiasm for offender treatments a range of programmes have been developed and evaluated in terms of their compliance with the RNR principles. Treatment interventions that do not adhere to any of the three principles have been found to increase recidivism. This situation is particularly exacerbated when the treatment is given in residential/custodial settings. However, if a treatment intervention begins to adhere to one of the principles we start to see reductions in recidivism and when all three principles are evident in a rehabilitation program then we see average recidivism differences between the treated and non-treated offenders of 17% when delivered in residential/custodial settings and 35% when delivered in community settings. This would seem to indicate that forensic services, whether

provided by the Prison or Probation services or within Health settings, need to develop and deliver interventions that demonstrate the principles of risk, need and responsivity.

Clearly, for services to develop and deliver interventions that are responsive to the needs of offenders the identification of criminogenic needs is a central requirement. Within the context of rehabilitation attempts, criminogenic needs are those characteristics of an offender that have a relationship with the likelihood of further offending.

Within the mainstream offender populations criminogenic needs, or risk factors, have been conceptualised in terms of those items that are stable aspects of a person's history (such as number of previous offences) and those individual characteristic that fluctuate and mediate the immediate potential of further offending. These dynamic factors have been further considered in terms of those that are stable, though potentially changeable (such as personality characteristics) and those that demonstrate more acute changes (such as mood, intoxication).

Although traditionally considered as conceptually distinct, a number of studies have recently begun to consider the relationship between static and dynamic risk items (eg Ward & Beech, 2004; Mann, Hanson & Thornton, 2010), with the suggestion that static items provide markers for long-term vulnerabilities and that long-term vulnerabilities may became activated as a consequence of more acute variables arising from the interaction of an offender within his socio-environmental context.

Whilst the awareness and understanding of risk factors has developed considerably in the general offender population over recent years, such understanding remains somewhat lacking for offenders with intellectual disability and personality disorder, indeed, many ID services fail to identify the presence of PD within their service user population. In order to increase the

knowledge of areas of need relevant to offenders with ID it seems appropriate for practitioners and researchers to consider the specific needs of those with intellectual disability instead of relying on adaptations and modifications from the mainstream offender populations. As Camilleri and Quinsey (2011) have suggested, in order to address the specific criminogenic needs of offenders with ID, risk assessments should include the unique characteristics of intellectually disabled offenders that both lead to and maintain offending behaviours. The evidence from the general offender literature would suggest that the identification of these needs is likely to increase the efficacy of treatments programmes and subsequently promote both public safety and successful community reintegration.

Structure of the thesis

This thesis aims to contribute to the emerging evidence base by identifying those psychological factors that are shown to benefit from treatment intervention for offenders with ID and PD. The thesis is presented in five of chapters, which, whilst each representing a discrete piece of work, also highlights the sequence of work involved in the development of the TNM. The next chapter describes an overview and critique of a framework that is used in prison based Therapeutic Communities for offenders with PD. The methodology employed in the framework is reviewed along with the reliability and validity of the tool.

Chapter 3 provides a systematic review of the treatment needs of offenders with ID and PD. Initial searches revealed a distinct lack of empirical research for such a discrete population and the search was therefore broadened to include offenders with ID generally. Needs are

clustered within four domains to reflect the structure of the framework described in the previous chapter. All of the areas of need included in the Prison Service framework are reviewed while additional areas that may be specific to offenders with ID (and PD) are also included where relevant. The needs that have sufficient evidence for offenders with ID forms the basis of the Treatment Need Matrix (TNM).

Chapter 4 follows with an empirical study describing the inter-rater reliability and test-retest properties of the TNM. The thesis is concluded in chapter five with a general discussion of the findings presented across the various studies included in the thesis.

- CHAPTER TWO -

Assessing Change In Prison Therapeutic Communities: Evaluating the Treatment Need Framework

Introduction

Forensic Democratic Therapeutic Communities (DTC) provide a holistic residential treatment setting for high risk offenders. Initially developed within HM Prison Service as an experimental psychiatric prison at Grendon Underwood, DTCs were based on the principles that had been developed within a small number of psychiatric hospitals following the Second World War. Initially based on the four core principles identified by Rapoport (1960) DTCs sought to promote democratization (the process of sharing authority and decisions making with member of the community), permissiveness (the freedom to express habitual patterns of behaving and relating to others), reality confrontation (the willingness to give and receive feedback from other community members) and communalism (a commitment to contribute to the running and upkeep of the residential environment and the welfare of all those living within it). Subsequently outlined in a series of manuals describing the practices necessary to support these principles within forensic contexts, DTCs have increasingly come to be recognized as a treatment of choice for offenders with a personality disorder (National Personality Disorder Strategy, 2011). The high frequency of personality disorder among both prisoners and secure psychiatric patients intuitively suggests that individual personality characteristics and inter-personal styles may contribute to the risk of an individual developing anti-social behavioural repertoires. In a review of prevalence rates within the UK prison service, Fazel and Danesh (2002) estimate that

approximately 46% of the prison population have an Anti-Social Personality Disorder while it is estimated that up to 15% would meet the criteria for psychopathy as measured by the PCL-R (Hare, 2003). Blackburn et al. (2003) found similar rates of personality disorder (PD) in a high secure hospital, while Coid et al. (2006) found that those people with a diagnosis of a Cluster B personality disorder were ten times more likely to have a criminal conviction and eight times more likely to have received a custodial sentence, than people who do not have such a diagnosis. Similarly, Howard, Huband, Duggan, and Mannion (2008), found, that people with anti-social or borderline PD are more likely to have received a conviction for violence and a custodial sentence. They showed higher trait anger and impulsivity and a greater history of aggression, and scored significantly higher on a higher-order "psychopathy" factor.

For the DTC treatment model to be proved to effectively treat offenders with PD empirical research must show that graduates of DTCs demonstrate reduced reconvictions and reduced characteristics associated with PD in comparison to controls. Whilst there are numerous issues with the use of reconviction studies as a measure of treatment effectiveness of forensic TCs, they have nevertheless been used fairly routinely as a source of information about efficacy.

A number of studies have pointed towards a positive impact of the DTC model on recidivism. For example, Marshall (1987) assessed the reconviction of all prisoners who attended an English DTC between 1934 and 1989, and was also able to compare these findings with those of a group of men referred to DTC, but never admitted. At four year follow up Marshall found lower rates of reconviction for those prisoners who had been resident in the DTC. The rate of conviction had a clear relationship with the length of time spent with the TC with those men who had spent eighteen months or more in the programme showing the greatest reduction in relapse when compared to prisoners who remained in the programme for less than eighteen months.

In terms of characteristics associated with a range of Personality Disorders, Birtchnell and Shine (2000) explored the inter-personal style of men admitted to a U.K. prison based TC, and found such men to have significantly different styles of relating to others as measured by the Person's Relating to Others Questionnaire (PROQ). Two particular sub-scales of this measure, highlighting inter-personal styles characterised by suspiciousness and a fear of rejection and disapproval, appeared to differentiate forensic male populations from general populations. In a subsequent U.K. study into the impact of a TC treatment programme, Birchell, Shuker, Newberry and Duggan (2009) found a reduction in such interpersonal deficits and improved interpersonal functioning following treatment.

On the basis of this it would seem fair to assume that men who successfully complete treatment in a DTC effect some degree of change in a range of dynamic treatment needs, and that these changes appear to effect a reduction in the likelihood of further offending.

The Therapeutic Community Model

As an accredited offending behaviour intervention, the therapeutic programme of DTC's is manualised, accredited by the Correctional Services Accreditation Panel and recognized as an offending behaviour programme for high risk offenders, particularly those with PD. The treatment needs targeted by the programme are described in detail in both the theory and assessment manuals for DTC's.

The assessment manual (2007) identifies eighteen dynamic psychological variables within four domains (see figure 2.1), each of which is rated on a three point ordinal scale (present, partially present and not present). Ratings are completed on the basis of observations of behaviour during treatment, collateral file information and a range of psychometric assessments.

Although not formally presented as a structured clinical judgment approach to assessing risk, treatment need and change, the scores attributed for each variable (for each prisoner) form the basis of the treatment targets. Ratings are determined initially at the conclusion of assessment for admission to the programme and are revised at regular therapy reviews throughout the duration of treatment. At the conclusion of treatment progress is reported using a standardised report format which requires that progress is evaluated against these eighteen treatment targets.

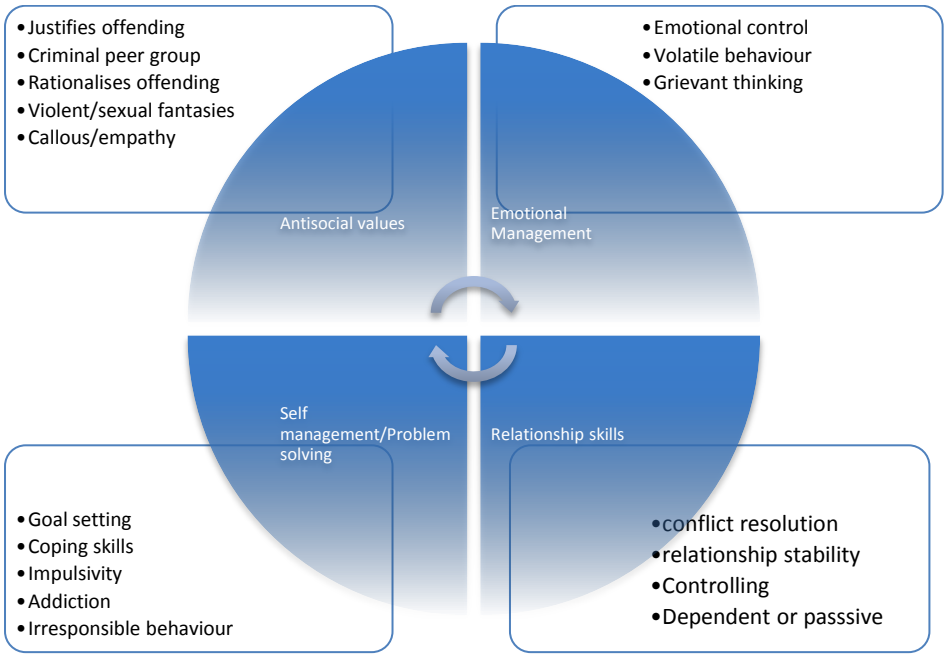

Figure 2.1: Treatment Domains and targets

A similar approach to the assessment of dynamic variables can be found in the widely adopted approach to the assessments of risk and treatment need for sex offenders as described by Thornton (2002). In developing the Structured Risk Assessment (SRA) Thornton reviewed three

kinds of research designs that provide evidence pertinent to the identification of stable dynamic risk factors underlying treatment need. These included longitudinal studies that investigate prospective correlations of psychological factors with sexual recidivism, comparisons of groups known to differ in their past histories and studies of offence precursors. From these studies Thornton identified four domains of treatment need for sex offenders; sexual interests, distorted attitudes, socio-affective functioning and self-management. From a review of the empirical literature a number of items were then identified for each domain and psychometric assessments were similarly identified for the domains. Although the psychometric assessments do not cover all of the items listed in each domain, the ones used to supplement the SRA all have acceptable internal consistency of .8 or higher (Thornton, 2002). In the same study repeat offenders have consistently been found to have higher scores on these tests (at either .01 or .005 level) suggesting that the variables contained in each domain contribute to the risk of reoffending.

As with the SRA, the DTC treatment need summary or matrix (hereafter referred to as the Treatment Need Matrix; TNM) is perhaps best viewed as a framework for coordinating the assessment of a range of psychological variables that are hypothesised to have a relationship with reoffending. As with the SRA, the matrix forms the basis for the evaluation of treatment gains and it is imperative therefore that it stands up to scrutiny as an assessment tool. Before considering the psychometric properties of the tool, however, it is worth briefly considering the development of the tool.

Test Development and Design

As a framework for rating the relative presence or absence of an area of treatment need the TNM bears some resemblance to both the SRA and the PCL-R (Hare, 2003). All three

assessment strategies require a rater to ascertain the salience of a range of items for a particular offender, although in the PCL-R all of the items are assumed to measure a higher order psychopathy factor. As already mentioned, the items included in both the SRA and PCL-R were determined from a systematic literature review (and expert consensus in the case of the PCL-R) and the tools were subsequently subjected to a number of studies to determine their predictive validity.

The TNM differs from both of these established tools quite significantly in this respect. First, as described in the DTC manuals, the TNM ostensible provides a summary of the treatment targets for DTC's and evaluates change across these target areas during the course of treatment. It is not described in the manuals as a formal assessment, whilst simultaneously is described in the *end of therapy report* as the basis for evaluating progress.

While the TNM appears to have been drawn from the literature, and the treatment domains and items bear some resemblance to those described in the SRA, there appears to be no literature describing the identification of the specific treatment targets, nor the allocation of these targets into four domains. Furthermore, and significantly, the treatment targets identified in the assessment manual are not described. This contrasts sharply with other tools that require assessments to be made about the relative presence of item characteristics (eg PCL-R, SRA) where detailed descriptions of the items are available for those undertaking the rating. Finally, and again significantly, the application of the assessment framework (ie the collation of collateral, observational and psychometric information to make a rating) is not described in the manuals.

Psychometric Properties of the Treatment Need Matrix

As has been documented, DTC's target eighteen dynamic risk/need variables across four domains. The formal evaluation of progress for community members is reported against these eighteen areas in a standardised report format (Assessment and Evaluation Manual, 2007). It would stand to reason that those men who successfully complete such a treatment programme will demonstrate reduced levels of need and risk across a range of these target areas at the conclusion of their treatment, and the treatment need summary, or matrix, therefore seeks to measure psychological change across these various treatment targets. As mentioned, in order to report on such changes with confidence, the TNM will need to demonstrate some fundamental properties in relation to the reliability and validity of the tool.

Reliability

Psychometric assessment tools are typically required to demonstrate two distinct aspects of reliability, internal consistency and test-retest reliability (Kline, 2000a). Although the TNM is clearly not a psychometric assessment in the true sense because it does not seek to identify the relative presence of a specific variable, it nevertheless seeks to establish the presence of a range of characteristics, and subsequently changes in the nature of those characteristics over time, and consequently will need to evidence the reliability with which those characteristics are identified. Approaches to assessment that draw on a similar methodology to the TNM, such as the SRA and PCL-R, have nevertheless sought to identify certain aspects of reliability in order to establish their usefulness. In particular the homogeneity obtained across different users of the tool, or the inter-rater reliability, establishes the degree of variation that can be expected between different

users of the tool. The relevance and the relative merit of these aspects of reliability for the TNM are outlined below.

Internal consistency is concerned with the degree of correlation between the various items that are contained within a particular test. As the majority of assessments are aiming to measure one particular variable (for example anxiety, anger etc) it is important that the items are measuring the same variable and thus correlate with each other. However, the TNM claims to measure a range of variables. While the assumption of the tool is that these variables all contribute to dynamic risk (as a higher order factor) they nevertheless represent differing aspects of risk and as such would not be expected to demonstrate internal consistency. For example, a high rating for impulsivity would not necessarily suggest that there should also be a high rating for criminal associates or grievant thinking. Similarly, items within the same domain would not necessarily have a high correlation, despite the fact that they are assumed to be representative of the same higher order factor. Again, as an illustration, controlling and passive/dependent are both items within the relationships domain and therefore are both considered to be indicative of interpersonal difficulties. However, it does not follow that a person assessed to have significant problems with their controlling behaviour would also be assessed to present as dependent in their relationships. Given the variation between items included within such assessment frameworks, it is perhaps not surprising that internal consistency correlations are not quoted for the PCL-R (Hare, 2003), the HCR-20 (Webster el al., 1997) or the SRA (Thornton, 2002).

Test-retest reliability on the other hand is concerned with the consistency of a test over time. In other words, a test with high test-retest reliability should produce similar scores when the same subject completes the test on separate occasions. Notwithstanding the problems already described with the TNM, test-retest reliability would seem to be paramount. As the TNM is a

framework that is completed by an observer rather than by the test subject, two aspects of test-retest reliability would appear to be important.

Intra-rater reliability describes the correlation between scores obtained from a single rater across different completions of the assessment of the same subject. High intra-rater reliability is clearly important for any assessment in order to demonstrate that scores obtained can be interpreted with confidence and are not unduly influenced by random error. Clearly, a number of factors can influence the degree of concordance of ratings over time, not least of which could be actual changes in the subjects being rated. However, neither the TNM, the PCL-R nor the SRA have published data concerning such an aspect of reliability

A related concept is that of inter-rater reliability which refers to the consistency with which a tool is scored between different scorers. Clearly, tests that have poor inter-rater reliability will struggle to demonstrate that they are measuring variables effectively as different scorers will contribute significant error. The approach taken by measures that rely on such scoring strategies tends to focus on the training of the scorer(s) and reducing subjectivity by establishing tight definitions of the items concerned (to reduce interpretation of the items). Both the PCL-R and SRA are good examples of this approach where detailed item descriptions are available and scorers have to undertake training that includes assessment of the reliability of their scoring practices. Furthermore, both of these tools have demonstrated good inter-rater reliability (Hare, 2003; Webster et al., 2006 respectively). However, the DTC manuals that are available do not provide descriptions of the items included in the TNM, inevitably leaving scorers to develop their own definition of each item and thus likely to introduce significant error. Furthermore, a literature search of DTC's has not revealed any research into the reliability of the

TNM, which would raise serious concerns in relation to the value of the framework as a mechanism for reviewing the progress of men admitted to such treatment programmes.

This said, the TNM also uses a range of assessment measures to support the identification of need (see Figure 2.2), these being the Eysenck Personality Questionnaire - Revised (Eysenck & Eysenck, 1991), the Psychological Inventory of Criminal Thinking Styles (PICTS, Walters 1995), the Blame Attribution Inventory (Gudjonsson, 1984), the Person's Relating to Others Questionairre (PROQ-3, Birtchnell & Shine, 2000) and the Hostility and Direction of Hostility Questionairre (HDHQ, Caine et al., 1967). In addition, the HCR-20 (Webster, Douglas, Eaves & Hart,1997), a structured judgment approach to the appraisal of violence risk, is also used to inform the rating of items within the TNM. The properties of these tools will also need to demonstrate sufficient reliability (and validity) if the assessment framework is to be considered suitable for the assessment of dynamic treatment needs and are discussed briefly later.

Validity

As is widely documented, a test is said to be valid if it measures what it claims to measure (Kline, 2000b). The TNM claims to measure a number of psychological variables that are hypothesised to represent dynamic risk factors. On the face of it, the four domains identified within the TNM represent appropriate areas of functioning, there is general overlap with the domains included in the SRA and the items similarly seem to be appropriate to their respective domains. Face validity may offer some benefits for those completing the assessment framework as it offers a "common sense" background to the items included.

Treatment targets/primary risk factors	Measures
EMOTIONAL MANAGEMENT AND FUNCTIONING	
Emotionally driven impulsivity	*EPQ-R (Impulsivity and extraversion scales), HCR 20 (C4 – impulsivity)*
Erratic and volatile behaviour/ temper control deficits Sudden fluctuations in mood / temperament	*EPQ-R (Neurotic and impulsivity scales), HCR 20 (C4 –impulsivity)* *HDHQ (Intrapunitive Hostility, projective hostility and criticism of others scales)*
Rumination over perceived injustices Grievant thinking Social/emotional isolation	*HDHQ (Intrapunitive Hostility, projective hostility and criticism of others scales)* *PROQ 3 (Neutral/Lower distant Octant), Problem checklist (factor 2)*
ANTI SOCIAL BELIEFS, VALUES AND ATTITUDES	
Anti-social values and attitudes Offence supportive beliefs Anti-authority attitudes	*PICTS EPQ-R ('P' 'C' scale)* *HCR-20 – C1, 2 (negative attitudes)*
Cognitive deficits: Perspective taking, Cognitive distortion, Appraisal biases Lack of empathy	*PICTS, Blame Attribution Inventory, HDHQ (Criticism of others scale), EPQ-R ('Pychoticism' scale)*
Acceptance of responsibility for offence/actions Lack of insight	*Blame Attribution Inventory* *HCR-20 – C2 (lack of insight)*
DEFICITS IN SELF-MANAGEMENT, COPING AND PROBLEM SOLVING SKILLS	
Difficulties achieving goals Irresponsible/reckless behaviour/ lifestyle	*EPQ-R I, V and C (impulsivity, venturesomeness and criminality sub scale)*
Impulsive decision making Deficits in coping skills and problem solving	*PICTS (Discontinuity/cognitive indolence scale)* *HCR 20 C4 (impulsivity)* *EPQ-R E (extraversion scale)*
Deficits in management of own risk	*HCR 20 'R' items*
Rule/boundary breaking	*EPQ-R P and C (psychoticism scale and criminality sub scale)*
INTERPERSONAL RELATING/ RELATIONSHIP SKILL DEFICITS	
Aggressive/passive approach to conflict resolution	*PICTS (power orientation)* *EPQ-R 'P' and 'E' (Psychoticism and extraversion scale)*
Controlling/aggressive towards others	*PROQ 3, EPQ-R 'P'*
Hostile, mistrustful, suspicious beliefs about others Empathy	*EPQ-R 'P' and 'E' (Psychoticism and extraversion scale) PROQ 3, HDHQ (projective hostility scale)*
Deficits in social/interpersonal skills Avoids/ dependent in relationships Relationship instability	*PROQ 3,* *Problem Checklist (factor 2 items)* *EPQ-R 'P', 'E'*

Figure 2.2: Risk/Need items and psychometric tests

Face validity, however, is insufficient in isolation to confer validity on to a test or assessment. Of more significance is the notion of concurrent validity where a test is found to correlate with other tests measuring the same variable. However, as Kline (2000) notes, identifying a criterion test to correlate against is problematic in most fields of psychology. However, established assessments of risk with high predictive and concurrent validity may be considered appropriate criterion tests for the TNM and two particular assessments widely used within the prison estate would seem to be suitable comparisons; the HCR-20 (Webster et al., 1997) and the Offender Assessment System (OASys). However, as the HCR-20 is used to inform the assessment of items within the TNM it would not be a suitable concurrent test as it would effectively include correlations with its own items. The OASys risk assessment tool on the other hand would seem to be a suitable and relatively easy measure for the TNM to be validated against and has been demonstrated good predictive validity (AUC .76).

Unfortunately, as with other aspects of the TNM, studies into the concurrent validity do not appear to have been undertaken, thus preventing any firm conclusions to be drawn. However, one possible measure that has been used with other tests that evaluate the presence of variables hypothesised to have a relationship with offending behaviour is the association with reoffending; the assumption being that those with higher scores on the TNM would be more likely to reoffend. As was mentioned earlier, graduates of prison DTC's relapse at a significantly lower rate than men released from prison with similar levels of pre-treatment risk. Similarly, Newton (2010) found adjudication rates in one English DTC to be lower for men who complete therapy when compared with their adjudication rates prior to transfer to the DTC. Newton suggests that adjudication rates could provide a useful measure of therapeutic progress and may also provide

behavioural confirmation of reductions in treatment targets, including impulsiveness, aggression and anti-authoritarian values.

In a study reporting reconviction data for another English prison Therapeutic Community, Miller and Brown (2010) found that 48% of the men released from Dovegate directly back into the community were reconvicted, a rate that is lower than has been found in other prison treatment programmes.

These studies consistently show reduced reoffending for TC graduates in addition to a treatment dose effect. It would seem reasonable to assume that those men who complete treatment, ie stay in the programme for eighteen months, will produce lower scores on the TNM than those who fail to complete the treatment. The correlation between these scores and criminal behaviour and adjudication rates would be able to offer some indication of the concurrent validity of the treatment need assessment format used in the DTC's.

Similarly, as a framework for determining the presence of psychological risk factors, the TNM would be expected to demonstrate predictive validity in relation to reoffending and/or prison behaviour. As has been seen, there is considerable evidence that the men entering DTC's have high levels of risk/need, and that men with similar levels of risk who do not engage in TC treatment reoffend at higher rates. However, while some studies have reported change on some of the psychometric tests used to support the completion of the TNM these do not comment on changes in the ratings of individual treatment targets.

The validity of the TNM is therefore highly questionable. This is not to say that the frame work is not valid, but rather reflects the lack of research evidence.

Psychometric Assessments

In order to promote the reliability and validity of the needs assessment process, the measures used to supplement the observational and collateral information will need to demonstrate sound psychometric properties.

Eysenck Personality Questionnaire – Revised (EPQ-R; Eysenck & Eysenck, 1991)

The EPQ-R has been widely used as a criterion test and has strong psychometric properties (Kline, 2000b). In a review of the EPQ-R Kline reports that internal consistencies are all satisfactory, with the four sub-scales generally scoring above .7 and many above .8. Test-retest reliability for the sub-scales falls within .7 - .9 and are thus highly satisfactory. Factor analytic studies have demonstrated almost complete separation of the *psychoticism*, *neuroticism* and *extraversion* scales and high loading of items on each scale (Kline & Barrett, 1983).

The Psychological Inventory of Criminal Thinking Styles (PICTS: Walters, 1996)

The PICTS is an 80-item self report measure designed to assess the eight thinking styles hypothesized to support and maintain a criminal lifestyle. The lifestyle model asserts that crime can take the form of a lifestyle in which the behavioral styles of irresponsibility, self-indulgence, interpersonal intrusiveness, and social rule breaking predominate (Walters, 1990). The Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995a) was constructed in an effort to assess the cognitive thinking patterns believed to serve as precursors to these four behavioural styles. The behavioural styles are considered descriptive of the lifestyle, whereas the thinking patterns play a key role in the evolution of the lifestyle. As such, the cognitive thinking patterns are believed to be predictive of the behavioural styles.

In a study of 107 male federal prison inmates (Walters, 2009) assessed using the Psychological Inventory of Criminal Thinking Styles (PICTS) and Psychopathy Checklist: Screening Version (PCL:SV). The PICTS General Criminal Thinking (GCT) score was found to predict general recidivism and serious recidivism when age, prior charges, and the PCL:SV were controlled. The PCL:SV, on the other hand, failed to predict general and serious recidivism when age, prior charges, and the PICTS were controlled. These findings support the hypothesis that content-relevant self-report measures like the PICTS are capable of predicting crime-relevant outcomes above and beyond the contributions of basic demographic variables like age, criminal history, and such popular non-self-report rating procedures as the PCL:SV. Similarly, O'Donnel and Healy (2006) examined the use of the PICTS with a sample of 72 Irish men on probation, and tested the hypothesis that probationers who reported no offending for at least a year (secondary desisters) would have lower PICTS scores - indicating a less active criminal belief system - than those who remained involved in crime. Furthermore probationers who did not report committing crime during the past month (primary desisters) would have lower scores than those who did. Significant differences ($p < .05$) were observed on three of the eight scales and on Current Criminal Thinking for the secondary desisters and on six of the eight scales for the primary desisters.

The PICTS manual (Walters, 2006) reports both reliability and validity studies during the development of the test. Internal consistency, as measured by alpha coefficients and inter-item correlations varied from .55 to .88 and .13 to .39 respectively, and suggests that the tool posses moderate to moderately high internal consistency. However, as noted by Kline (2000) alpha scores should not drop below .7 while five of the eight criminal thinking scales of the PICTS have alpha scores below this standard and the reliability of the scales with alpha scores below

this raises doubts over whether they are measuring a unified concept (ie the specific criminal thinking style). It should be noted, however, that some psychometricians (notably Cattell, 1957) argue that high internal consistency can reduce the power of tests by narrowing the breadth of the assessment. Indeed, as Kline also notes, there are many tests where the questions are merely paraphrases of each other. These tests achieve high internal consistency but have poor validity.

Similarly, the PICTS reports overall test-retest reliability of .7 after a two week repeat administration and .5 after a twelve week retest, again suggesting that such correlations represent moderately high test-retest reliability (Walters, 2006). However, as with the internal consistency data these scores raise some concerns. First, retest correlations are generally considered to need to be .8 or above for a test to have any value. Six of the eight thinking styles assessed by the tool achieve this standard at the two week repeat test. However, this raises a second concern with the data. Retest reliability is recommended at a three month time interval for repeat testing and at this time interval the PICTS retest reliability correlations fall some way below the .8 standard. To complicate this matter further the PICTS is a measurement of dynamic variables which are assumed to be amenable to change and lower retest reliability at the larger time interval may be influenced by actual change in subjects rather than due to measurement error.

The PICTS manual similarly describes measures of a number of types of validity. It reports positive content validity, pointing to the range of sub-scales measuring thinking styles that are believed to represent a criminal value system and the collaboration of prisoners in the development of the tool. In order to establish concurrent validity the PICTS scales were correlated with prior criminality on the assumption that a scale measuring criminal thinking should correlate with criminal behaviour. Although reporting modest concurrent validity, correlations of the various sub-scales with prior arrests do not get above.22, which falls well

short of the .75 recommendation. When correlated with the PCL-R factor two items, the thinking scales do however demonstrate moderate concurrent validity, though correlations all fall below .57.

The Hostility and Direction of Hostility Questionnaire (HDHQ: Cain, Foulds & Hope, 1967))

The HDHQ is a self-report questionnaire designed to measure different aspects of hostility. Early versions of the assessment were examined by Hope (1963) with findings suggesting that all five of the sub-scales were positively correlated with one component (*General Hostility*) and three sub-scales were contrasted with the two remaining sub-scales in terms of their *Direction of Hostility*. Direction of hostility refers to the relative strength of the expression of hostility which may be directed outwards towards others, or directed inwards towards oneself. Research from one Prison based DTC has found then mean total hostility score to be significantly higher than means cited in the original manual, though the mean direction of hostility score was not found to be significantly different. Furthermore, follow up studies (Newton 2000) found a small but significant correlation between the HDHQ total score and the HDHQ extrapunitive hostility score (comprising three sub-scales) with reconvictions.

However, despite these findings and although widely used and cited as evidence for a number of areas of dynamic risk in the TC manuals, the psychometric properties of the HDHQ have been found to be somewhat inconclusive.

Crawford (1977) administered the HDHQ to prisoners as part of routine psychological assessment (n = 100) and analyzed results in terms of the prisoners' past and present criminal and institutional behaviour. The results showed that the prisoners had a significantly higher total hostility score than the HDHQ sample population but did not differ significantly in the direction

of their hostility. Violent offenders were significantly more extrapunitive than non-violent offenders, and prisoners who had attempted suicide were similarly more extrapunitive than those with no history of attempted suicide. Apart from these findings no significant relations were found between the HDHQ results and criminal and institutional behaviour, leading to the conclusion that the HDHQ would be of little value in making predictions about future violent or criminal behaviour.

The psychometric properties of the HDHQ were further examined by Arrindell, Hafkenscheid and Emmelkamp (1984). Drawing on data from a sample of psychiatric outpatients (N = 295) they suggested that while the dimensions of *acting out hostility*, *critical of others* and *paranoid hostility* were found to be fairly well distinguishable from each other, the *self-criticism* and *guilt* scales were not. Similarly, there was limited evidence (in the sample population) that the total hostility score represented a uni-dimensional concept, thus undermining the use of total hostility scores. However, all subscales had adequate internal consistency and there was similar evidence of construct validity. Miller and Hafner (1989) also evaluated the psychometric properties of the HDHQ (n = 250). Results supported the theoretical scoring structure except for the *guilt* sub-scale and *total hostility*. Internal consistency reliabilities for all scales were modest and only recommended to be sufficient for research purposes. Finally, the DTC assessment manual (2007) reports high (.75) test-retest reliability.

The Person's Relating to Others Questionnaire (PROQ3, Birtchnell and Shine, 2000)

The PROQ3 was designed to measure negative relating as organized around a theoretical structure called the interpersonal octagon. Each questionnaire has an upper, lower, close and distant scale and four intermediate scales (e.g., upper close). Moderately high positive

correlations were observed between primary scales (upper, lower, close and distant) and neighboring intermediate scales. Correlations diminished with increasing separation around the octagon. The psychometric properties of the PROQ3, and its predecessor the PROQ2 were examined within four national samples. Alpha coefficients were consistently acceptable across samples (Birtchnell & Evans, 2004; Birtchnell et al. 2011). Concurrent validity was also established using a number of comparison measures (Birtchnell & Shine, 2000; Birtchnell et al., 2008).

Blame Attribution Inventory (BAI: Gudjonsson, 1984)

The BAI is a self-report measure that assesses the way in which an individual attributes blame and responsibility for their offending behavior. The BAI includes three scales; *external attribution* (blaming the crime on victims, society or social circumstances), *mental element attribution* (externaling responsibility on mental illness or poor self-control), and *guilt feeling attribution* (feelings of regret or remorse concerning the offence).Factor analysis of the Gudjonsson Blame Attribution Inventory (Gudjonsson, 1984) revealed three independent factors. External attribution of blame was found to be positively correlated with psychoticism, hostility, and external locus of control. Guilt attribution correlated with neuroticism and introversion, but negatively with psychoticism suggesting concurrent validity. However, reliability data does not appear to be available for the measure.

The HCR-20 (Webster, Douglas, Eaves& Hart, 1997)

The HCR-20 is a violence risk assessment scheme that guides users to identify the presence of a range of risk factors and establish their relevance for an individual. The HCR-20

reviews ten historical items, five clinical items and five risk related items and provides an overall estimate of the risk of future violence. The clinical and risk management items of the HCR-20 have been reported to possess high predictive validity (Belfrage, Fransson & Strand, 2000) , with moderate to large effect sizes. Similarly, Douglas and Webster (1999) assessed the concurrent validity of the HCR-20 through comparison to other risk instruments and to the presence of several past indexes of violent and antisocial behavior. The HCR-20 showed moderate to strong relationships with the concurrent measures. Reports of inter-rater reliability are similarly good, with a total intra-class correlation of 0.8 (Douglas, Ogloff, Nicholls & Grant, 1998).

In summary, the range of psychological tests that are used to support the ratings of various risk items demonstrate psychometric properties ranging from modest to good. The internal consistency of the PICTS scales raises some concern about the reliability of the tool, particularly given its use in the rating of a number of the items included in the TNM. Similarly, the total score of the HDHQ is questionable, although it is only sub-scale scores that are used in making ratings.

Summaryand Conclusions

DTCs have demonstrated a positive treatment effect for men who remain in the programme for a period of eighteen months or more (Taylor, 2000; Miller & Brown, 2010). As we have seen, the methods used to monitor progress during treatment are based on changes on eighteen dynamic variables hypothesised to be related to offending behaviour. DTC's evaluate changes on these variable on a three-point scale, drawing information from a range of psychometric assessments and observations of behaviour within the treatment setting. Offenders

who engage in the treatment programme are expected to demonstrate change on a range of these variables and the official report documenting progress is based on such an assessment.

However, the framework used to evaluate these changes, the treatment need summary or matrix, does not appear to have been subjected to scrutiny. The lack of item descriptions raises significant concerns about the inter-rater reliability of the tool and similarly test-retest correlations have not been undertaken. Although the framework appears to have face validity and the content (i.e. the items included in the assessment) seem similarly valid, the concurrent and predictive validity have not been established, again raising questions about the value of the framework for assessing treatment progress.

Having said this, DTC's have demonstrated positive effects on recidivism and institutional behaviour for those who complete the treatment. The TNM, as the basis for reporting on treatment gains would therefore benefit from further development. It would seem reasonable to suggest, on the basis of the preceding discussion, that a number of issues could be addressed. Correlations between ratings obtained at the point of assessment and criminal and adjudication history would provide a measure of concurrent validity and may also be used to highlight the potential predictive validity of the tool. Reliability of the framework could also be addressed by developing standardized descriptions of the items included in the matrix, training of raters and some investigations into the inter-rater reliability of trained raters. Increasing the confidence in the value of the tool would support those working in DTCs to gather evidence to support the efficacy of the treatment model, which, in a climate that appears to be moving towards outcome based commissioning of treatments, would seem particularly important.

- CHAPTER THREE -

The Criminogenic Needs of Offenders with an Intellectual Disability and Personality Disorder: A Systematic literature Review

Abstract

Background: The treatment of offenders with a learning or intellectual disability has gained momentum over the last twenty years. The advancement of such treatments has tended to rely on developments in the mainstream offender literature with researchers and clinicians increasingly seeking to identify adaptations and modifications to increase the responsivity of treatments for this particular population. Alongside these developments, attention has recently been drawn to the treatment needs of offenders with a personality disorder and it has become increasingly apparent that treatment providers need to consider those offenders with a personality disorder comorbid with intellectual disability (National Offender PD strategy, 2011).

Objective: To identify the criminogenic needs of offenders with intellectual disability comorbid with personality disorder.

Search strategy: The OVID online library using PsychINFO, MEDLINE and EMBASE and Web of Science were searched using a strategy combining (Offenders or synonyms) and (Learning disability or synonyms), (personality disorder and synonyms) and (dynamic risk or criminogenic need or treatment need

and synonyms). Additional references were identified from previous reviews and contact with experts.

Study selection: All references obtained from the searches were screened against the inclusion and exclusion criteria and then subjected to a quality assessment

Main Results: Thirty papers were identified from computerised searches and perusal of previous review papers.

Conclusions: Although there is sufficient evidence to identify a range of criminogenic needs in offenders with intellectual disability and personality disorder, much of the evidence is based on reviews of other literature, cross-sectional descriptive reports or treatment outcome studies. Furthermore, many papers do not distinguish between ID offenders with or without PD. Until more rigorous and systematic studies employing randomised controlled trials are employed within the forensic ID services, treatment targets will continue to be based on a "best fit" model rather than on strong scientific evidence.

Introduction

Over recent years the treatment of offenders with intellectual disability (ID) in general, and the treatment of offenders with ID and personality disorder (PD) in particular has received increased attention (e.g., Taylor & Morrissey, 2012). A number of recent studies have begun to explore the relationship between personality disorder and offenders with ID. Lindsay et al. (2006) examined the prevalence rate of personality disorder in a number of forensic ID settings. Drawing on a range of assessment methodologies they found an average prevalence rate of 39.5 %, rising to 57% in a high secure setting, which compares to prevalence rates found in high secure patients without ID (Blackburn at al., 2003). Anti-Social Personality Disorder was the most frequent diagnosis, though interestingly a formal diagnosis was only recorded in clinical files in almost 23% of cases, suggesting significant under diagnosis and potential neglect of important criminogenic and psychological needs.

Subsequently, Lindsay et al. (2007) found a similar factor structure for personality disorder in offenders with ID as has been found for other offender groups (Blackburn et al., 2005), again suggesting that the concept of personality disorder may be a valid construct and useful in the treatment of offenders with ID. In a further study examining the relationship between emotional problems and personality disorder, Lindsay et al. (2010) used the Chart of Interpersonal Relationships in Closed Living Environments (CIRCLE; Blackburn, Logan, Renwick & Donnelly, 2005) and the Emotion Problem Scales (EPS; Prout & Strohmer, 1991), both of which have been validated on ID populations, and found a number of significant correlations between various sub-scales of the measures and personality disorder. The *dominance dimension* (characterised by strong opinions, a tendency to dominate conversations

and influence others) of the CIRCLE had a significant positive relationship, with large effect size, with a diagnosis of narcissistic personality disorder, while the nurturance dimension had a significant negative relationship with a diagnosis of anti-social personality disorder. Similarly, the EPS externalizing scale had a significant positive relationship with narcissistic personality disorder and Anti-Social Personality Disorder and with the VRAG and HCR-20 clinical scale.

In the same multi-site study referred to above, the relationship between risk and personality disorder was systematically examined in a population of intellectually disabled offenders (Hogue et al., 2006). Using a range of risk assessments those men with a diagnosis of PD were consistently found to present greater levels of risk. As may be expected, increasing levels of psychopathic traits were also associated with increased levels of risk, while those men who satisfied the criteria for Dangerous and Severe Personality Disorder (i.e., a PCL-R score over 30 or a PCL-R score over 25 along with additional PD diagnoses) presented the greatest risk for both sexual and violent offences. Using the same study's data, it was also found that those with ID and personality disorder presented with significantly more externalising and internalising problems than those without (using ratings from independent the PD ratings), further validating the diagnosis in a forensic ID population (Johnston, Morrissey, 2010).

In a review of the literature, Torr (2008) notes that a diagnosis of Anti-Social Personality Disorder is associated with placement in higher security settings, serious and repeat offending and poorer long-term outcomes for people with ID, findings that resemble the evidence in mainstream forensic settings and again suggest that the diagnosis of personality disorder can add valuable information to treatment considerations for the ID population. Furthermore, Alexander et al. (2006) found that ID offenders with a personality disorder were nine times more likely to re-offend.

In a series of studies Morrissey (2003, 2006) and Morrissey at al. (2005, 2007a,b) explored the reliability and validity of the construct of psychopathy to forensic ID populations. High levels of psychopathic traits were found to be predictive of poor treatment outcome as measured by progress to conditions of lower security, suggesting that the cluster of items included in the PCL-R (Hare, 2003) represent criminogenic or responsivity needs. However, the predictive value of the PCL-R, which has been consistency demonstrated in non ID forensic settings, was not replicated in these studies, although Gray et al. (2007) did find that the PCL-SV (Hart, Cox, & Hare, 1995) predicted recidivism when assessed retrospectively in a medium secure heath sample with ID.

Although a number of debates remain, there would seem to be sufficient evidence to suggest that personality disorder is as relevant to those with ID as it is to those without. Indeed, Reid, Lindsay, Law and Sturmey (2004) suggest that knowledge of personality disorder is as important when working with people with ID as it is with any other population, and it seems likely that the criminogenic and psychological difficulties arising from the PD will require attention of treatments are to prove to be effective.

Assessment of risk and criminogenic Needs in Offenders with Intellectual disability

The last 20 years has seen a steady growth of research and interest into the assessment and treatment of offenders with an intellectual disability (ID). Alongside this the mainstream offender literature has seen substantial progress in the assessment of risk of reoffending. Perhaps unsurprisingly the development and dissemination of a range of risk assessments for mainstream offenders has provided a foundation for the assessment of risk in the ID offender population.

Pragmatically, given the prevalence of ID within the prison population, it seems reasonable to assume that a number of existing risk assessments will have been developed with a proportion of the sample population having ID. The STATIC 99 (Hanson & Thornton, 2000) for example, explicitly acknowledges the proportion of ID sex offenders included in the sample population. Similarly, in an evaluation of the Violent Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice & Cournier, 1998) the accuracy and predictive validity of the tool was found to be as valid for offenders with ID as it was for offenders without ID (although the ID population included men with an IQ up to 80). In a further investigation into the predictive validity of the VRAG with ID offenders, Quinsey, Book, and Skilling (2004) found it to show significant predictive value with medium effect size. Interestingly over 50% of the men included in this study had an additional diagnosis of personality disorder.

Actuarial assessments, however, only represent one component of the conceptualisation of risk. There is broad recognition that dynamic risk, or criminogenic needs, are equally significant in an assessment of an individual's propensity to relapse and therefore should form a core component of treatment. A particularly good example of this is Thornton's Structured Risk Assessment (SRA, 2002) for sex offenders, which identifies risks from the empirical literature and clustered these risks within four conceptualised domains of functioning. In a series of studies Thornton(2002) demonstrated a relationship between ratings of items on the SRA and reconviction.

A number of other assessments have since been developed that combine static and dynamic risk factors in a structured clinical judgement approach to the assessment of risk. The Historical Clinical Risk - 20 (Webster, Eaves, Douglas & Wintrup, 1995) and the Sexual Violent Risk – 20 (Boer, Hart, Kropp & Webster, 1997) combine static (historical) factors with more

clinical and psychological variables (clinical and risk) to support clinicians to develop comprehensive formulation of an individual's risk of future violence or sexual violence and treatment needs. It is pertinent, given the focus here on the identification of treatment needs for offenders with ID and PD, to note that in a number of established risk assessments a diagnosis of PD (HCR-20) and a diagnosis of psychopathy (SVR-20, RSVP) would increase the risk estimate for individuals. Similarly, Coid et al. (2006) found that those people with a diagnosis of a Cluster B personality disorder, namely borderline, anti-social, histrionic and narcissistic, were 10 times more likely to have a criminal conviction and eight times more likely to have received a custodial sentence, than people who do not have such a diagnosis. When considering people with a diagnosis of PD who remained living in the community, Howard, Huband, Duggan, and Mannion (2008), found, that those people having anti-social or borderline PD were more likely than the remainder to have received a conviction for violence and a custodial sentence, suggesting that the characteristics of APD and BPD are likely to be areas requiring intervention for offenders with these difficulties.

In addition to the use of established risk measures, a number of forensic ID practitioners have developed ID specific risk assessments. Boer, Tough, and Haaven (2004) developed the Assessment of Risk Manageability for Intellectually Disabled (sex) Individuals who Offend (ARMIDILO), a checklist containing 30 stable and acute dynamic risk factors, scored in relation to the individual offender and the staff team (see Table 3.1). Recent analysis (Blacker, Beech, Wilcox, & Boer, 2011) of the predictive validity has shown that the ARMIDILO- acute scale is a strong predictor of sexual recidivism for offenders with ID.

Table 3.1: ARMIDILO dynamic risk factors (for ID sex offenders

Stable dynamic	Acute dynamic
Attitudes to supervision/treatment	Changes in social support
Insight into risk factors	Substance misuse relapse
Sexual self management	Sexual preoccupation
Mental health	Poor emotional regulation
Planning ability	Increased victim access
Substance abuse	Reduced compliance
Victim selection and acquisition	Reduced problem solving/relapse plans
Coping abililty	Changes to routine
Relationship skills	Offender specific factors
Use of violence	
Impulsiveness	
Offender specific problems	

While the ARMADILO was designed for use with sex offenders with ID, Lindsay et al. (2004) developed a system for the assessment of dynamic risk for ID offenders in general. The Dynamic Risk Assessment and Management System (DRAMS) draws on Thornton's SRA domains to identify broad clusters of risk factors relevant to offenders with ID (see Table 3.2). In a field trial of the DRAMS Lindsay and colleagues suggested that the instrument may be predictive of institutional aggression with four items (mood, psychotic symptoms, self-regulation and compliance with routine) achieving high reliability and a further two items (antisocial behaviour and thoughts/attitudes) intermediate reliability. A subsequent study (Steptoe, Lindsay, Murphy & Young, 2008) found that mood, antisocial behaviour and intolerance had significant predictive values in relation to future incidents of violence.

Table 3.2: Dynamic Risk Assessment and Management System (for ID offenders)

Risk variable	Specific items
Mood	Anger, anxiety, mania, sadness
Antisocial behaviour	Verbal and non verbal threats; violence to self, others and property; sexually inappropriate behaviour; lack of consideration for others
Thoughts	Aberrant sexual thoughts; suspicious thoughts; criminal thoughts
Self-regulation	Impulsiveness; sexual impulsiveness
Psychotic symptoms	
Substance abuse	Alcohol abuse; drug/solvent abuse
Compliance with routine	Looking after room; looking after self; follow daily routine
Renewal of recent emotional relationship	
Opportunity for victim access	

The application of a range of actuarial assessments and structured clinical judgement frameworks to offenders with ID would seem to demonstrate the importance and utility of risk assessments to this population. Furthermore, the predictive validity of both the ARMIDILO and the DRAMS would also indicate the importance of dynamic risk factors in the treatment and management of offenders with ID. With this in mind, the framework for assessing criminogenic need in offenders with PD, as used in the Democratic Therapeutic Communities (DTCs) in the UK Prison Service (see Table 3.3), has been adopted to assess and monitor progress for high risk male offenders with ID and PD in a residential treatment programme drawing on the principles of DTC's (Taylor, Trout, Christopher & Bland, 2012). However, although the risk items appear to have face validity it is not clear whether these risk items have been derived from empirical research, and the relevance of this framework for offenders with ID and PD has not been established.

Table 3.3: Treatment Need Domains used in Prison Therapeutic Communities

Antisocial attitudes	**Self management and problem solving**	
Anti-social attitudes	Difficulties achieving goals	
Anti-authority attitudes	Impulsive decision making	
Criminal peer group	Poor coping and problem solving	
Does not accept responsibility	Addictive behaviour	Anxiety Depression Personal distress Self – esteem Insecure/avoidant attachments
Cognitive deficits	Risk taking behaviour and lifestyle	
Lack of insight	Deficits in management of own risk	
Lack of empathy		
Relationship skills	**Emotional management**	
Aggressive/passive approach to conflict resolution	Emotionally driven impulsivity	
Controlling/aggressive to others	Social/emotional isolation	**Psychological & emotional needs**
Deficits in social/interpersonal skills	Volatile behaviour/problems with temper control	
Hostile, mistrustful, suspicious beliefs	Rumination over perceived injustices	
Avoids/dependent in relationships	Grievant thinking	
Lack of empathy	Sudden fluctuations in mood/temperament	
Relationship instability		

The aim of this systematic review is therefore to identify factors that have been empirically shown to be related to offending behaviour in offenders with intellectual disability and personality disorder. Specific objectives include:

- To identify the criminogenic needs of offenders with intellectual disability and PD described in the literature
- To present criminogenic needs for this population within a conceptual framework that supports clinicians in the identification of primary treatment needs.

Method

Scoping

An initial scoping exercise was undertaking by searching the Cochrane dataset for previous reviews. No reviews were found relating to the criminogenic needs of offenders with Intellectual disability and personality disorder.

Sources of Literature

The following databases were searched for the purposes of this review:

- Psychinfo
- Medline
- Embase
- Web of Science

Review papers identified in the search were perused for additional relevant literature. More papers were identified through this process than relevant hits in the systematic review, a situation described previously by Lindsay (2002). Details of these papers are provided later.

Search Terms

A hierarchy of search terms were used to assist the identification of suitable literature:

1. Offender* OR crimin*
2. Learning disab* OR intellectual* disab* OR mental* retard* OR mental* handicap*
3. Personality disorder*
4. Dynamic risk* OR criminogenic need* Or risk* factor* OR treatment need*
5. 1 and 2 and 3 and 4

Inclusion criteria

Population

As the study aimed to identify the psychological and criminogenic needs of offenders with an intellectual disability and personality disorder, the population was a broad spectrum of offenders with intellectual disability, regardless of their offence type. Due to the limited number

of papers (one) returned from the original population search and the evidence that, although often undiagnosed, many offenders with ID also have PD, studies identifying criminogenic needs in offenders with ID (but not PD) were included. All studies included in the review were therefore required to identify the presence of an intellectual disability by a recognised method. Similarly, papers were required to demonstrate the "forensic" nature of the population. However, due to the policy of diverting people with intellectual disabilities from the criminal system the use of convictions/charges was unreliable. Instead, the nature of the behaviours described in the population were used to make judgement. If behaviours described in a study would be likely to be criminal in people without an intellectual disability studies were retained.

Intervention:

As with the population the intervention was broadly defined. The aim of the search was to identify those psychological variables that were targeted by treatment providers and could be demonstrated to be responsive to treatment and/or have a relationship with recidivism. Studies considering a range of treatments were therefore included along with studies examining predictive validity of assessment tools.

Comparator:

As has been identified in previous systematic reviews (e.g., Duggan, Huband, Smailagic, Ferriter & Adams, 2007), this proved problematic. Many interventions were compared against a treatment as usual condition, waiting list controls or no control and instead relied on pre/post treatment designs. For pragmatic reasons, all three designs were included, though it is recognised that this limits the generalisation of the research, particularly for those studies that only used pre/post treatment design.

Outcome :

Outcome was similarly problematic to define. Studies identified during preliminary scooping exercises used a wide variety of outcome measures and many relied on frequency of certain behaviours rather than changes in the psychological factors underlying the behaviour. As offending behaviours may occur infrequently or may be inhibited by placements in custodial environments a reliance on observed behaviour clearly raises problems for determining the value of an intervention. Studies therefore were included when a specific outcome was identified in terms of either offending or offence-related behaviour, or changes in psychological variables postulated to mediate behaviour were reported.

Assessment of Methodological Quality

A consideration of research quality can be found in the different levels that are considered by the National Institute of Clinical evidence:

- Level A: Consistent Randomised Controlled Clinical Trial, cohort study, all or none, clinical decision rule validated in different populations.
- Level B: Consistent Retrospective Cohort, Exploratory Cohort, Ecological Study, Outcomes Research, case-control study; or extrapolations from level A studies.
- Level C: Case-series study or extrapolations from level B studies.
- Level D: Expert opinion without explicit critical appraisal, or based on physiology, bench research or first principles.

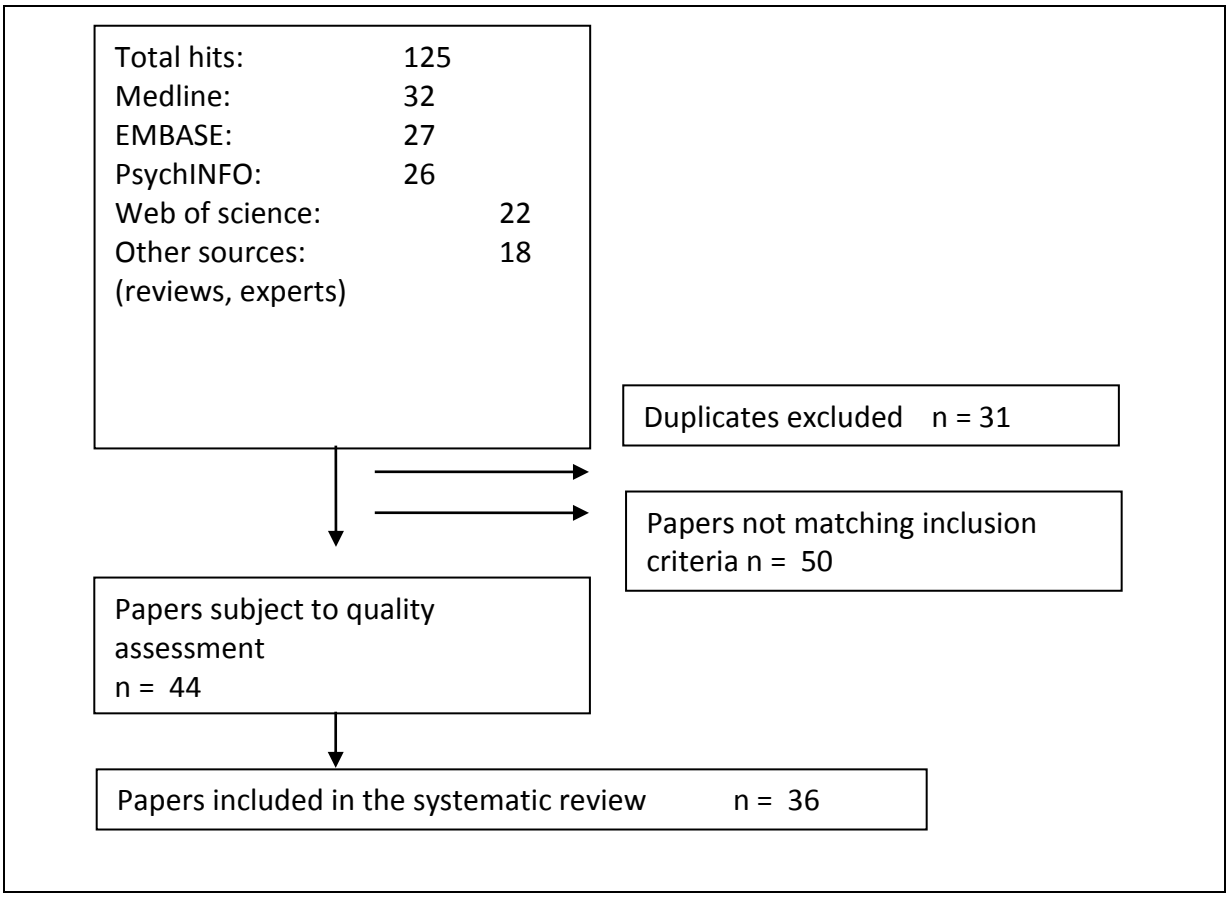

Figure 3.1 : Search Results (Criminogenic need in Offenders with ID)

The search returned no results that would satisfy the criteria for randomised control trials. The majority of papers returned from the overall search strategy were therefore located at level B. Studies that employed methodologies located at level C or level D were not included in the final review. Figure 3.1 provides a summary of the search and extraction process. Based on a hierarchy of evidence papers drawing on single case designs or the author's opinion were not included in the final analysis. Similarly, papers that did not provide a clear methodology were excluded.

Results

In order to promote clarity the evidence for specific risk items or criminogenic needs identified are presented within the domains of anti-social attitudes; relationship skills; self-management and problem solving, and; emotional management. This is to structure the results according to previous thinking in this area, as discussed in the introduction, for the sake of consistency. Papers idenitifed in the review, and included in the evidence presented below are presented in Table 3.4 (review papers) and Table 3.5 (papers identified from experts).

Pro-criminal values

Antisocial and anti-authoritarian values and fantasies

Seven papers identified in this review highlighted the potential role of antisocial values in influencing the probability of recidivism. In a pilot study exploring the utility of the Dynamic Risk Assessment and Management System (DRAMS) Lindsay et al. (2004) found that the item labelled "thoughts", which included criminal thinking, to have intermediate reliability for the prediction of institutional aggression. In an exploration of factors predictive of sexual offence recidivism, Lindsay, Elliot and Astell (2004) used a retrospective correlational design (n = 52) to consider the relationship between a range of variables and re-offending. Using multiple regression the authors found antisocial attitudes to be a significant predictive factor (at the 0.05 level of significance). Numerous studies have also identified the role of beliefs and attitudes in sexual offending within this population, while McGrath, Livingston and Faulk (2007) found that both sexual attitudes and sexual interests were significant treatment needs in sex offenders with

ID. However, in the same study criminal attitudes were not found to have the same significance, although the authors considered this item to be somewhat more subjectively defined and therefore more problematic to identify.

In a follow up study of men with antisocial histories, Quinsey, Book and Skilling (2004) found an item called dynamic antisociality was one of three that significantly predicted future antisocial behavior. Similarly, Fitzgerald (2011) found a general criminal history, which would imply a values base supportive of criminal behaviour, was associated with increased rates of recidivism, and using a grounded theory approach Courtney et al. (2006) identified a super-ordinate theme of attitudes and beliefs that was found to impact on every stage of the offence process for offenders with ID.

In a further study involving sex offenders with intellectual disability, Lindsay et al. (2007) developed the Questionnaire on attitudes consistent with sex offences (QACSO) and found that the tool reliably distinguished between sex offenders with ID and people with ID who did not engage in sexually abusive behaviour. The scale incorporates attitudes supportive of a range of sexual offences. Using the same assessment, Langton and Talbot found significant differences between treated and untreated sex offenders with ID, suggesting that pro-criminal values are both apparent in ID sex offenders and amenable to treatment. Treatment amenability was also apparent in the Murphy et al. (2010) paper. Repeated measures " t- tests" on a group of men undertaking sex offender treatment (n = 46) found significant changes on two attitudinal measures, the QACSO ($t = 8.39$, $p < 0.001$) and the SOSAS ($t = 2.25$, $p < 0.03$). Post treatment improvements in attitudes were also apparent in the Keeling et al. paper (2006). Paired sample t tests revealed significant changes in attitudes as measured by the QACSO ($t = 3.88$ $p < 0.015$) and the Modified Abel and Becker Cognition Scale ($t = 2.08$, $p < .32$).

Table 3.4: Studies identifying criminogenic needs in offenders with ID (from database search)

Author	Study Design	Measures	Findings/outcomes
Embregts P. van den Bogaard K. Hendriks L. Heestermans M. Schuitemaker M. van Wouwe H.		Risk Inventarization Scale on Sexually Offensive Behaviour of clients with Intellectual Disabilities (RISC-V)	35 dynamic items.
Fitzgerald, S., Gray, N., Taylor, J. & Snowden, J. (2011)	Predictive validity study (n = 145). ID offenders released from medium secure units	Reconvictions (Home Office Offenders Index) Criminal history variables (previous offences, age at first offence) Lifestyle variables (drug and alcohol misuse)	Re-offenders (n=14) different from non re-offenders in terms of: Previous acquisitive offences Previous drug offences Bail offences History of alcohol/drug misuse
Keeling JA ; Rose JL; Beech AR (2006)	Sex offender Treatment evaluation using pre/post measures (n = 18, FSIQ x = 71.78)	UCLA loneliness scale Criminal Sentiments Scale Miller Social Intimacy Scale Modified Able and Becker Cognitions Scale Victim Empathy Distortions Scale Self Control Ratings Scale Paulhul Deception Scale	Measures of attitudes, empathy and self-control showed significant change with large effects (paired sample t tests)
Kelly, J., Goodwill, A. M., Keene, N. & Thrift, S. (2009).	Retrospective case control/comparison design (n = 20) fire setters with ID.		Significant association between perceived inability to effect social change and index offence (p, 0.01).
Langdon PE. Talbot TJ. (2006)	Between subjects design (n = 41); sex offenders who had completed treatment, untreated sex offenders and non offenders.	Questionnaire on attitudes consistent with sex offenders Nowicki-Strikland Internal-External Scale	Untreated sex offenders scored significantly higher than other groups on rape, exhibitionism, homosexual assault, pedophilia, stalking and sexual harassment scales of QACSO. No significant difference between the three groups on locus of control measure.
Lindsay WR. Hogue TE. Taylor JL. Steptoe L. Mooney P. O'Brien G. Johnston S. Smith AH. (2008)	Between group comparison (n = 212)	HCR-20, VRAG, SDS, Emotional Problem Scales	HCR-20 and EPS discriminated between groups. VRAG, HCR-20-,SDS and EPS showed significant predictive validity. EPS had highest AUC and is a dynamic assessment only.
Lindsay, W. R; Elliot, S. F.	Retrospective correlational design	Checklist of static and dynamic factors	Significant variables:

&Astell, A. (2004)	using two independent raters compared the presence of risk factors with re-offending (n = 52)	derived from the literature.	allowances made by staff antisocial attitude, poor maternal relationship denial of crime sexual abuse in childhood.
McGrath R.J., Livingston J.A., Falk G.	Pre/post treatment evaluation ID sex offenders (n = 87)	Treatment Intervention and Progress Scale Assessment of treatment progress	Changes on a number of dynamic factors correlated with independent assessments of treatment progress ($F(2,69) = 9.981$, $P < 0.001$). TIPS significantly correlated with level of service involvement ($t(85) = 2.81$, $p < 0.01$)
Murphy, GH; Sinclair, N; Hays, SJ; Heaton, K; Powell, S ; Langdon, P; Stagg, J; Williams, J; Scott, J; Mercer, K; Lippold, T; Tufnell, J; Langheit, G; Goodman, W; Leggett, J; Craig, L (2010)	Pre/post group treatment evaluation ID sex offenders	Sex Offender Self Appraisal Scale Questionnaire on attitudes consistent with sex offenders Victim Empathy Scale Sexual Knowledge Scale	Pre – post treatment changes Victim empathy $t=3.30$, $p= 0.002$ SOSAS $t = 2.25$, $p = 0.030$ QAKSO $t = 8.39$, $p < 0.001$ SAKS $z = 3.81$, $p < 0.001$
Parry CJ. Lindsay WR. (2003)	Between group comparison: sex offenders with ID, non-sex offenders with ID and non-offenders with ID.	Barratt Impulsivity Scale	Significant difference in levels of impulsiveness between sex offenders with ID and non-sex offenders with ID ($t = 2.83$, $p< 0.01$). Sex offenders were less impulsive.
Rice M.E., Harris G.T., Lang C., Chaplin T.C.	Between group comparison ID and non ID sex offenders (n = 138)	phallometric assessment	ID sex offender group demonstrated increased sexual deviancy
Sakdalan, J. A; Shaw, J; Collier, V. (2010)	Evaluation of treatment effectiveness (DBT) for offenders with ID using a range of pre/post measures (n = 6).	Short term assessment of risk and treatability (START, Webster at al 2004). Vineland Adaptive Behaviour Scale – second edition (Sparrow et al. 2005) Health of the Nation Outcome Scales for people with learning disabilities (HONOS-LD; Wing et al. 1996)	START risk domain: post treatment gains ($p < 0.05$) START strength domain: post treatment gains ($p < 0.01$) HONOS-LD post treatment gains ($P < 0.05$)
Steptoe L.R., Lindsay W.R., Murphy L., Young S.J. (2008)	Predictive and concurrent validity study	Dynamic Risk and Management Scale (Lindsay) Incident analaysis Ward Anger rating Scale.	Mood, antisocial behaviour and intolerance/agreeableness predicted incidents with medium effects sizes as did the total DRAMS score.
Taylor JL. Novaco RW. Gillmer BT. Robertson A. Thorne I. (2005)	Pre/post treatment evaluations with waiting list control group comparison.	Novaco Anger Scale, Novaco Provocation Index Stait Trait Anger Expression Inventory, Ward Anger rating Scale	Pre-treatment, no significant differences between the two groups. Analysis of linear trend found significant interaction effects for NAS total and NAS arousal scale, $F(1,33) = 4.74$, p , .05, $r = .35$ and $F(1,33) = 6.72$, p , .05, $r = .41$, with the treatment group showing greater declines in anger. Similar analysis of the cognitive and behavioural scales showed no significant differences between the treatment and control

			groups. Between group comparisons for the PI did not show significant differences between the groups following treatment, though ther was a significant difference on the unfairness/injustice sub-scale, F(1,33) = 9.88, p , .005, r = .48 No significant differences on the STAXI or staff ratings.
Taylor JL. Novaco RW. Gillmer BT. & Thorne I (2002a)	Delayed waiting list control design (n = 40). Men allocated to anger treatment group or routine care waiting list.	Novaco Anger Scale, Anger expression scale of the STAXI Ward Anger rating Scale.	Analysis of covariance revealed significantly lowered self report of anger in the treatment group compared the control group following treatment completion.
Taylor JL. Thorne I. Robertson A. Avery G. (2002b)	Pre/post treatment design for fore-setters (n = 14)	Fire Interest scle Fire Attitude Scales Goal Attainment Scales Novaco Anger Scale Culture free self-esteem inventory Beck Depression Inventory	Significant improvements on the FIRS (t=2.19, p< 0,05) Significant improvement on the FAS (t = 2.5, p < 0.05) Significant improvements on victim interest (t = 4.84. p < 0.001), emotional expression (t = 2.10, p < 0.05) and understanding risk (t = 3.79, p <0.005) on Goal attainment scales. Significant change on CFSEI (t = 2.64, p < 0.05)

Table 3.5: Studies identifying criminogenic needs in offenders with ID (from experts/reviews)

Author	Study design	Measures	Findings/outcomes
Basquill, M.F., Nezu, C.M., Nezu, A.M., Klein,T.L. & MacLean, W.E. Jr. (2004)..	Between group design: Adults with mild ID (aggressive vs. nonaggressive)	Viignettes depicting various problem situations	Aggressive participants were less accurate in correctly identifying interpersonal intent, characterized by more problem-solving deficits, and generated higher numbers of aggressive solutions to resolve problems
Blacker, J., Beech, A.R., Wilcox, D.T. & Boer, D. (2011)	Predictive validity of your risk assessments compared across two matched groups; offenders with special needs and offenders without special needs (n = 88).	ARMIDILO SVR-20 RM 2000 RRASOR.	ARMIDILO best predictor of recidivism among offenders with special needs. ARMIDILO-acute, SVR-20 psychosocial affect and overall scales best predictors of sexual recidivism for ID offenders.
Courtney, J., Rose, J., & Mason, O. (2006).	Using a grounded theory approach, qualitative interviews with ID sex offenders are analyzed to generate a model of the offence process (n=6)		The study highlights the importance of attitudes and beliefs at all stages of the offence process. Additionally, the authors identify the lack of decency insult in these offenders, i.e. an inability to empathize with society's view of sex offending

Doody, G. A., Thomson, L. D. G., Miller, P., & Johnstone, E. C. (2000).	Between group comparison: (1) Forensic individuals with comorbid ID and schizophrenia (n=14); (2) Comorbid community control subjects n=34); (3) Forensic ID and no psychosis (n=33); and (4) 27 community control subjects with mild ID	The four groups were compared on a range of socio-demographic, historical and clinical variables obtained from case records and subject interviews.	Non psychotic forensic ID sample increased: suicide attempts, Alcohol abuse or drug misuse Single
Holland, S. & Persson, P. (2011)	Between group comparison: prisoners with ID and prisoners without ID released during a set time period.		Prisoners with ID were characterised by: significant prior involvement in the criminal system, high risk of offending Difficulties in progressing to lower levels of security. employment problems accommodation problems Limited family and social support.
Jahoda, A., pert, C., Squire, J. & Trower, P. (1998).	Controlled comparison groups aggressive and non-aggressive people with intellectual disability	Sentence completion test.	Significant difference in response style of aggressive and non-aggressive participants (Mann-whitney, $p < 0.01$)
Hogue, T., Steptoe, L., Taylor, J. L., Lindsay, W. R., Mooney, P., Pinkney, L., Johnston, S., Smith, A. H.W. and O'Brien, G. (2006),	A clinical-record-based comparison of offenders with intellectual disability in high security (n = 73), medium/low security (n = 70), and a community service (n = 69).		More complex presentations, in particular comorbid personality disorder, was more likely in the highest security group. Both fatal and non-fatal interpersonal violence convictions were significantly related to group, with more in the high security group sustaining a conviction both at the index offence and prior to that. Over 50% of all groups had at least one conviction for a sexual offence.
Lindsay, W. R., Hamilton, C., Moulton, S., Scott, S., Doyle, M., & McMurran, M. (2011).	Pre/post treatment design with two groups (violent offenders n= 5, sex offenders n=5)	Social Problem Solving Inventory - Revised	Three scales of the SPSI-R showed significant difference between testing points
Lindsay, W. R., Smith, A.H.W., Law, J. Quinn, K., Anderson, A., Smith, A., Overend, T. & Allan, R. (2012)	Analysis of treatment needs from referrals to an ID department between 1990-1997		22% of referrals highlight problems with anger and aggression 12% highlight alcohol problems 45% relationship problems. Treatment termination or self-discharge was correlated with increased rate of re-offending.
Lindsay, W.L., Whitefield, E.	Between groups comparison (ID	Questionnaire on Attitudes Consistent with	All scales successfully discriminated between the

& Carson, D. (2007)	sex offenders, ID offenders, ID non offenders and non-ID non offenders)	Sex Offending	groups suggesting that sex offenders with ID hold a range of beliefs that are pro-criminal.
Lindsay, W.R., Murphy, L., Smith, G., Murphy, D., Edwards, Z., Chittock, C., Gieve, A. & Young, S. (2004)	Cohort study (n=5)	Daily ratings of the Dynamic Risk Assessment and Management System. Ratings were compared with incidents of aggression.	Four items achieved high reliability; Mood psychotic symptoms self-regulation Compliance with routine. Two items achieved intermediate reliability; antisocial behaviour and problem thinking/attitudes.
Lindsay, W.R., Smith, A.H.W., Law, J., Quinn, K., Anderson, A., Smith, A. & Allan, R. (2004b)	Between group comparison study using consecutive referrals to a community forensic service between 1990-2001 (n = 11 sex offenders, n= 91 non sex offenders)		Sex offenders significantly more likely to have relationship difficulties. Non sex offenders significantly more likely to have anger control problems.
Lindsay, W.R., Taylor, J.L., Hogue, T., Mooney, P., Steptoe, L. & Morrissey, C. (2010)	Reviewed the relationship between the EPS, the CIRCLE, PD and risk in offenders with ID (n=212).	Emotional Problem Scales (Prout & Strohmer) The Chart for Interpersonal relations in Closed Living Environments (CIRCLE; Blackburn) Violent Risk Appraisal Guide HCR-20 (Webster et al.)	Positive correlations with EPS externalising scale and antisocial and narcissistic PD. Strong significant relationships between the EPS externalising scale and VRAG and HCR-C scale. Significant relationship between CIRCLE dominance dimension and narcissistic PD. For nurturance dimension there was a strong negative relationship with antisocial and schizoid PD.
Lunsky, Y., Gracey, C. Koel, C., Bradley, E., Durbin, J. & Raina, P. (2011)	Cross-sectional sampling process comparing In patients with ID and forensic needs with non-forensic ID patients and forensic patients without ID.	Colarado Client Assessment record Level of care assessment	Personality disorders were more present in ID forensic sample, Mood disorders, substance use and psychotic disorders less prevalent. Id forensic group more likely to have a history of neglect.
McGillivray, J. A., & Moore, M. R. (2001).	Between group comparison: Offenders with ID (n=30) and non-offenders with ID (n=30).	Self-reported drug and alcohol misuse. Performance on an alcohol and other drug knowledge test was also compared.	Individuals who had offended reported greater use of substances than their non-offending counterparts and many reported that they had been under the influence of alcohol or illicit drugs at the time of committing the offence that had resulted in their current placement within the criminal justice system. Offenders demonstrated greater overall knowledge about alcohol and other drugs
Morrissey, C., Mooney, P.,	Sample of 60 patients in high	PCL-R,	HCR-20 total score and EPS externalising scale were

Hogue, T., Lindsay, W. R., & Taylor, J. L. (2007).	secure ID services followed for 12 months.	HCR-20 EPS Institutional records of aggression	significantly correlated with type 1 (physical/interpersonal) and type 2 (verbal/property) aggression. EPS externalising scale significantly correlated with type 3 (high risk) aggression.
Morrissey, C., Taylor, J. & Bennett, C. (2012)	Between group comparison; milieu based therapy vs. TAU (n=11)	Emotional Problem Scales (Prout & Strohmer) The Chart for Interpersonal relations in Closed Living Environments (CIRCLE; Blackburn)	TC group only: Reduced positive impression scale in treatment group (Z ¼ 22.0, p , 0.05). Reduction in self-rated anxiety (Z ¼ 21.8, p , 0.05). Between groups: anxiety (Z ¼ 21.79, p , 0.05), hyperactivity (Z ¼ 21.7, p , 0.05), internalising problem behaviours scale (Z ¼ 21.7, p , 0.05) Increased differences between the groups on thought disorder and distractibility (Z ¼ 22.74, p , 0.01; Z ¼ 22.99, p , 0.01). On the EPS-SRI (self-report), there were no differences between the groups prior to intervention. At 12-months post-intervention there were differences in the predicted direction on thought disorder (Z ¼ 21.9, p , 0.05), impulse control (Z ¼ 21.9, p , 0.05), anxiety (Z ¼ 22.6, p , 0.01), and the total pathology composite scale (Z ¼ 22.0, p , 0.5).
Quinsey, V.L., Book, A. & Skilling, T.A. (2004)	Follow up cohort study (n = 58)	VRAG Problem Identification Checklist (Rice, Harris, Quinsey & Cyr) Dynamic antisociaility subscale of Proximal Risk Factor Scale	Medication compliance, poor compliance and dynamic antisociailty all significantly discriminated between men who displayed antisocial behavior and those who did not.
Taylor, J., Morrissey, C., Trout, S. & Bennett, C. (2012)	Treatment needs (pre-treatment) of a cohort of men with ID and PD admitted to TC treatment N = 13	IPDE screening version PCL-SV Young Schema Questionnaire Emotional Problem Scales PICTS CIRCLE	Participants typically scored above the threshold for a full IPDE on six PD scales. Borderline PD was the highest mean score, followed by paranoid and avoidant PD. Mean PCL-SV = 18.3 Prominent schema include mistrust/abuse, emotional deprivation, abandonment, self-sacrifice, emotional inhibition. High current and historical criminal thinking and fear of change (PICTS)
Williams, Wakeling & Webster (2007)	Pre/post treatment change for sex offenders with ID (n = 212)	Sex Offenders Self-Appraisal Scale Sex Offenders Opinion Test	Denial and minimization reduced post treatment with medium to large effect size (0.70)

	Treatment change examined using repeated measures analysis of variance (ANOVA). Two repeated measures ANOVAs were carried out for each measure using static risk and offence type in turn as the between-subjects factor, and pre- and post-treatment scores as the within-subjects factor	Adapted Victim Empathy Consequences Task. Adapted Relapse Prevention Interview Adapted Self-Esteem Questionnaire Adapted Emotional Loneliness Scale	Attitudinal change as measured by SOOS post treatment with medium effect size (0.61). Post treatment gains on victim empathy consequence task with large effect size (0.81) Significant improvements in self-esteem post treatment with small effect size (0.42) Significant post treatment change on RP with large effect size (1.34) SOSAS differentiated between risk levels pretreatment ($F(3,178 = 4.49, p < 0.01$) and post treatment ($F(3, 158) = 4.84, p < 0.01$) with higher risk offenders showing less denial PR discriminated between risk categories ($F(3,183 = 7.66, p < 0.001$) pre-treatment with differences disappearing post treatment. Higher risk offenders showed poor RP insight pre-treatment.

In addition, attitudes and beliefs are a key target for interventions based on cognitive behavioural principles and a number of programmes based on these principles have been shown to have positive results for offenders with ID (e.g., Novaco & Taylor 2004; Williams, Wakeling & Webster, 2007). Williams et al. (2007) reported significant post-treatment change in sex offence supportive attitudes as measured by the Sex Offenders Opinion Test (SOOT; Bray, 1997) with large effect size.

Taking a slightly different approach Langdon, Clare and Murphy (2011) suggested that moral reasoning is likely to be related to intellectual development. They further propose, based on the literature, that lower levels of intellectual functioning would be associated with the first stage of moral development described by Kolberg (1983) and would be likely to obey rules in a unilateral manner and show lower levels of criminality. Stage two of moral development, however, which is demonstrated by an egocentric view characterised by meeting the individuals own needs, is likely to be associated with intelligence in the borderline region. People with borderline levels of intellectual functioning would therefore be more likely than those with lower or higher levels of IQ to engage in criminal activity as a result of their moral development.

Taken together, these papers would seem to highlight a consensus within the academic literature that antisocial values represent a risk factor for offenders with intellectual disability. Although few studies include controlled comparison groups there is some indication that such a valued system holds predictive validity in relation to re-offending.

Criminal Peer Group

Five of the papers included in the review identified the role of criminal peers groups in offending and recidivism amongst offenders with ID. Broadly speaking, the nature of the criminal influences fell into two groups; familial influences and peer group influences. Family criminality was included as an item in a dynamic risk scale developed by McGrath, Livingston and Faulk (2007) for sex offenders with ID and the overall scale score was found to correlate with problem severity. Although analysis of the scale suggested that the item was not a significant or highly significant treatment need, the authors considered the subjective definition of criminality may have led to an under-rating of the items significance. Although this conclusion by McGrath et al. may seem to be a case of fitting the data to the theory is it plausible that defining peer group influences can raise some cautions for this population. Numerous authors (e.g., Holland, Clare & Mukhopadhyay, 2002; Camilleri & Quinsay, 2011; Boer, Frize, Pappas, Morrissey & Lindsay, 2010) have highlighted the potential suggestibility of offenders with ID and the role that such suggestibility may place in the development of criminal associations.

In relation to criminal peers, Lindsay et al. (2004) found a criminal lifestyle and negative social influences to be highly predictive of recidivism amongst ID offenders. Although not included in this review it is also pertinent to note that Boer et al. (2010) suggest that the increased suggestibility in this population may make them more vulnerable to the influence of a criminal peer group. Similarly, in a qualitative study of the accounts of offenders with ID Isherwood et al. (2007) note that the association with criminal peer groups may compensate for a more general sense of isolation for offenders with ID. Although only a small scale study (n=6), dual themes of *offending to fit in* and *offending with others* were apparent in all offence accounts.

As has been found in the mainstream offender literature, criminal peer groups and associations would therefore seem to be a relevant area of need for offenders with ID. Indeed, the potential role of suggestibility may increase the vulnerability of this population to the influence of associates with pro-criminal values suggesting that this would be an important area for intervention and consideration for successful rehabilitative programmes.

Denial or minimisation of responsibility

As with the mainstream offender literature, denial and minimisation of responsibility were a prominent target for treatment programmes for this population and featured in five papers.

Courtney, Rose and Mason (2006) used a grounded theory approach to analyse interview data from sex offenders with ID in an attempt to develop a model for sexual offending within this population. The model developed highlighted the importance of attitudes and beliefs at all stages of the offence process. Four particular types of denial and minimisation were apparent; blaming the victim, denial of offender status (by minimising their role in the offence or denying any recollection of the offence), claims of ignorance concerning relationships and the law and adopting a victim stance. Lindsay et al. (2004) found denial of crime was one of the dynamic factors that was most predictive of relapse in intellectually disabled sex offenders. Furthermore, Lindsay and colleagues (2007) found the QACSO differentiated between sex offenders with ID and non-offenders with ID and a key theme running through the items was concerned with responsibility. Williams et al. (2007) reported on the adapted sex offender treatment programme delivered to offenders with ID within the prison service. Using and adapted Sex Offenders' Self-Appraisal Scale (SOSAS: Bray, 1996) significant changes were found post-treatment with

medium to large effect sizes, suggesting that levels of denial of responsibility can be addressed as a component of treatment.

Similarly, in a description of a treatment programme for fire setters with ID, Taylor et al. (2002) targeted deviant cognitions in relations to responsibility as a central aspect of treatment, and significant improvements in responsibility was found post treatment as measured by the Fire Interest Rating Scale (Murphy & Clare, 1996) Fire Attitude Scale (Muckley, 1997) and the Fire Interest rating Scale (t=2.19, p 0,05, t = 2.5, p 0.05 respectively).

In a somewhat different approach to denial and minimisation, some studies have shown that staff team attitudes may also have an influence on how an individual offender rationalises his offending behaviour. Lindsay et al. (2004) found some evidence that staff attitudes which make allowances for offence related behaviour (the offenders behaviour being attributed to the intellectual abilities rather than to criminogenic attitudes) and in the development of the ARMIDILO, Boer et al. (2004) included items covering staff knowledge of sexual offending and staff awareness of individual risk factors for offenders with ID.

Notwithstanding current debates concerning the role of denial in the etiology of offending behavior, as with other items discussed so far it would seem that there is sufficient evidence to retain this item for offenders with ID. However, there is an interesting nuance in relation to the influence that the attitudes of staff may have. Two of the papers highlighted a theme of minimisation or denial of responsibility within staff teams and, although not included in this review, some authors have also highlighted the inaccuracy of staff team risk judgments (Green et al., 2003).

Misreads situations/others behaviour

Six papers identified in the review cited the tendency to misrepresent situations as a risk item for offenders with ID and PD. Basquill, Nezu, Nezu and Klein (2004) compared people with ID who were aggressive with a matched group who did not display aggression. They found that the aggressive sample were significantly more likely to misinterpret interpersonal situations ($f = 5.13$, $p = 0.029$) and significantly less likely to identify interpersonal intent accurately Furthermore, participants in the aggressive group were significantly more likely to generate aggressive responses ($t = 2.49$, $p = 0.017$).

In a controlled group comparison study investigating the benefits of cognitive-behavioural anger treatment, Taylor, Novaco, Gillmer, Robertson and Thorne (2005) found that situations interpreted as unfair/unjust, as measured by the Novaco Provocation Index (Novaco, 2003) produced rapid and intense reactions from participants in the study ($n = 36$).

A numbers of authors (e.g. Day, 1994; Craig, 2010) have suggested that sex offenders with ID may engage in *inappropriate sexual behaviour* as a result of deficits in socio-sexual knowledge or socio-sexual and legal knowledge, rather than as a consequence of offence related beliefs or deviancy. In the so-called "counterfeit deviance" model of sexual offending in this population, intellectually disabled sex offenders who produce a PPG profile that is not deviant are considered to offend against children and engage in coercive sexual practices due to deficits in social and sexual knowledge and limited opportunities, rather than on the basis of sexual preferences. It is therefore possible that some offenders with ID misrepresent situations or behaviour on the basis of lack of knowledge and/or experience rather than on the basis of cognitive interpretations. This lack of knowledge was cited by McGrath et al. (2007).

Nevertheless, the consequences for subsequent behaviour may remain the same and lack of such knowledge would therefore seem to be an appropriate treatment target.

Despite some suggestions that lack of knowledge may contribute to the misrepresentation of situations a number of other studies point to the role of cognitive processes in misreading rather than misunderstanding situations. The items included in the QACSO (Lindsay, Whitefield & Carson, 2007) were centered around three themes, one of which was concerned with attribution of responsibility. The QACSO has been found to have robust psychometric properties and discriminative validity and has been used as an outcome measure in a number of subsequent studies. Murphy et al. (2010) found significant changes on the QACSO following completion of an adapted sex offender treatment programme ($t = 8.39$, $p < 0.001$). Similarly, Keeling, Rose and Beech (2006) found significant post treatment change on the Abel and Becker Cognitive Distortions Scale, a number of items of which again scrutinize the attributions an offender makes in relation to victim behavior. Finally, the Taylor, Morrissey, Trout and Bennett paper (2012) identifies a range of prominent treatment needs in men with ID and PD. Notable areas of need in this population include mistrust/abuse schema as measured by the Young Schema Questionnaire – Short Version (Young & Brown, 2003) and high levels of characteristics associated with paranoid PD. Both paranoid PD and mistrust/abuse schema are associated with a pervasive suspiciousness towards others and a tendency to attribute malicious intent to others' actions.

With five papers identifying the misrepresentation of others actions as a treatment target and two papers highlighting post treatment improvements this would seem to be a viable area for intervention with this particular population of offenders.

Deviant sexual preferences and sexual preoccupation

As is the case within the mainstream forensic literature, sexual deviancy has been identified as a significant area of need within the intellectually disabled sex offender population, and was named in four papers. Craig (2010) suggested that the "counterfeit deviancy" argument proposed by some authors to explain sexual offending by people with an ID is neither sufficient nor adequate to explain sex offending in this population and suggested that the evidence to support it is limited. Blacker, Beech, Williams and Boer (2011) found a range of assessments tools that incorporate sexual deviancy to demonstrated good predictive validity for ID offenders. In a rare study using phallometric assessment of sexual interests in this population, Rice, Harris, Lang and Chaplin (2008) compared 69 sex offenders with ID with 69 sex offenders without ID. The ID sex offender group were found to exhibit more deviant preferences for pre-pubertal children, male children and young children than the comparison group.

The significance of deviant arousal is apparent in the range of treatment programmes that have been developed for sex offenders with ID. In a description of the treatment of intellectually disabled sex offenders in the National Offender Management Service, Williams and Mann (2010) highlight sexual interests as one of your primary treatment domains. Similarly, Lindsay (2009) incorporates sexual fantasy into a treatment protocol for ID sex offenders, while the role of masturbatory fantasy has been included in the treatment of men undertaking the SOTSEC-ID treatment programme (Sinclair, Booth & Murphy, 2002).

Although the treatability of deviant arousal remains highly questionable (Mann et al., 2010) and none of the studies identified in the review reported any significant changes in arousal the evidence as it stands suggests that it remains as area of need for offenders with ID and PD.

Relationship/Interpersonal skills

Poor conflict resolution

Four papers included in the review cited conflict resolution as an appropriate area for intervention for offenders with ID. Much of the research exploring anger and aggression in offenders with ID suggests that interpersonal conflict is a common antecedent factor for assaultative behavior and four of the papers satisfying the methodological criteria for the review highlighted this as an. area of need. For example, Taylor et al., (2005) reported on improvements in self-reported levels of anger in a group of men with ID and histories of aggression. A strength of this study was the inclusion of a control comparison group (waiting list), however, as is the case with much of the research in this area, measures of anger were not compared with those of people with ID who do not have aggressive histories.

Similarly, Lindsay et al. (2004) found that a verbally aggressive style, threats and property damage all achieved intermediate reliability when predicting institutional assaults with ID offenders in a field trial of the DRAMS.

Lindsay et al. (2004) found low levels of assertiveness to be a dynamic risk factor in sex offenders with ID which would suggest that those offenders who have the skills to assert their position in order to resolve conflict present a lowered degree of risk than those who are unable to manage such conflict. In a study of the predictive validity of the PCL-R, Morrissey et al. (2007) found the Emotional Problem Scales (Prout and Strohmer 1989) to be highly predictive of institutional aggression. The externalising sub-scale was particularly correlated with violence and includes items such as verbal aggression and non-compliance, both of which are suggestive of poor conflict resolution.

The ability to resolve conflict in a pro-social manner would therefore appear to be an appropriate component of treatment for offenders with ID.

Relationship instability

As was evidenced in the seminal work of Andrews and Bonta (1996), relationship stability was recurring factor in the review and featured in eight of the papers. In a series of studies Morrissey (2007) explored the reliability and validity of the PCL-R (Hare 2003) measure of psychopathy to forensic ID populations. Emerging from these studies was a set of comprehensive guidelines for the use of the PCL-R with ID offenders. These guidelines highlight the difficulty of assessing the PCL-R item *short-term marital relationships* due to the general lack of opportunity that people with ID have to engage in intimate relationships. However, where such relationships have been evident Morrissey recommends that the item be scored in line with the PCL-R guidelines. McGrath et al. (2007) also found intimate adult relationships to be a significant area of treatment need for sex offenders with ID. Similarly, Boer, Tough and Haaven (2004) identified relationship skills as a dynamic risk item in the ARMIDILLO assessment. Blacker et al. (2011) have subsequently found the acute scale of the ARMADILLO to be a significant predictor of relapse.

Support for a more liberal approach to the assessment of this factor, to included non-intimate social support systems, can be found in a number of articles. The quality and stability of family relationships have also been cited as potential sources of risk and need for offenders with ID. In an analysis of factors predictive of relapse in sex offenders with ID, Lindsay et al. (2004) found a poor maternal relationship to be one of the factors that correlated significantly with recidivism, although it is not clear whether this refers to current or historical relationships.

Furthermore, Jackson's (1994) *Only Viable Option* theory of pathological arson in offenders with ID postulates that a range of family difficulties contribute to elevated levels of risk, including high levels of family disruption, poor conflict resolution and emotional instability. A number of fire-setter treatment programmes developed from this model (e.g., Taylor et al., 2002) have demonstrated a positive impact of relapse for fire-setters, albeit with low sample sizes. However, Keely et al. (2009) did not find a significant association between fire-setting and unstable family relationships when analysing case notes of ten men with mild ID. On the other hand, Holland and Persson (2011) found family and social support to be a recurring area of need in a large sample of ID prisoners (n = 102).

Lindsay et al. (2004) compared sex offenders with ID with non-sexual ID offenders and found relationship problems to be significantly higher in the sex offender group. Similarly, in a controlled comparison between ID and non-ID sex offenders, Blacker et al. (2011) found the ID group to have significantly greater ratings in the psychosocial items of the SVR-20 (Boer et al. 1997). Relationship problems is one of the items included within the psychosocial domain of the SVR-20.

There would seem to be strong evidence therefore that instability in social support systems, including intimate and family relationships, is a recurring area of need for this population and would, again, be an important consideration for treatment delivery.

Hostile/mistrustful beliefs about others

Four papers included in the review identified hostility and suspiciousness as areas of need. In the Basquill et al. (2004) study referred to earlier the aggressive group were found to be significantly less likely to accurately identify non-hostile intent when responding to short video

vignettes. As has already been described, the study included a matched comparison group and results were subjected to a number of analyses. Similar findings were apparent in the Jahada, Pert, Squire and Trower paper (1998) in a matched comparison group design.

In an analysis of the first cohort of men transferred to a reside in a treatment culture based heavily on the principles of DTCs in the National High Secure Learning Disability Service Taylor, Morrissey, Trout and Bennett (2012) found scores on the paranoid personality disorder sub-scale of the IPDE screen to be second only to borderline PD scores. Furthermore, repeated administration of measures twelve months into treatment revealed significant changes in the paranoid sub-scale of the IPDE screening tool within the same population (Morrissey, Taylor & Bennett, 2012). Notably, significant changes were apparent on the paranoid personality sub-scale of the International Personality Disorder Screen and there was a strong, though not significant, trend towards reduction in seclusion hours. Whilst this study did not investigate the relationship between paranoia and violence, the Basquill (2004) study did report on increased aggressive responses from the group who made more hostile interpretations.

Whilst four papers included in the review identified hostility and suspiciousness as a relevant area for intervention the value of this as a standalone item is questionable. Two of the papers included in the review referred to the same cohort of men and arguably represent two components of a larger piece of research and therefore effectively reduce the number of papers identified in the review. Furthermore, the men included in these studies represent a fairly unique and highly complex group and the generalisability of the results are perhaps therefore questionable. Finally, hostile/mistrustful beliefs perhaps represent a particular illustration of the tendency to misrepresent the actions of others, an area already covered by the review. It is

therefore recommended that this item is not retained as a discrete area and is merged with the misrepresentation of others referred to previously.

Entitlement

Six papers made some reference to entitlement. As entitlement, and a concern for one's own needs, is a feature of a number of personality disorders and particularly the cluster B PDs that are associated with offending behaviour, it is pertinent to note that a number of studies have highlighted the prevalence of personality disorders in the forensic ID population. Lunksy et al. (2011) found an increased diagnosis of Personality Disorder in a cross sectional population of offenders with ID, while Taylor et al. (2012) found high levels of PD in a cohort of men with ID transferred to a developing Therapeutic Community in a high secure ID hospital setting.

A series of papers have described the profile of a large population of ID offenders resident in a range of differing secure services (Lindsay, Hogue, Taylor, Steptoe, Mooney, O'Brien, Johnston, & Smith 2008; Lindsay, Taylor, Hogue, Mooney, Steptoe, & Morrissey. 2010; Morrissey, Mooney, Hogue, Lindsay, & Taylor, 2007). These studies describe the relevance of a PD diagnosis to the forensic ID population, highlight the relationship between risk and PD and note the significance of a personality disorder diagnosis in relation to treatment responsivity. Using data from the same population, Hogue et al. (2006) found a significant relationship between a diagnosis of PD and risk as measured by the HCR-20, VRAG and RM2000.

The sense of entitlement and disregard for the needs and rights of others (that is a feature of both antisocial and narcissistic personality disorders) would suggest that this item remains

pertinent. However, it should be noted that the evidence currently is somewhat tenuous and inferential.

Interpersonal Manipulation

Five papers identified a manipulative interpersonal style as a relevant criminogenic need for offenders with ID. Morrissey's research into the use of the PCL-R for assessment of psychopathy in offenders with ID (2007) suggests that the conning/manipulative item remains a valid construct for this population. However, the guidelines developed from this research highlight a number of issues when assessing manipulation in offenders with ID.

In an evaluation of the clinical profile of a cohort or men admitted to a developing TC in Rampton hospital (Taylor et al,. 2012), positive impression management was found to be significantly higher than both standardised population scores and high secure hospital patient scores when measured using the EPS – SRI (Prout & Strohmer 1989). Morrissey et al. (2012) reported that after twelve months of treatment positive impression was found to be significantly reduced for the TC group ($Z = 2.2$, $p < 0.05$).

In a study investigating the predictive validity of a range of risk assessment tools, Blacker et al. (2011) found the SVR-20 psychosocial items to be a good predictor of violent recidivism in sex offenders with an IQ below 80 and a strong predictor of sexual recidivism in offenders with an IQ below 75. While the specific items in the psychosocial component of the SVR-2- were not differentiated in the study, psychopathy is included within the domain. It seems probable therefore that the traits associated with psychopathy, which includes a conning and manipulative inter-personal style, increase risk for the ID population. Further support for this proposal can be

found in the Lunsky et al. (2011) paper in which a comparison of offenders and non-offenders with ID found a diagnosis of PD was significantly more likely in the offender group.

Taken together these papers provide some evidence that a deceptive and manipulative interpersonal style is an appropriate treatment target for offenders with ID and PD and in the Morrissey at al (2012) paper there is evidence that when treatments specifically target such characteristics, positive gains can be achieved.

Self-management, coping & problem solving

Difficulties achieving pro-social goals

The ability to remain focused on pro-social goals, including relapse prevention strategies, was apparent in seven papers. In an evaluation of the DRAMS, Lindsay et al. (2004) found poor compliance with routine (which appears to include both day to day routine and a more long-term treatment pathway) to be one of the items most predictive of institutional violence. Boer, Tough and Haaven (2004) also include *time management and planning ability* as a stable dynamic risk item in the ARMADILO, which has subsequently been found to have good predictive validity with an AUC of 0.76 (95% confidence interval 0.61-0.91) (Blacker et al. 2010).

McGrath et al. (2007) found stage of change (based on Prochaska & DiClemente 1998) to be a significant treatment need for offenders with ID, which would suggest that those men who have difficulties retaining a focus on their long-term goals are more likely to relapse than those who are able to remain engaged in their treatment pathway. Similarly, non-compliance with treatment has been consistently found to be a significant predictor of both relapse and problematic institutional behaviour (Quinsey, Book and Skilling 2004). Furthermore, in a study exploring risk factors associated with recidivism in intellectually disabled sex offenders, Lindsay

et al. (2004) found erratic treatment attendance to be a significant predictor of re-offending while a further study by Lindsay and colleagues (2012) found treatment termination was correlated with recidivism. Clearly, erratic attendance implies some difficulties with an individual's ability to sustain a focused approach to long-term goals. In a follow up study of men with histories of antisocial behavior, Quinsey et al. (2004) found poor compliance to be one of three factors that discriminated between relapse and non-relapse when static risk was controlled for.

Alternatively, however, some offenders may demonstrate an ability to pursue goals but their goals have an antisocial component, either in terms of the outcome or in terms of the methods used to obtain an outcome. For example, Courtney et al. (2006) found that sex offenders with ID were able to identify clear goals from their offending (usually sexual satisfaction) but clearly used antisocial and harmful methods to satisfy their goals.

The ability to remain engaged in criminogenic treatments, educational and vocational programmes, alongside retaining relapse prevention strategies would therefore seem to be another particular strong area of need for ID offenders and would again be an important treatment consideration.

Poor problem solving

Six papers described problem solving as an area of need for offenders with ID. Lindsay et al. (2011) describe the development of a problem solving group for offenders with ID, based heavily on the "Stop and Think" programme, that aims to promote both problem recognition and problem solving. They report on the overall difficulties that offenders with ID experience with social problem solving and suggest that it is a primary area of need and risk for such individuals. Using a Pre/post treatment design with two groups (violent offenders n= 5, sex offenders n=5)

they found significant changes on the Social Problem Solving Inventory – Revised on three sub-scales at four months follow up. Positive problem orientation and impulsive/careless style were highly significant with F-values at the p, 0.01 significance level, while avoidant style was significant at the p, 0.05 level. Post hoc Bonferroni corrections found significant difference for positive problem orientation and impulsive/careless style between pre-treatment and follow-up administrations, while for the avoidant style sub-scale differences were significant between pre and post treatment administrations, but not between pre-treatment and follow-up. A later study by Lindsay et al. (2012) found poor problems solving in a range of areas was a feature of a forensic ID populations, while Boer at al (2004) describe the reduced use of coping strategies in the ARMIDILLO which was subsequently found to be a strong predictor of relapse (Blacker et al. 2011). Kelly et al. (2009) found a significant association between a perceived inability to effect change in personal circumstances and offending within a small sample of arsonists with ID, Taylor et al. (2002) also cited problem solving as a central treatment component for intellectually disabled arsonists and for offenders with ID who presented with violent behaviour (Taylor et al., 2005).

On the basis of an expert consensus and a literature review, McGrath et al. (2007) incorporated an item referred to as *application of risk knowledge* into a dynamic risk assessment for offenders with ID. The item refers to the ability of an individual to apply their knowledge of risk factors (including personal states and situational circumstances) in a manner that manages risk effectively. The tool, which contains 25 items in total, was found to have a significant relationship with levels of supervision/security deemed necessary on the basis of the seriousness of index offences. Furthermore, problem solving as a more general item was included within the same tool and was found to be a significant treatment need.

As with the focus in the mainstream offender literature, the development of effective and pro-social problem solving strategies would seem to be another important treatment consideration for this particular population.

Impulsivity

The significance of impulsivity in the general offender population is recognized by its inclusion in a number of recognized risk assessment tools (including the HCR-20, the PCL-R and the VRS). Similarly, impulsivity is considered by many to be associated with ID, and it is perhaps therefore unsurprising that it featured in seven papers.

In a comparison of impulsivity between sex offenders with ID, non-sexual offenders with ID and non-offenders with ID, Parry and Lindsay (2003) found higher levels of impulsivity among the non-sexual offender group, perhaps reflecting the ability of (some) sexual offenders to engage in delayed gratification in order to facilitate access to a suitable victim. Despite the lower levels of impulsivity in this study, Boer at al (2004) nevertheless includes impulsivity within the ARMIDILO assessment framework. In an investigation of the predictive validity of a range of assessments Blacker et al. (2011) compared sex offenders with and without ID. For the ID group stable dynamic factors, which included impulsivity, were found to be highly predictive of recidivism (AUC = 0.86). Similarly, McGrath et al. (2007) found impulsivity to be an area of significant treatment need for intellectually disabled sex offenders, and in a recent evaluation of a problem solving group for offenders with ID, Lindsay et al. (2011) found reduced levels of impulsivity following successful completion of the programme.

Despite these inconsistencies, impulsivity is one of the clinical items included within the HCR-20 (Webster et al. 1997) and retained as an item in adaptations to the HCR-20 (Boer et al.

2010). Finally, studies exploring the viability of the HCR-20 with ID offenders (Fitzgerald et al., 2011; Morrissey et al., 2007) have found the clinical scale to have good predictive validity (with an AUC of 0.68), suggesting a strong relationship between those items and reoffending. Furthermore, Morrissey et al. (2012) reported improved impulse control in comparison to a treatment as usual comparison group following 12 months of a TC intervention.

Although there seems to be some inconsistency in relation to the significance of impulsivity as a dynamic risk factor, it seems plausible that there may be difference across offence typologies, with some offences (e.g. child sexual abuse, armed robbery) requiring some degree of planning and self-regulation, while others (e.g., violent assault) may be more influenced by impulsivity. Indeed, Courtney et al. (2006) analysed offence accounts of intellectually disabled sex offenders and highlighted the differing strategies that were employed by the same individual across different offences. At times men were found to engage in considerable levels of planning and self-control in order to facilitate access to a victim, while at other times the men engaged in highly impulsive and opportunistic offending. As such, impulsivity would nevertheless seem to be a relevant area for treatment for offenders with ID.

Addictive behaviour

Six papers in the review identified substance misuse as a treatment need for offenders with ID. Winter, Holland and Collins (1997) compared a sample of individuals with ID both with and without involvement in forensic services and found that those with forensic involvement were more likely to have a history of illicit drug use. McGillivray and Moore (2001) compared the rate of self-reported alcohol and other drug use in a sample of adult offenders with mild intellectual disability with a matched comparison group of non-offenders, a finding replicated by

Lindsay et al. (2012). The results indicated that many individuals with mild intellectual disability regularly consumed alcohol and used illicit drugs. Furthermore, the data suggest a possible link between substance abuse and offending behaviour in this population. Individuals who had offended reported greater use of both legal and illicit drugs than their non-offending counterparts and many reported that they had been under the influence of alcohol or illicit drugs at the time of committing the offence. Similarly, in a comparison of the demographic characteristics of people with mild ID living in the community and those admitted into secure psychiatric accommodation, Doody, Thomson, Miller and Johnstone (2000) found those in secure accommodation to be more likely to have a substance misuse problem.

Fitzgerald et al. (2011) used drug and alcohol misuse as an indicator of a deviant lifestyle and found that offenders who were reconvicted were significantly more likely to have a history of drug and alcohol misuse. In a rare controlled comparison study in this population Winter et al. (1997) found a higher rate of abuse of non-prescription drugs among suspected offenders with ID than a broadly matched comparison group. Finally, substance misuse is an item in both the HCR-20 and the VRAG, both of which have been found to have good predictive validity in offenders with ID with AUC of 0.79 and 0.73 respectively (Gray, Fitzgerald, Taylor, MacColloch & Snowden 2007).

On the basis of these findings, substance misuse work would clearly form a central aspect of treatment for many offenders with ID.

Emotional management & Functioning

Emotional regulation

Eight of the papers retained in the review cited poor emotional regulation as a treatment need. Lindsay et al.'s (2004) research into the DRAMS found mood to be have significant predictive value in relation to institutional violence. Langton, Maxted and Murphy (2007) found Ward and Hudson's self-regulation theory (1998) of the offence process to be applicable to offenders with ID. The self-regulation model identifies avoidant goals as a primary motivation for some sex offenders and a recent study by Lindsay et al. (2008) supported Langton et al.'s (2007) findings, suggesting that some sex offenders with ID are likely to be motivated to offend in order to manage negative emotional states.

Emotional coping skills generally and fluctuations in emotional coping skills are both included as client related items in the ARMIDILO assessment. The acute factors of the assessment have been found to be good predictors of sexual recidivism in sex offenders with an IQ below 80, while the stable dynamic factors have been found to be a significant predictor of relapse in sex offenders with ID (Blacker et al., 2011).

The EPS internalising scale, which is an aggregate scale comprising anxiety, depression and self-esteem has been found to have significant predictive value in relation to institutional aggression (Morrissey et al. 2007, Lindsay et al. 2008). Given that the EPS is completed on the basis of an individual's presentation over a four week period it suggests that the composite sub-scales are important considerations of dynamic risk. Emotional management was also found to be one of eleven items that were considered to represent areas of considerable or very considerable need in sex offenders with ID (McGrath et al., 2007).

In a small scale study evaluating the effectiveness of Dialectic Behaviour Therapy with offenders with ID, Sakdalan, Shaw and Collier (2010) recorded significant changes on the Short Term Assessment of Risk and Treatability (START, Webster at al., 2004). The DBT programme incorporated a substantial piece of work covering distress tolerance and emotional regulation. Post treatment improvement would suggest that these areas benefitted from intervention as measured by the START. Finally, in a controlled study, Winter et al. (1997) found a recent significant life event differentiated between the experience of suspected offenders with ID and a matched comparison group. The life events described in the study are likely to have caused significant emotional distress and therefore imply that the emotional regulation skills of those who were suspected of offending were limited.

With eight papers identifying poor regulation of a range of emotions and the association between this dysregulation and problematic behavior would suggest this is another important area for treatment.

Volatile behaviour/anger regulation

Eight papers also highlighted the role of anger as a specific area of need. Taylor, Novaco, Gilmer and Thorne (2002) found that almost half the male population of a specialist forensic service for people with intellectual disabilities had been physically assaultive following admission, and anger, as assessed by patient self-report and by staff ratings, was found to be significantly related to patient history of aggression. Significant treatment effects were found for men who completed anger treatment, which included an emphasis on the acquisition of anger regulation skills. This would suggest that knowledge of, and ability to implement anger regulating strategies represents an area of criminogenic need for violent offenders with ID. In a

later study Taylor et al. (2005), using ANCOVA, reported lower levels of self-reported anger on a range of measures following treatment in comparison to a control group, suggesting that levels of anger and anger regulation strategies can benefit from direct treatment. Similarly, Lindsay's (2002, 2004) research into the DRAMS found mood, which includes an item on anger, to be have significant predictive value in relation to institutional violence.

In a description of group treatment for arsonists with ID, Taylor et al. (2002) also found high levels of anger, as measured by the Novaco Anger Scale (NAS; Novaco 1994). Post treatment evaluation revealed statistically significant reductions on the NAS total score. In a comparison of sexual and non-sexual offenders with ID, Lindsay et al. (2004) found problems with anger to be a significant difference between the two groups and a feature of the non-sex offender groups in over 50% of men referred to services.

Both the Taylor et al. (2012) paper and the Morrissey et al. (2012) paper report reduced rates of seclusion in a small group of offenders with ID and PD following inclusion in a specific treatment programme. The primary reason for seclusion in this setting is assaultative behavior which, although not always associated with anger, is often precipitated by increased anger arousal. A second Morrissey et al. (2007) paper found the EPS externalizing scale to be highly correlated with aggression towards both property and others.

Perhaps unsurprisingly, poor anger regulation was one of the most regularly cited treatment needs for offenders with ID and is clearly a primary area for intervention.

Rumination over perceived injustices

Four papers described rumination as a treatment area. In a pilot study into anger treatment for offenders with ID Taylor, Novaco, Gilmer and Thorne (2002) found group

members to have similar scores on the Provocation Index as has been found in non-ID offender populations. One of the sub-scales of this assessment evaluates a tendency for individuals to perceive a sense of unfairness/injustice. In a subsequent study, Taylor et al. (2005) the unfairness/injustice component of the Provocation index was significantly reduced following treatment. It is notable that the treatment protocol explicitly targeted attentional focus which is concerned with a pervasive preoccupation with anger arousing situations.

Although not concerned with offenders per se, Jahoda et al. (1998) compared the responses of people with ID with and without histories of aggression, on a sentence completion tasks designed to explore responses to stressful social situations. Participants with histories of aggression were found to produce a significantly greater proportion of aggressive responses (Mann Whitney, $p<0.01$). A follow up study that investigated the salience of stressful situations also found that the group with histories of aggression were significantly more likely to perceive that they were being treated in a derogatory manner and particularly in relation to their disability ($p<0.01$). Although not clearly linked to injustice, Taylor et al. (2002) noted that fire-setters with ID reported a preoccupation with fire and feelings of anger in relation to not being listened to as a precursor to their offending.

Ruminating over injustices therefore seems to be a precursor to offending behavior for some individuals and as such is a relevant area for intervention.

Perspective taking & empathy

Six papers reported on the role of empathy in offending for men with ID. A number of studies (e.g., Lindsay et al. 2010) point to the high prevalence of Anti-Social Personality Disorder in secure ID settings. Given that one of the central diagnostic criteria for antisocial PD

is concerned with remorse it would seem reasonable to suggest that a number of offenders with ID may be indifferent to the harm caused by their offending.

In a study investigating the discriminative properties of the QACSO, Lindsay et al. (2007) found that seven of the sub-scales discriminated between sex offenders with ID and other offenders with ID (with one standard deviation between the two groups means scores), leading the authors to suggest that the assessment provides a valid and reliable measure of the cognitive distortions held by intellectually disabled sex offenders. All items in the assessment were designed to measure one of three themes in relation to a range of sexual offences; intent, responsibility or victim awareness. The inclusion of victim awareness items, along with the discriminative properties of the tool, would suggest that sex offenders with ID have poorer levels of perspective-taking, empathy or remorse than their non sex offending peers and than non-offenders with ID.

Williams et al. (2007), reporting on a relatively large scale evaluation of treatment for sex offenders with ID found significant post treatment gains on victim empathy consequence task with large effect size (0.81), suggesting that empathy can be enhanced through treatment. The studies reported by Murphy et al. (2010) and Keeling et al. (2006) add further support to this finding. Similarly, in the Taylor et al. (2002) study into fire setting already discussed, significant improvements on victim interest ($t = 4.84$. $p < 0.001$) were found post treatment. However, Proctor and Beail (2007) found offenders with ID to perform better on second order theory of mind tasks than non-offenders with ID.

Discussion

This review set out to determine the general criminogenic needs of offenders with an intellectual disability and personality disorder that are described in the existing empirical and research literature, though few papers identified personality disorder in particular. Developing an awareness of such needs would seem to be critical if treatments are to be effective for this particular population. The review forms one component of a larger piece of work which aims to develop a valid and reliable framework for the assessment of such needs.

A computer based search of a range of databases produced a limited number of papers that matched the inclusion criteria and quality requirements. Furthermore, as noted in the methodology, papers referring to ID offenders but not referring to co-morbid PD were also included due to the under-diagnosis of PD inn this particular population. However, from contact with experts in the field and from reviewing references from papers obtained from the search, a number of additional papers were included in the review. Although this creates a potential bias in the sampling procedure it is a difficulty that has been highlighted in relation to systematic reviews in forensic ID previously. Lindsay (2002) noted a considerable lack of search returns when undertaking a review and suggested that many published articles may appear in low impact journals due to the highly specialist nature of the client population and as a consequence may not be included in databases.

This aside, thirty-two papers were included in the review and there would seem to be sufficient evidence to identify 17 items in total as relevant criminogenic needs for offenders with ID. Of these needs, two are perhaps particular to offenders with ID and PD (manipulation and entitlement) and one (sexual deviancy) is largely exclusive to sex offenders with ID.

Furthermore, two items, *misreading others* and *hostile/mistrustful beliefs* appear to be tapping into the same construct and a recommendation to merge the two items into one has been recommended. All items retained in the framework have been highlighted as relevant treatment factors in a minimum of four independent papers.

However, there are a number of important methodological considerations that raise some degree of caution with these findings. First, as described in the methodology, there were no RCT papers included in the review, and to the authors knowledge no such trial exist in the forensic ID literature. This immediately raises questions about the quality of the research that can be used to inform decisions about the treatment needs of offenders with ID.

Nevertheless, papers included in the review were required to meet a minimum level of methodological rigor and there are a number of practical impediments facing researchers working in forensic ID settings in relation to conducting RCT studies with sufficiently large sample populations.

Second, to supplement the volume of information retrieved from the computerised searches, additional literature was sourced from previous reviews. As these were hand selected, so to speak, the sampling process employed in the review is open to potential bias. To mediate against this possibility, papers identified in this way were subjected to the same inclusion criteria and assessment of methodological quality. Nevertheless, it remains pertinent to recognize a potential source of bias in the sampling procedure.

Table 3.6: Papers identifying evidence for criminogenic needs			
Pro-criminal values and beliefs		**Relationship/Interpersonal skills**	
Antisocial values & beliefs	Boer et al. (2004); Fitzgerald (2011); Keeling et al. (2006); Langdon et al. (2011); Langdon & Talbot (2006); Lindsay et al. (2004);Lindsay, Elliot & Astell (2004); Lindsay et al. (2007); Murphy et al. (2010); McGrath et al. (2007); Novaco & Taylor (2004); Quinsey, Book & Skilling (2004); Williams, Wakling & Webster (2007);	**Conflict resolution**	Lindsay et al. (2004, 2008); Morrissey et al. (2007); Taylor et al. (2005)
Criminal peer group	Boer at al (2010); Camilleri & Quinsey (2011); Holland et al. (2002); Isherwood et al. (2007); McGrath et al. (2007);	**Relationship instability**	Blacker et al. (2011); Holland & Persson (2011); Isherwood et al. (2007); Lindsay et al. (2004); McGrath et al. (2007); Morrissey et al. (2007); Taylor et al. (2002)
Denial/minimisation	Courtney et al. (2006); Lindsay et al. (2004); Lindsay et al. (2007); Taylor et al. (2002); Williams et al. (2007)	**Hostile/mistrustful**	Basquil et al. (2004); Jahoda et al. (1998); Morrissey et al. (2012); Taylor et al. (2012)
Misreads	Basquil et al. (2004); Jahoda et al. (1998); McGrath et al. (2007); Murphy et al. (2010); Taylor et al. (2005); Taylor et al. (2012)	**Entitlement**	Lindsay et al. (2007, 2008); Lunksy et al. (2011); Hogue et al. (2006); Morrissey et al. (2007); Taylor et al. (2012)
Deviant sexual preferences	Blacker et al. (2011); Rice et al. (2008);	**Manipulation**	Blacker et al. (2011); Lunsky et al. (2011); Morrissey et al. (2007); Morrissey et al. (2012); Taylor et al. (2012)
Self-management, coping & problem solving		**Emotional management & functioning**	
Pro-social goals	Blacker et al. (2010); Courtney et al. (2006); Lindsay et al. (2004a,b,); Lindsay et al. (2012); McGrath et al. (2007); Quinsey et al. (2004)	**Emotional regulation**	Blacker at al (2011); Lindsay et al. (2004); Lindsay et al. (2008); Langton et al. (2007); McGrath et al. (2007); Morrissey et al. (2007); Sakdala et al. (2010); Winter et al. (1997)
Problem solving	Kelly et al. (2006); Lindsay et al. (2011); Lindsay et al. (2012); McGrath et al. (2007); Taylor et al. (2002); Taylor et al. (2005)	**Volatile behaviour/anger**	Lindsay et al. (2002); Lindsay et al. (2004a,b); Morrissey et al. (2007); Morrissey et al. (2012); Taylor et al. (2002); Taylor et al. (2005); Taylor et al. (2012);
Impulsivity	Blacker et al. (2011); Courtney et al. (2006); Fitzgerald et al. (2011); Lindsay et al. (2011); Morrissey et al. (2007); Morrissey et al. (2012); Parry & Lindsay (2003)	**Rumination**	Jahoda et al. (1998); Taylor et al. (2002a, b); Taylor et al. (2005);
Addictive behaviour	Doody et al. (2000); Fitzgerald et al. (2011); Gray et al. (2007); Lindsay et al. (2012); McGillivray & Moore (2001); Winter et al. (1997)	**Perspective taking/empathy**	Keeling et al. (2006); Lindsay et al. (2010); Lindsay et al. (2007); Murphy et al. (2010); Williams et al. (2007).

Third, the majority of studies included in the review relied on comparison groups who were other groups of offenders. The reliance on outcomes measures is therefore somewhat dubious as, despite post treatment gains, it is difficult to claim that the variables being measured are peculiar to offenders. Indeed, as we saw with Proctor and Beail (2007), offenders with ID may have superior abilities than their non-offending peers, thus raising some questions about the usefulness of targeting certain psychological variables in treatment. For some confidence to be established in the relevance of treatment gains it seems important that the significance of the variables being measured in the offender groups can be compared with non-offender populations. Similarly, the majority of measures employed in studies have been taken from the mainstream forensic literature and comparable norms for the non-offender ID population are not available. The validity of these measures is also therefore questionable.

Fifth, there is clearly a vast array of outcome measures that are used across forensic ID service, which makes comparison of treatments problematic. Although there were some notable exceptions to this (for example, the QACSO has robust psychometric properties, norms from a range of populations and has been used across a number of ID sex offender programmes), treatment providers may benefit from identifying core outcome measures that identify criminogenic needs and use these consistently, within and across services. Certainly, the large scale studies included in this review benefitted from using the same assessments across a large sample population, with a consequential increase in effects sizes and statistical power. Within forensic ID services it is currently almost impossible to compare efficacy of different interventions due to the significant variations in the different treatments delivered (even when referred to as the same intervention, for example

SOTP), and the wide variety of measures used, many of which also have questionable psychometric properties.

Additionally, and linked to the issues described above, a number of studies adapted outcome measures utilised within the mainstream offender population. Whilst adaptations were likely to have been designed to increase the accessibility of the particular measures being used, no studies reported on the psychometric properties of the adapted measures. Clearly, the adaptation of measures raises the possibility that the adapted tool is no longer measuring the same construct as the original measure.

Finally, In addition, it seems important that treatments for offenders with ID are designed to address criminogenic needs. The importance of developing correctional programmes that address criminogenic needs and risks has been widely documented in the Risk-Need-Responsivity literature and the relationship between programmes that adhere to these principles and recidivism is similarly well documented. From an ethical perspective, it would seem imperative that the criminogenic needs of offenders with ID form the basis of treatment programmes. Treatment providers have currently based practice on evidence drawn from the mainstream literature, but for these needs to be considered criminogenic the predictive validity of each particular risk item will need to be established and this would be a suitable area for future research.

- CHAPTER FOUR -

Testing the Reliability of the Treatment Need Matrix

Abstract

The Treatment Need matrix provides a framework for clinicians to identify the criminogenic needs of offenders with Intellectual Disability and Personality Disorder. The reliability of any assessment framework is a key concern for practitioners and provides some degree of confidence for practitioners. This paper presents three preliminary studies that aim to assess the reliability of the Treatment Need Matrix. Study 1 examined the inter-rater reliability of the Treatment Need Matrix with four "expert" practitioners and developed gold standard scores for two case studies that were used in the subsequent studies. Study two then examined the inter-rater reliability of a sample of practitioners (n = 66) working across four residential forensic intellectual disability services. The third study describes an investigation into the intra-rater reliability of the tool using a smaller sample of the same staff members (n = 18) from across the same four sites. Results suggest that overall the TNM possesses moderate to good inter-rater reliability, although some items were notable for their poor reliability. With appropriate training, however, the TNM may prove a useful tool for the identification of criminogenic needs in offenders with ID and PD.

Introduction

People with personality disorders (PD) and forensic needs have often experienced difficult, neglectful or abusive relationships with parental and authority figures (McCann, Bail & Ivanoff, 2000). The traits that may develop from these experiences, including mistrust, hostility and inter-personal manipulation may be re-enacted and exacerbated within custodial settings (Jones 1997, 2004; Shuker, 2010). Disorders of attachment are prevalent (Ward, Hudson, & McCormack , 1997; Gross & Hanson, 2000; Frodi, 2001; Beech & Mitchell, 2009), levels of self-efficacy and self-esteem can be poor (Bateman & Fonagy, 2000) and there is increasing evidence that many individuals with a personality disorder and offending behaviour experience high levels of shame (Hanson, 1997; Bumby, 2000).The high prevalence of offending amongst people with PD (Samuels, et al., 2004; Howard, Huband, Duggan & Mannion, 2008), and particularly those with Cluster B personality disorder (Coid, Yang, Tyrer, Roberts, & Ullrich 2006), would suggest that the characteristics of PD are particularly criminogenic, and are therefore important areas for treatment intervention if this population are to be supported to reduce their risk and re-integrate into society. Indeed, in a recent review of psychological treatments for offenders with PD Duggan (2007) and Duggan, Huband, Smailagic, Ferriter and Adams (2008) recommend that offending behaviour programmes may benefit offenders if they specifically address those needs arising from the personality disorder. This would seem to imply that the psychological variables underpinning offending behaviour are central targets for criminogenic intervention programmes.

Similarly, there is considerable evidence that people with a learning disability may face an increased risk of psychological difficulties throughout their lifetime.

Smiley (2005) estimated that the total prevalence of mental health problems in adults with learning disability is higher than in the general population, with a rate that lies somewhere between 30% and 50%. A number of studies have indicated an increased rate of conduct disorder in children with a learning disability (Emerson, 2003; Moffit, Arseneault & Jaffee, 2008) and a higher probability of a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) when compared with children who do not have a learning disability (Hastings, Beck, Daley & Hill 2005). It is poignant to note that the combination of ADHD with conduct disorder is a predictive factor for an adult diagnosis of psychopathy (Soderstrom, Sjodin & Forsman, 2004; Johanssen, Kerr & Andershed, 2005), which is similarly predictive of offending behaviour and violence (although the predictive capacity of the PCL-R as a diagnostic tool is less clear in the learning disabled population; Morrissey, Mooney, Hogue, Lindsay & Taylor 2007a). Similarly, there is some evidence of a relationship between childhood intelligence and adult hospitalisation with PD (Moran, Klinteberg, Batty& Vagero 2009). Furthermore, people with a learning disability are more likely to experience various forms of abuse than their non-disabled peers (Turk & Brown, 1993), and may be less resilient to such abuse. Traumatic experiences are manifest in a similar manner to the non-disabled population (Brown & Beail, 2009), which may therefore include the development of a personality disorder and the re-enactment of abusive experiences.

The significance of PD within the forensic ID population has recently received increased attention in the academic literature (Morrissey 2003; Morrissey et al., 2005; Alexander, Crouch, Halstead & Pichaud 2006; Morrissey & Hollin, 2011). Lindsay et al. (2006) examined the prevalence rate of personality disorder in a number of forensic ID settings. Drawing on a range of assessment methodologies

they found an average prevalence rate of 39.5 %, rising to 57% in a high secure setting, a rate which is comparable to those found in high secure patients without ID (Blackburn, Logan, Donnelley & Renwick 2003). Anti-social personality disorder was the most frequent diagnosis, though interestingly a formal diagnosis was only recorded in clinical files in almost 23% of cases, suggesting significant under diagnosis.

In a further study, Hogue et al. (2006) examined the relationship between risk and personality disorder in a population of intellectually disabled offenders. Using a range of risk assessments (including the HCR-20, VRAG and RM 2000), those men with a diagnosis of PD were consistently found to present greater levels of risk. As may be expected, increasing levels of psychopathic traits were also associated with increased levels of risk, while those men who satisfied the criteria for DSPD presented the greatest risk for both sexual and violent offences. Using the same study's data, it was also found that those with ID and personality disorder presented with significantly more externalising and internalising problems than those without (using ratings independent from the PD ratings), further validating the diagnosis in a forensic ID population (Johnston &Morrissey 2010).

Although a number of debates remain, there would seem to be sufficient evidence to suggest that personality disorder is as relevant to those with ID as it is to those without. Indeed, Reid, Lindsay, Law and Sturmey (2004) suggest that knowledge of personality disorder is as important when working with people with ID as it is with any other population.

The prevalence of those with PD within the offender population would seem to suggest that the psychological needs of those with PD may be particularly relevant to the assessment of forensic risk. The central significance of attending to both the

presence and severity of risk factors has received widespread acknowledgement since the seminal work of Andrews and Bonta (1996). Broadly, risk has tended to be conceptualised as comprising two components during recent times; static factors and dynamic factors (Hanson & Harris, 2000). Static factors are those aspects of an individual's history that have an empirical relationship to recidivism. Dynamic factors, on the other hand are considered to represent psychological variables that fluctuate under differing conditions and are therefore amendable to treatment. Hanson and Harris further distinguish between stable dynamic factors and acute factors. Stable factors are enduring characteristics or difficulties that an individual experiences (such as personality disorder, drug use), while acute factors represent a more temporal state that significantly impacts on the likelihood of re-offending and may include intoxication, proximity to a victim, emotional dysregulation etc.

Although the conceptualisation of risk factors proposed by Hanson and Harris (2000) has been largely adopted by practitioners, alternative proposals have emerged more recently within the academic literature. Rather than separating stable and acute factors, Beech and Ward (2004), and Ward and Beech (2004; 2006), suggest they are both aspects of a similar underlying construct and thus for each underlying stable factor (or trait) there is an acute, state factor that responds to triggering contexts. Furthermore, they anchor dynamic factors, both acute and stable, with static items by suggesting that static risk factors have predictive significance because they act as markers of the past operation of dynamic risk factor. Thus, a history of offending against children can be an indicator of a dynamic factor such as deviant sexual interests, which in turn may be mediated by contextual factors including proximity to victims or sexual preoccupation.

Taking this relationship further, Mann, Hanson and Thornton (2010) raise a number of significant concerns with Ward and Beech's proposal. For instance, Mann et al. highlight the difficulty the model has in explaining the degree of influence an individual's context may have on the activation of acute dynamic risk. Citing evidence that there is a relationship between victim access and relapse in sex offenders (Hanson, Harris, Scott & Helmus 2007), Mann et al. also note that the Ward and Beech model is not able to differentiate between the role an offender may play in the mediation of risk and illustrate this point with reference to offenders who actively seek out victims as opposed to those who encounter a potential victim by chance.

To address this issue, Mann et al. (2010) propose a different relationship between static or stable dynamic factors and acute dynamic risk. Using the phrase *psychologically meaningful risk factors*, they propose that risk factors can be viewed as individual propensities that may or may not be present at any particular time. Similar to the concept of traits, the authors propose that these propensities give rise to similarities in thoughts, feelings and actions and are evident in an individual's interactions with others and with their environment. Furthermore, offenders can affect the nature of their risk of recidivism as a consequence of these consistencies. For example, the tendency of an offender to gravitate towards high risk situations may be a "conceptually better" indicator of risk than the high risk scenario itself. Mann et al. (2010) refer to the term propensities to highlight that offending behaviour results from an interaction with the environment and that meaningful risk factors may not be active all of the time. As they state, "Aggressive offenders are not aggressive all the time—they become aggressive given certain interpretations of their environment" (p 195).

The assessment and identification of those factors that contribute to the likelihood of recidivism has developed considerably over the last twenty years. While early risk assessments relied on the prediction of probabilities depending on the aggregation of static, historical factors from an offender's background, contemporary assessments seek to establish the presence and the significance of more dynamic changeable psychological variables.

A number of risk assessments have subsequently been developed in order to assist in the identification of criminogenic needs. The HCR-20 (Webster et al., 1997), RSVP (Hart et al., 2003,) and VRAG (Quinsey et al., 1998,) are all examples of frameworks that guide clinical judgement and support the assessment of risk, the identification of criminogenic needs and the formulation of treatment. The PCL-R (Hare, 2003), although largely considered to be a static assessment has also been used to guide the direction of treatment (Thornton, 2011) and again uses a methodology that supports clinicians to consider the salience of various psychological and behavioural variables.

However, these assessments continue to rely on the separation of static and dynamic features and offer little consideration of the role of long term psychological vulnerabilities and their role in mediating the level of risk posed by an offender. Although perhaps not originally designed with the notion of psychological meaningful risk in mind, the Structured Risk Assessment (SRA; Thornton, 2002) is a particularly good example of a framework that supports clinicians to determine relevant treatment needs in terms of long term propensities and more acute factors that influence the progression of an offence repertoire. The SRA, a framework designed specifically for sexual offenders, anchors risk using a static actuarial scale (The Risk Matrix; Thornton et al. 2003) and then determines the salience of a range

of psychological factors in relation to an offenders general lifestyle functioning and their offending behaviour. The SRA thus offers a mechanism for understanding the functioning of a range of long term propensities and the interaction of these propensities with offending contexts. The items included in the SRA have also been derived from the empirical research and therefore have evidence linking them to sexually abusive conduct.

The Treatment Need matrix

The Treatment Need Matrix (TNM) was developed to support practitioners working in ID services to identify criminogenic needs that are relevant for this particular population (Taylor, in press). The framework was evolved from the criminogenic needs that are central to the evaluation of progress in Prison Service Therapeutic Communities (TC). This particular framework for the identification of risks and needs was chosen pragmatically; i.e Therapeutic communities provide an offending behaviour intervention for offenders with range of offence typologies and therefore do not limit needs to one specific type of offender.

As with the SRA, items considered to be areas of criminogenic need are clustered into four domains; values and beliefs, inter-personal relating, emotional management and self-control/problem solving. The risk factors, or criminogenic needs identified within the Prison Service TC manuals do, however, suffer from a number of shortcomings. First, the items, although appearing to have face validity, have not been established from the empirical literature and the relevance of each item is therefore difficult to ascertain in terms of its relationships to risk. Second, the items are not defined and therefore rely on the interpretation of practitioners, allowing potential variance between different assessors. Finally, although a graded

scoring system is used, the differential between the grades is similarly unspecified, again allowing for considerable subjectivity. Although the identification of items to guide an assessment of treatment needs and risk, the matrix used within TCs remains essentially unstructured and therefore open to the criticism levelled towards risk appraisals based on such judgements alone. The inability of clinicians to distinguish between high and low risk offenders has been widely reported in the literature (e.g., Rice & Harris, 1995) and the predictive accuracy of the typical clinical judgement is only slightly above chance levels (Hanson & Bussière, 1998). The lack of structure provided to support clinical staff when using this framework therefore has the potential to seriously undermine the determination of valid and reliable judgements.

Development of the TNM

In order to address these concerns a number of steps were taken to develop a suitable framework for offenders with ID and PD and therefore increase the validity and reliability of the TNM. In the first instance a systematic literature review was undertaken in order to identify criminogenic needs cited in the forensic ID literature (Taylor & Dixon, unpublished). Although the systematic review identified a number of concerns with the current research base within such services, the items identified could be considered the current best fit for offenders with ID (see Table 4.1). Each item contained within the matrix had support from a minimum of four independently conducted studies which cited post treatment improvements in that particular area of need. Following this the literature was again reviewed in order to establish suitable definitions for each item and a clear scoring system, based on that used in the SRA, was then applied. As a further step, training in the first version of the TNM was provided to a group of colleagues of the first author. Although the training was

intended to provide those attending with the knowledge and skills to complete the TNM, feedback was also taken in order to review the clarity of the definitions. Finally, the evidence base, scoring procedure and definitions of items have been manualised to support users of the tool (Taylor, in press).

Table 4.1: Treatment Need Matrix Domains and Items

Domain	**Criminogenic Need**
Values and beliefs	Antisocial values Criminal peer groups Denial and minimisation Mis-reads others/situations Sexual deviancy
Relationship skills	Conflict resolution Relationship instability Entitlement Impression management/manipulation
Emotional management	Emotional regulation Anger control Rumination Perspective taking
Self-control and problem solving	Goal focus Problem solving Impulsivity Addictive behaviour

Information gathered in the TNM is drawn from a range of sources, including performance in formal therapeutic activity, residential behaviour, historical and file information and from the administration of a range of psychometric assessments.

Four particular psychometric assessments are used to support the clinical judgement process (see Appendix 5); The Psychological Inventory of Criminal Thinking Styles (Walters, 1994), The Person's Relating to Others Questionnaire (PROQ3, Birchnell 2003), the Blame Attribution Inventory (Gudjohnsson, 1984) and the Emotional Problem Scales (Prout & Strohmer 1989).

The Psychological Inventory of Criminal Thinking Styles (PICTS) is an 80-item self-report measure designed to assess crime-supporting cognitive patterns (Walters, 2006). Meta-analyses of studies in which the PICTS has been administered reveal that besides correlating with measures of past criminality, several of the PICTS thinking and content scales are capable of predicting future adjustment/release outcome at a low but statistically significant level, and two scales are sensitive to programme-assisted change beyond what control subjects achieve spontaneously. The language content of the PICTS has been adapted to make it more accessible for offenders with ID and is administered as a structured interview in order to compensate for literacy difficulties (PICTS-ID, Taylor 2012).

The Emotional Problem Scales were specifically designed to assess and identify maladaptive behaviours and emotional problems among adolescents and adults with mild intellectual disabilities. The scales were constructed for use with individuals 14 years of age or older who have IQ scores in the range of 55 to 83. The EPS contains two scales; the Behaviour Rating Scales (BRS) and the Self Report Inventory (SRI). The BRS is a 135 item assessment that asks a rater to identify how often an individual displays a range of behaviours. Item scores yield a range of clinical scales, many of which are combined to derive an externalising behaviour scale and an internalising scale. The EPS has been shown to be highly predictive of disruptive institutional conduct in offenders with ID and PD (Lindsay et al., 2007).

The Person's Relating to Others Questionnaire (PROQ3, Birchell & Shine, 2000) was designed to measure negative relating as organised around a theoretical structure called the interpersonal octagon. Each questionnaire has an upper, lower, close and distant scale and four intermediate scales (e.g., upper close). Moderately high positive correlations were observed between primary scales (upper, lower, close and distant) and neighbouring intermediate scales. Correlations diminished with increasing separation around the octagon. The psychometric properties of the PROQ3 were examined within four national samples. Alpha coefficients were consistently acceptable across samples. Gender differences varied between samples. Concurrent validity was also established using a number of comparison measures.. The PROQ3 has been used extensively to measure change in interpersonal relating in offenders with PD (Birchnell et al. 2000), has been used extensively in prison TC sites and has been identified as a core measure for the recently opened TCs for prisoners with ID. As with other assessments used within these treatment sites the language content of the measure has been adapted for people with ID to increase accessibility for offenders with ID (Taylor, 2012).

The Blame Attribution Inventory (BAI: Gudjonsson, 1984) is a 42 item questionnaire designed to identify offender's attribution of blame for their offences. Factor analysis of the Gudjonsson Blame Attribution Inventory revealed three independent factors; *external attribution* (i.e. blaming the crime on social circumstances, victims or society), *mental element attribution* (i.e. blaming responsibility for the crime on mental illness or poor self-control), and *guilt feeling attribution* (i.e. feelings of regret and remorse concerning the offence). External attribution of blame was found to be positively correlated with psychoticism, hostility, and external locus of control. Guilt feeling attribution correlated with

neuroticism and introversion, but negatively with psychoticism suggesting concurrent validity. The BAI has also been adapted, with the permission of the author for offenders with ID (Taylor 2012)

The reliability of the Treatment Need Matrix

While the structure and procedural guidelines for the TNM are in accordance with best practice guidelines (British Psychological Society, 2007) and is fairly typical of structured clinical judgement, the reliability of the tool is clearly an essential requirement if it is to be used with any confidence. In particular, the inter-rater reliability and test-re-test reliability will need to be established.

Inter-rater reliability

A crucial consideration for any assessment framework is that it guides the user towards a judgement in a manner that is consistent across different users of the instrument. Inter-rater reliability (IRR) tends to be reported within the literature in one of three ways; percentage agreement, Cohen's Kappa (Cohen, 1960) or intra-class correlation coefficient (ICC; Shrout & Fleiss, 1979). In a review of the different methods employed for calculating IRR, Hallgren (2012) notes that percentage agreements, although widely used, are an inadequate measure of IRR as they fail to correct for agreements that would be expected by chance and therefore over estimate the level of agreement between raters. Kappa statistics, however, correct for chance agreements and can be used for categorical or nominal variables. Kappa values can range from +1 to -1, where +1 represents perfect agreement, 0 indicating random agreement and -1 representing perfect disagreement. Guidelines have been provided for interpreting kappa values (Landis & Koch, 1977) with values

from 0.0 to 0.2 showing slight agreement, 0.21 – 0.4 fair agreement, 0.41 – 0.6 moderate agreement, 0.61 – 0.8 substantial agreement and 0.81 – 1.0 showing almost perfect agreement.

Kappa statistics, however, are designed to measure IRR between two raters and typically consider exact agreement (although weighted kappa variations are available for measuring degrees of agreement). In relation to this particular study the design included multiple raters assigning scores on the TNM across two case studies, thus rendering kappa an inappropriate statistic. However, the generation of standard score for each case study allows for each rater to be compared to the standardised scores using kappa, as will be discussed later.

The intra-class correlation, however, is suitable for studies using multiple raters when all raters rate the same sample of subjects. Furthermore, ICC computes the magnitude of agreement between raters rather than exact agreement, a more suitable approach where rating scales have differential scoring options, as is the case in the TNM. A further advantage of the ICC computation is that it identifies the reliability of the ratings based on averages of ratings provided by several raters and single measures based on a single rater. As will be discussed later, the difference between these values has significance for the methodology of the TNM.

Test-retest reliability

Intra-rater reliability, or test-retest reliability is a similarly important consideration for procedures designed to determine the relative presence or absence of particular constructs. Test-retest reliability measures the consistency with which individual raters assess the presence of factors in the same subjects over different time intervals. Test-retest reliability is measured by correlating the scores from

subjects who have taken a test on two occasions. As with kappa values, scores range from +1 to -1 as agreement moves from perfect agreement to complete disagreement. As the TNM is designed to identify criminogenic needs in offenders with ID and PD, and to track changes in the salience of these needs over time, the test-retest reliability is a crucial component to enable clinicians to have confidence that changes noted with the framework are due to actual change in offenders rather than due to measurement error.

The aim of this study is to examine the reliability of the TNM. Three distinct research questions are addressed within the remainder of this thesis. Study one seeks to establish the inter-rater agreement of a small group of experienced practitioners and establish "gold standard" scores for cases rated in the subsequent studies. Study two explores the inter-rater agreement across a larger sample of staff members working across a number of forensic ID services. Three separate aspects of inter-rater agreement are examined. Kappa values are calculated to determine the overall agreement of participants with the expert scores derived from study one. As significant variation was found amongst the study participant's kappa values were also calculated to allow a comparison of different professional groups with the expert consensus for each case study. Finally, overall agreement between raters across each of the items is analysed using the same ICC process cited above.

Finally, study three examines the test-retest reliability of the TNM using a smaller sample of staff who participated in study two.

Methodology

Study One

Participants

Expert practitioners were considered to be professionals with a minimum of three years experience working with offenders with ID and PD. In addition to this experience, experts were also required to have experience and formal training in the use of structured clinical judgement tools for this particular population. All four raters were forensic psychologists working within forensic mental health and prisons settings within the U.K. who had received additional training in both the SRA and the PCL-R. Experts were aged between 30 and 45 and had a minimum of five years experience in the assessment and treatment of offenders. Raters were asked to score two case studies using the TNM. All scoring was completed independently with no dialogue taking place between the raters during the scoring process.

Materials

Each rater was provided with a copy of two case studies (see Appendix two), a recording form to gather evidence for the items in the TNM and a manual describing the item definitions and the scoring procedures for each item (see Appendix one).

Case studies included information covering the offender's background (family history and education), forensic history and institutional behaviour. Information from a range of psychometric assessments was also included along with explanations of each assessment used (see Appendix three).

Briefly, the first case (M) was a 32 year old man serving a life sentence for murder with a minimum tariff of 18 years. He remained a cat A prisoner for the first

six years of his sentence due to persistent assaults on staff and other prisoners. He has numerous adjudications dating back to this time and also spent long periods of time in segregation units. He had three adjudications for brewing hooch during the first two years of his sentence but has had none since. Mr M has a number of juvenile convictions for criminal damage and theft. He received a custodial sentence at the age of sixteen for assault. Mr M was reported to have hit a friend over the head with a wooden object and kicked him a number of times in the face and upper body. Mr M received a second custodial sentence for burglary and criminal damage in 2005. Mr M broke into the house of a former girlfriend and stole a number of electrical items. Considerable damage was caused to the house during the break-in including graffiti aimed at his former girlfriend sprayed on the outside of the house. He received a life sentence for murdering his partner, claiming that she had become pregnant deliberately to trap him.

The second case (K) concerned a 26 year old man serving an IPP sentence with a five year tariff for wounding with intent. His index offence took place in a city centre after he had spent a night out with some friends. They had become involved in an altercation with another group of men in a night club and had eventually been removed from the club by the bouncers. Mr. K reported feeling a strong sense of grievance following this and has suggested that the other group of men had triggered the incident by knocking a drink out of Mr K's hand while he was stood at the bar. He told one interviewer that he had a reputation to uphold and couldn't let others think that someone had got the better of him. After trying to convince his friends to return to the club with him Mr K says that he decided that he would "show them who's boss". He smashed a local hardware shop window and stole a hammer and screw driver. Mr K reported having waited for approximately 45

minutes until he saw a group of three men leave the club and recognized one of them as the person who he said had "shown me disrespect". He said he followed them down the street for a while until they were away from the more populated areas and then approached the group from behind and struck one of the men over the head with the hammer, before stabbing a second man with a screw driver. Mr K had strong family relationships and was committed to engaging in work to reduce his risk so that he could return to his wife and children.

Procedure

Raters were asked to complete the scoring of one case study at a time. Scoring of items was based on a three-point Likert scale, with values ranging from not characteristic (0), partially characteristic (1) and strongly characteristic (2). Each item was rated in terms of the relevance to the offenders general lifestyle functioning and in terms of the relevance to the offence chain. With 17 items there were thus a total of 34 ratings for each case study. All raters completed scoring individually and without discussion.

Study Two

Participants

Staff members attending the training (n= 62) were selected by the host sites and the training was available to all staff working within the specific services. The staff attending the training came from a range of backgrounds, including psychologists (12%), nurses (20%), prison officers (23%), nursing assistants (39%) and other professions (psychiatry, psychotherapy and occupational therapy, 6%) and had a range of experience working in forensic ID services (from six months to twenty years).

Materials

As with the previous study, each rater was provided with a copy of each case study, a recording form to gather evidence for the items in the TNM and a manual describing the item definitions and the scoring procedures for each item.

Procedure

Training in the use of the TNM was provided by the first authors across four intellectual disability forensic services. Two services were located within the Prison Service and two services were located within the Health Sector. Scoring was preceded by a brief presentation over viewing different types of risk assessment, the development of the TNM, item definitions and the scoring procedure were also covered in the presentation.

Raters were then asked to complete the scoring of one case study at a time. All raters completed scoring individually and without discussion. After completion of the first case study delegates provided group feedback and some discussion was encouraged to explore differences in scoring practices and allow feedback to delegates about their scores. Completed forms were not, however, altered. Rather, the purpose here was to provide training to course participants and direct attention to specific nuances of the scoring practices. Following discussion the second case study was provided and scoring was undertaken in the same manner. The presentation of cases was randomised across the training events (nine in total).

Data analysis

Study two represents the primary investigation into the inter-rater reliability of the TNM and a number of statistical investigations have therefore been

undertaken. Individual ratings were compared with the G score using kappa values, differences between professional groups were investigated and ICC values were again calculated for each item across all raters.

Cohen's Kappa (Cohen, 1960) examines the degree of agreement between two raters while correcting for chance agreement. Kappa can only be applied to two raters and was therefore employed to compare individual raters with the G standard scores. Average Kappa scores were then calculated in order to compare average ratings of differing professional groups with the g score. Item scores were included in the analysis, though not the total TNM score or domain totals. The rationale for this decision was based on the assumption that individual items are particularly pertinent due to the conceptualisation of risk discussed earlier and at this stage of the development of the tool little can be drawn from the domain or total scores.

Data for the ICC was analysed using a two-way mixed effects model on the basis that the raters were drawn from a pool of experienced forensic psychologists and the case studies were developed from experiences of working with a large sample of offenders. As the scoring procedure for the TNM ustilises a three-point likert-type scale a consistency measure was used.

Study Three

Participants

All participants who attended a one day workshop outlining the use of the TNM were asked if they would volunteer to score one of the case studies for a second time. Delegates at the workshops had provided contact details which were used to contact volunteers. A random sample of workshop delegates were contacted

(n=25) and TNMs were completed by 72% (n = 18) of those contacted on one case study.

Method

Participants were contacted between four and twelve weeks after completing their initial training in the use of the TNM. As with the initial training, participants were asked to score the case study in isolation from other raters and were not given access to their previous scores.

Participants were asked to complete the scoring within two weeks and return the form either electronically or on paper to the first author. Participants were asked to include their name on the form to allow direct comparison with their previously completed TNM.

Materials

As with the previous study, each rater was provided with a copy of one of the case studies from the previous study, a recording form to gather evidence for the items in the TNM and a manual describing the item definitions and the scoring procedures for each item.

Results

Study One

Table 4.2 presents the intra-class correlation coefficients for expert raters across the two cases.

Table 4.2: Expert ICC agreement

Item	Intraclass correlation		95% Confidence Interval	
	Single measure	Average measure	Single measure	Average measure
Antisocial attitudes (general)				

Antisocial attitudes (offence)	1.000	1.000	1.000 – 1.000	1.000 – 1.000
Criminal peer group (general)	1.000	1.000	1.000 – 1.000	1.000 – 1.000
Criminal peer group (offence)	1.000	1.000	1.000 – 1.000	1.000 – 1.000
Denial/minimisation (general)	.333	.667	- .261 - .998	- 4.814 – 1.000
Denial/minimisation (offence)	.000	.000	- .308 - .995	- 16.443 - .999
Misreads situations (general)				
Misreads situations (offence)				
Poor conflict resolution (general)				
Poor conflict resolution (offence)	.000	.000	- .308 - .995	- 16.443 - .999
Relationship instability (general)	.867	.963	.120 – 1.000	.354 – 1.000
Relationship instability (offence)	.923	.980	.311 – 1.000	.644 – 1.000
Entitlement (general)	.333	.667	1.196 - .999	-4.814 – 1.000
Entitlement (offence)	.556	.833	-.196 - .999	- 1.907 – 1.000
Impression management (general)				
Impression management (general)				
Difficulty achieving goals (general)	.333	.667	-.261 - .998	-4.814 – 1.000
Difficulty achieving goals (offence)	.267	.593	-.274 - .998	-6.107 – 1.000
Problem solving (general)	.000	.000	-.308 - .995	-16.443 - .999
Problem solving (general)				
Impulsivity (general)				
Impulsivity (offence)				
Addictive behaviour (general)	1.000	1.000	1.000 – 1.000	1.000 – 1.000
Addictive behaviour (offence)	1.000	1.000	1.000 - 1.000	1.000 - 1.000
Poor emotional regulation (general)				
Poor emotional regulation (offence)				
Volatile behaviour (general)	.000	.000	-.308 - .995	-16.443 - .999
Volatile behaviour (offence)	.556	.833	-.196 - .999	-1.907 – 1.000
Rumination (general)				
Rumination (offence)				
Perspective taking (general)	.667	.889	-.138 - .999	-.938 – 1.000
Perspective taking (offence)	1.000	1.000	1.000 – 1.000	1.000 – 1.000
Average	0.834	0.945		

Single measures ICC range from .000 (i.e. no agreement) for some items to 1.000 (i.e. perfect agreement for other items), with a mean value across all items 0.834. Average measures ICC range from 0.000 to 1.000 , with a mean value across all items of 0.945. ICC was not calculated for those items where the same value was attributed to the item across both case studies by all four raters. However, in such instances there was perfect agreement between raters.

Study Two Results

Table 4.3 presents the kappa scores. It is evident there is considerable variation between the total kappa values for each rater and the G score, though the mean kappa value across the case studies shows some consistency, as does the range.

Table 4.3: Mean Kappa value for all TNM raters * G score

Case study 1		Case study 2	
Mean kappa	.563	Mean kappa	.441
Range	.241 - .952	Range	.235 - .819

In order to investigate the degree of variation further analysis was undertaken. Kappa values for the different professional groups were compared to investigate the impact of differing training backgrounds (see Table 4.4). Psychologists produced the highest mean kappa value within the professional groups, followed by prison officers with good overall agreement between raters. Nursing staff and health care assistants produced moderate inter-rater agreement across all of the items.

Table 4.4: Mean kappa values for professional groups

	Nursing	Health care assistant	Psychology	Prison officer
Mean	.479	.454	.671	.638
N	13	26	8	15
Std. Deviation	.132	.124	.138	.234

The qualitative level of agreement between all raters and the expert scores are indicated in Figure 4.1, showing fair to almost perfect agreement.

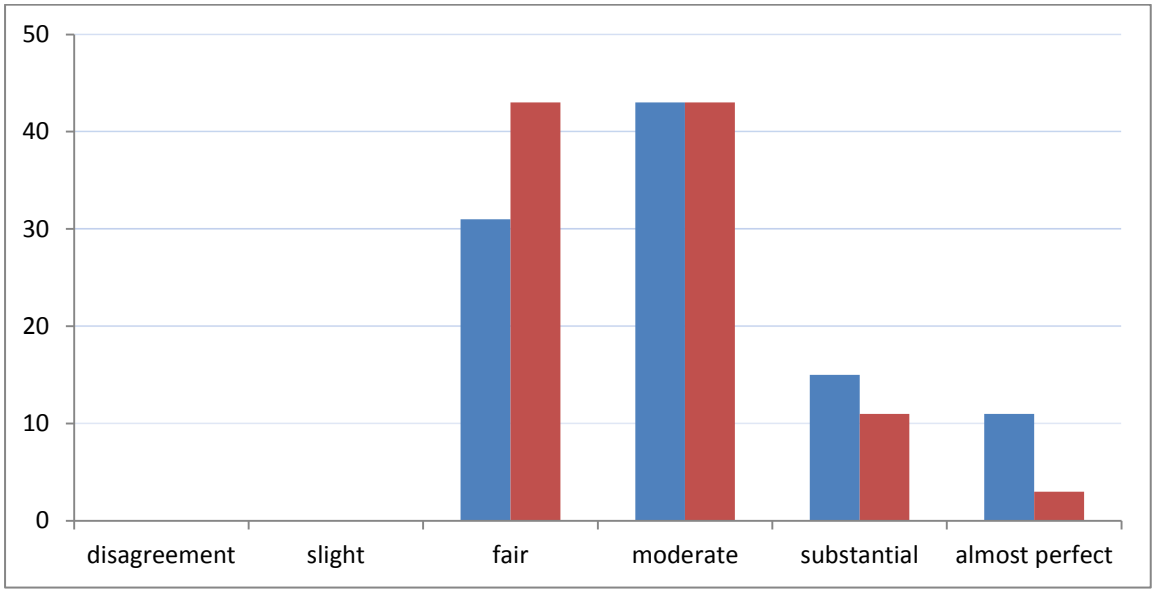

Fig 4.1: Distribution of qualitative kappa values across case studies (%)

Finally, an ICC analysis was undertaken for each item in the TNM (see Table 4.5). ICC computations report both single and average measures and confidence intervals.

Table 4.5: ICC analysis for TNM items

Antisocial attitudes (general)	.020	.510	-.013- .976	-1.619-1.000
Antisocial attitudes (offence)	.179	.916	.024-.996	.551-1.000
Criminal peer group (general)	.894	.998	.611-1.000	.987-1.000
Criminal peer group (offence)	.597	.987	.207-.999	.929-1.000
Denial/minimisation (general)	.034	.641	-.010-.982	-.920-1.000
Denial/minimisation (offence)				
Misreads situations (general)	.130	.882	.011-.994	.367-1.000
Misreads situations (offence)	.038	.666	-.009-.984	-.784-1.000
Antisocial values domain total (general)	.460	.977	.125-.999	.877-1.000
Antisocial values domain total (offence)	.382	.969	.09-.998	.832-1.000
Poor conflict resolution (general)	.032	.624	-.01-.982	-1.013-1.000
Poor conflict resolution (offence)	-.012	-1.361	-.019-.895	-11.622-.998
Relationship instability (general)	.734	.993	.333-1.000	.962-1.000
Relationship instability (offence)	.894	.998	.611-1.000	.987-1.000
Entitlement (general)	.217	.933	.034-.997	.640-1.000
Entitlement (offence)	.325	.960	.069-.998	,787-1.000
Impression management (general)	.128	.880	.011-.994	,357-1.000
Impression management (general)	.131	.883	.012-.994	.373-1.000
Interpersonal relating (general)	.207	.929	.031-.996	.619-1.000
Interpersonal relating (offence)	.225	.936	.037-.997	.656-1.000
Difficulty achieving goals (general)	.004	.163	-.016-.960	-3.474-.999
Difficulty achieving goals (offence)	.384	.969	.091-.998	.834-1.000
Problem solving (general)	.071	.793	-.002-.990	-.108-1.000
Problem solving (general)	-.020	-26.531	-.020-.416	-146.208-.973
Impulsivity (general)	.236	.939	.040-.997	.675-1.000
Impulsivity (offence)	.046	.709	-.007-.996	-.558-1.000
Addictive behaviour (general)	.480	.979	.135-.999	.886-1.000
Addictive behaviour (offence)	.312	.958	.064-.998	.774-1.000
Self-management total (general)	-.011	-1.247	-.019-9.00	-11.016-.998
Self-management total (offence)	.334	.962	.072-.998	.795-1.000

Poor emotional regulation (general)	.470	.978	.130-.999	.882-1.000
Poor emotional regulation (offence)	.333	.961	.072-.998	.794-1.000
Volatile behaviour (general)	.182	.918	.025-.996	.560-1.000
Volatile behaviour (offence)	.312	.958	.064-.998	.774-1.000
Rumination (general)	.052	.735	-.006-.987	-.419-1.000
Rumination (offence)	.082	.816	.000-.991	.018-1.000
Perspective taking (general)	.439	.975	.115-.999	.867-1.000
Perspective taking (offence)	.125	.878	.010-.994	.345-1.000
Emotional regulation (general)	.544	.984	.172-.999	.912-1.000
Emotional regulation (offence)	.496	.980	.144-.999	.894-1.000

The qualitative assessment of items based on the guidelines previously quoted (Cicchetti, 1994) can be seen below (see Table 4.6).

Table 4.6: Qualitative rating of ICC agreement

Disagreement	Denial (offence). Poor conflict resolution (general), Poor problem solving (general), Self-management domain total
Poor agreement	Difficulties achieving goals
Fair agreement	Anti-social attitudes (general), Misreads situations (offence), Poor conflict resolution (general), Impulsivity (offence), Rumination (general))
Good agreement	Denial (general)
Excellent agreement	Criminal peer group (offence), Misreads situations (general), Antisocial values domain total (general). Antisocial values domain total (offence), Relationship instability (general), Relationship instability (offence), Entitlement (general), Entitlement (offence), Impression management (general), Impression management (general), Interpersonal relating (general), Interpersonal relating (offence), Difficulty achieving goals (offence), Problem solving (general), Impulsivity (general), Addictive behaviour (general), Addictive behaviour (offence), Self-management total (offence), Poor emotional regulation (general), Poor emotional regulation (offence), Volatile behaviour (general), Volatile behaviour (offence) ,Rumination (offence), Perspective taking (general), Perspective taking (offence), Emotional regulation (general), Emotional regulation (offence)

Study Three Results

Test-retest data was calculated for the four domain totals of the TNM and the overall TNM score (see Table 4.7)

Table 4.7: Test-retest correlations

			Test	Retest
TNM total	Test	Pearson Correlation Sig (2-tailed) N	1 144	.852** .000 144
	Retest	Pearson Correlation Sig (2-tailed) N	.852** .000 576	1 576
Antisocial values	Test	Pearson Correlation Sig (2-tailed) N	1 144	.898** .000 144
	Retest	Pearson Correlation Sig (2-tailed) N	.898** .000 576	1 576
Interpersonal relating	Test	Pearson Correlation Sig (2-tailed) N	1 144	.864** .000 144
	Retest	Pearson Correlation Sig (2-tailed) N	.864** .000 144	1 144
Self-Management	Test	Pearson Correlation Sig (2-tailed) N	1 144	,712** .000 144
	Retest	Pearson Correlation Sig (2-tailed) N	.712** .000 144	1 144
Emotional management	Test	Pearson Correlation Sig (2-tailed) N	1 144	.861** .000 144
	Retest	Pearson Correlation Sig (2-tailed) N	.861** .000 144	1 144

**, correlation is significant at the 0.01 level

Kline (2000) proposes test-retest values should be 0.8 or above for a test to be considered to have adequate intra-rater reliability. The results reported above compare favourably with recommended correlations for test-retest reliability. Overall test-retest scores and three of the domain scores are above the correlation coefficient recommended, while the value for the self-management domain falls marginally below the recommend value.

Discussion

The Treatment Need Matrix is an empirically driven tool that has been designed to support staff working in forensic ID services to identify relevant criminogenic needs. This study aimed to establish preliminary reliability characteristics of the tool using a variety of methods in three separate studies.

Specifically, three objectives were addressed across the three studies. The first study examined the inter-rater agreement of a small group of expert raters. Average ratings ICC values showed a high degree of inter-rater reliability and the scores derived from this study was used to establish "gold standard" scores for the subsequent two studies.

Study two provides inter-rater reliability data from a sample of sixty-two members of staff working in range of forensic ID services. Two calculations were undertaken; kappa values to establish the agreement with the expert scores and ICC correlations to examine the inter-rater reliability across the TNM items. Agreement with expert scores ranged from moderate to almost perfect across the average of all TNM items. ICC analysis revealed disagreement between participants for four items within the TNM and poor agreement with one item. The remaining items (scored for

generality and offence chain had agreement ranging from fair to excellent, with the significant majority of items demonstrating excellent agreement.

Study three then reports test-retest data from a smaller sample of staff working across these services. Significant correlations were produced across the TNM total and across the four domains.

Expert consensus and *G* score

As previously mentioned, four experienced forensic psychologists completed ratings on two case studies. Cicchetti (1994) has provided commonly cited cut-offs for ratings of agreement on the basis of ICC estimates as follows; poor IRR for ICC values of .4 or less, fair for ICC values between .4 - .59, good agreement for values between .6 - .74 and excellent for values falling between .75 – 1.0.

As reported in the previous section, the ICC for the expert rating was fair to high across all items within the TNM, domain totals and across the total TNM score. These findings compare favourably with similar tools that use structured clinical judgement and would seem to suggest that the TNM possess good inter-rater reliability for professional staff with experience in using SCJ tools.

The high degree of reliability suggests, at least for experienced practitioners, that the item definitions are sufficiently detailed to guide professional judgement in the collection of evidence and that the guidance provides direction towards evidence that results in reliable decision making.

However, despite the high levels of ICC between the experts, there are some cautions to consider in relation to the findings. First, all four expert raters were working in services for offenders with ID and PD and all four services had adopted the TNM as a framework for assessing the presence of criminogenic needs. Each

rater, although having expertise in assessment tools as described earlier, had been exposed to the content and methodology of the TNM for some time and therefore had considerable familiarity with the tool. While training in the use of the TNM clearly intends to provide participants with this level of expertise and familiarity, it is possible that the expert group had a particularly keen interest in the tool which may have inflated agreement. Similarly, the expert raters, arguably, had a vested interested in the use of the TNM given that their respective services had decided to adopt the tool as a framework for the identification of needs and the delivery of treatment.

Inter rater reliability

As reported previously, IRR was calculated using both Cohen's Kappa and ICC statistics. The value of the first method is that it allows an overall comparison across the TNM items between each individual rater and the g score for each case study. The drawback of this method, as mentioned, is that is compares exact agreement rather than the degree of agreement. Kappa values for each case study were reported in the previous section (see table 3). Both case studies returned similar mean kappa values and comparable ranges. On the basis of the guidelines developed by Londis & Koch (1977), the distribution of kappa values for individual raters indicates fair to almost perfect agreement, with the majority of raters falling in the moderate level of agreement and almost 70% achieving moderate or higher levels of agreement with the g scores .

The higher the value of an ICC the greater the degree of agreement between raters about the item of measurement, in this case the needs identified in the TNM. As with other kappa values 1 represents perfect agreement between raters and 0 indicates only random agreement. Negative values are indicative of systematic

disagreement which can exceed a value of -1 when there are three or more raters (Halligren, 2012). As indicated previously, the qualitative assessment of items based on the guidelines previously quoted (Cicchetti, 1994) were generally excellent, though some items were notable due to systematic disagreement between raters.

Results from the ICC analysis for each item highlight values from -.20 to .894 *(M* = .269) for a single rating and from -.26.5 to .998 *(M* = .788) for average ratings. Taking the mean score of the ICC values across the items would therefore suggest fair agreement for single measures and good agreement for average measures. Taken with the results of the kappa analysis, these results suggest that the TNM possess good IRR across a moderately large sample of raters and would seem to support the use of the tool to establish the relevance of a variety of criminogenic needs for offenders with ID and PD.

Test retest reliability

The test-retest data presented in study three suggests that the TNM has moderate to high retest reliability. To place these results in a suitable context it is prudent to consider factors influencing this particular reliability characteristic. Klein (2000) highlights a number of factors that may influence test-retest reliability. First, he notes that a challenge to re-test reliability is actual changes in subjects who are tested. Repeating a measure on subjects who would be expected to change would lower the unity of scores over time, thus making the test-retest reliability appear to be lower. Within correlational tests of significance this change would be assumed to be due to measurement error rather than actual chance. However, in this reliability study case study information was used, thus ensuring that there was no actual change in the subjects who were rated. Changes in scores provided by the raters would

therefore be reasonably assumed to represent measurement error. However, as indicated in the previous section, the degree of variation between ratings performed over time was minimal and the correlation between the scores is therefore representative of a true test-retest measure.

Second, Klein discusses a number of factors that may artificially boost retest reliability. First, the duration of the time elapsed between testing may influence the degree of agreement between the two sets of scores and a recommended time elapse of twelve weeks is cited. Due to pragmatic constraints of the study workshop participants were asked to re-rate a case study at any point between 6 and 20 weeks after participation in training and a proportion of those who completed the retest may therefore have had some recollection of scoring the items from the workshops, potentially increasing their re-test reliability score. Similarly, although a random sample of workshop participants were approached for the purposes of obtaining retest values, participation in this phase of the study remained voluntary and it is possible that those people who volunteered had some interest or enthusiasm for the tool, again potentially inflating the scores obtained at the second point of rating.

Limitations and implications for practice

Encouraging though these results are, it is equally important to consider potential sources of error that may impact on the generalisation of the results. Klein (2000) discusses a number of factors contributing to measurement error, including poor test instructions, subjective scoring and guessing, each of which is a possible source of error in this particular study. In terms of test instructions there are two possible sources of error within the TNM. First, the item definitions may give rise to some ambiguity, subsequently misleading those people who attended the training.

Although care was taken with the clarification of items, the results of the ICC analysis indicate that certain items had systematic disagreement across the total number of workshop participants. Although it is possible that the disagreement within these items arose from other sources (for example the content of the case studies) a consideration of the evidence gathered within the scoring forms provided for workshop participants would seem to highlight some confusion about the essence of the item. For example, *conflict resolution* and *problem solving* were two of the items found to show systematic disagreement between raters. However, evidence cited for these items was relatively stable across raters, suggesting that despite raters identifying similar features of the case study their scoring decision was significantly different. One possible explanation for this disagreement concerns the item title, with a number of workshop delegates suggesting that they awarded high scores for positive conflict resolution and problem solving whereas other workshop delegates awarded high scores for poor conflict resolution and problem solving. The item titles in these two instances therefore appeared to cause some confusion in relation to the direction of scoring.

A second possible source of error relating to the test instructions concerns the nature of the training. Training consisted of a one-day workshop covering an introduction to criminogenic need and risk factors, an overview of the development of the TNM, the scoring procedure, item definitions and practice scoring of two case studies. All of the teaching components of the workshop were provided by a consistent power-point presentation, though the interactive style of the workshops meant that inevitably different discussions arouse in each workshop (nine in total) and such discussions may have influenced the scoring practices of participants on one way or another.

In terms of further sources of error identified by Klein, namely subjective scoring and guessing, the TNM procedures would appear to offer some mitigation. Notwithstanding the concerns raised in relation to certain items earlier. The TNM does provide a consistent definition and a consistent scoring procedure for each item and, due to the provision of a manual, a consistent guide for each rater. Although item definitions do not mitigate against individual interpretations of the written material they do prevent the type of subjectivity associated with unstructured clinical judgement. Similarly, the guidance provided for scoring items, both in relation to the difference between generality and offence chain, and in terms of the allocation of a score prevent individual scorers from guessing the relevance of items.

A particularly interesting finding from the ICC study concerns the discrepancies between single and average ratings. Scores across the items consistently indicate that average measure produce higher reliability values than single measures. While this is to be expected in ICC statistics, the findings are nevertheless significant in terms of the practice of determining risk or need for offenders when using the TNM. Although the case studies were scored independently during training, the TNM practice manual emphasises that the whole staff team are encouraged to contribute to the collation of evidence in relation to individual items and a sample of the staff team are required to score each item at various stages of an individual's treatment pathway.

Similarly, Confidence intervals show wide variation, which reflects variation across raters. However, a key feature of the TNM process is to complete scoring of items within a team context, thus reducing the weighting of individual raters and promoting a consensus opinion.

A final consideration arising from the IRR study can be drawn from the Kappa values reported in table 4.2. Considerable variation is apparent in the kappa values and whilst all values reported indicate some degree of agreement there is nevertheless poor absolute agreement between some raters and the g score. Further analysis of this data indicates clear differences between different professional groups with a positive trend towards those professions that receive specific training in forensic risk assessment as a component of their core profession. This clearly raises the possibility of the role of training in the use of the TNM. It is notable that a number of other assessment frameworks that rely on structured clinical judgement adopt a more thorough training strategy than has been used in the preliminary reliability studies for the TNM. Training in the SRA typically involves a three day course involving scoring of a number of case studies along with recommendations for dual scoring following completion of the training in order to promote inter-rater reliability. Similarly, training to use the PCL-R consists of three days and trainees are required to complete assessments and submit those evaluations for assessment of reliability. Given that the TNM is perhaps most similar to these assessments, the adoption of a similar training strategy may ensure improved kappa values for individual raters and minimum correlations with the g scores on case studies could be a requirement of using the TNM.

Conclusion

The results suggest that the TNM possesses good IRR, moderate to high test-retest reliability and compares favourably with similar assessment frameworks. Although remaining a somewhat experimental framework the items included in the TNM have been drawn from the empirical literature, with each item being cited by a minimum

of three independent studies. Clearly, to establish the value of the TNM in the treatment of offenders with ID and PD further studies are required. Theoretically, those offenders with higher scores across the items are likely to have greater needs and therefore pose higher levels of risk related psychological vulnerabilities. It would be reasonable to assume that those offenders with greater levels of need present a significantly greater level of treatment need, require a higher treatment dose and are more likely to relapse while retaining high levels of need. Predictive validity studies would therefore add value to the TNM. This said, the findings of this study offer some encouragement for the use of the TNM as a framework for the assessment of criminogenic needs for offenders with ID and PD and may be of value to service providers and treatment providers alike.

- CHAPTER FIVE -

General Discussion

Offenders with intellectual disability (ID) and personality disorder (PD) present a number of challenges to service providers whilst simultaneously facing a number of challenges of their own. Within the Prison Service, offenders with ID have traditionally been excluded from offending behavior programmes (OBPs), the notable exception being the adapted sex offender treatment programme (Williams & Mann, 2010). The exclusion of prisoners with an IQ below 80 from the available programmes clearly prevents such individuals from accessing treatments designed to reduce risk, thus inhibiting potential progressive moves through levels of security and, ultimately for life sentence prisoners, favourable parole decisions. On the other hand, on the back of the Bradley Report (2009), the Disability Discrimination Act (1995) and R vs. Gill (2009) the Prison Service faces the potential of judicial reviews if they are unable to provide appropriate rehabilitation.

Health Service providers on the other hand have often drawn on the forensic expertise of the prison service programmes in order to deliver criminogenic interventions whilst incorporating a range of modifications designed to increase responsivity. In doing so such interventions have relied on the assumption that mainstream OBPs have captured relevant areas of criminogenic need. Perhaps a good example of this approach is the SOTSEC-ID model for ID sex offender treatment (Sinclair, Booth & Murphy, 2002), which draws heavily on Finkelhors pre-conditions model of offending (1984) and incorporates modules on sex education and empathy. Despite evidence of post-treatment gains (Murphy et al., 2010), the

merit of these gains becomes questionable if the variables being measured do not reflect criminogenic need. As an illustration, the counterfeit deviance model of sexual offending in ID draws on the assumption that men with ID who commit sexual offences have poor sexual knowledge, which, as we saw in Chapter 3, does not stand up to empirical scrutiny. Indeed, some studies even suggest that sex offenders with ID have superior sexual knowledge to their non-offending counter-parts (Michie, Lindsay, Martin, & Grieve 2006).

Similarly, the value of empathy training as a target for intervention has come in for some criticism (see for example, Mann 2013) within the mainstream sex offender populations and would again raise similar doubts about the merit of post-treatment gains in empathy for this population. However, as was again apparent in chapter three, there is strong evidence that offenders with ID respond positively to empathy training, though Procter and Beail (2007) found offenders with ID to outperform their non-offending peers on theory of mind tasks, potentially raising the same questions posited by Mann.

To counter these difficulties it seems imperative for forensic ID service providers to develop interventions that target relevant areas of need for this population. This piece of research was design to facilitate that process by seeking to identify relevant areas of criminogenic need for offenders with ID and PD.

In chapter two a framework used to summarise areas of need for prisoners with PD was reviewed in relation to the reliability and validity of the framework. Although the items included appeared to have some face validity, and change in these items forms the basis of the post-treatment report for TCs, significant concerns were raised in relation to the reliability of the framework. In particular, the items identified as targets for intervention were not defined and the scoring procedure,

although based on a simple Likert scale, was similarly unstructured. These omissions in the framework would seem to allow for considerable subjectivity in scoring thus raising serious doubts about the credibility of post-treatment reports. However, chapter two concludes with a number of recommendations that would help to address these shortcomings, which are elaborated upon in the subsequent work within the thesis.

Despite the limitations of the assessment framework discussed in chapter two, it nevertheless offers some utility as a methodology for establishing the needs of offenders with PD. Chapter three drew on this framework to examine the relevance of the items for offenders with ID and PD and addressed one of the primary failings of the framework by establishing the validity of the items through a systematic literature review. The literature search found little in the way of RCT evidence, but drawing on research using controlled comparison groups and pre/post treatment designs, seventeen items were identified for offenders with ID and PD. Each of these items was cited in a minimum of four independent pieces of research and would seem to reflect a consensus amongst forensic ID practitioners. In terms of the identification of criminogenic needs for offenders with ID and PD the framework, or Treatment Need Matrix, therefore offers a unique and valid mechanism to guide practitioners towards appropriate treatment targets for offenders with co-morbid ID and PD.

Chapter four then described some preliminary reliability studies into the Treatment Need Matrix, a structured clinical judgment tool based on the framework used in the Prison TCs. Intra-class correlation coefficients showed the TNM to have moderate to good inter-rater reliability for a range of professionals who received training.

As was highlighted towards the end of chapter three, the study into the reliability of the TNM had some methodological drawbacks and further research is necessary to establish the discriminative and predictive validity of the tool. However, on the basis of current research, the TNM would appear to reflect the relevant areas of criminogenic need for offenders with ID and PD. The framework, albeit in the early stages of development, would seem to offer practitioners a mechanism for identifying the psychological vulnerabilities of this particular population and therefore offers a framework for both organizing treatment delivery and evaluating treatment effectiveness.

Conclusion

Collectively, the thesis therefore presents the development of a reliable and valid methodology for establishing the needs of offenders with intellectual disability and personality disorder. Although the forensic ID literature makes reference to adaptations designed to increase responsivity of programmes for this population, few, if any, studies make specific reference to the risks, or criminogenic needs, of ID offenders. The RNR model described in the introduction makes explicit reference to the importance of dynamic risk and the available research has highlighted the positive impact of programmes that adhere to the three principles of RNR in contrast to those that fail to adhere to the principles of risk, need and responsivity. Clearly, for treatment programmes to embrace the three principles of the RNR model, the criminogenic needs of the target population must be clearly addressed by the content of the treatment, must be assessed explicitly and must be empirically associated with the nature of the offending behavior that the treatment is designed to reduce. To date, interventions for offenders with ID have relied on the assumption that the needs of

this particular group of offenders are the same as those for offenders without ID and PD. The TNM, however, provides a systematic approach to assessing the needs of ID offenders, considers needs that have been systematically identified for these offenders and allows treatment providers to develop interventions that target relevant areas. Although further validity studies are required, particularly in relation to predictive validity, the framework provides a dynamic and ID sensitive approach to assessment and treatment, an approach that to date has been absent for the forensic ID methodology.

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TREATMENT NEED MATRIX VERSION 2

Identifying Risks and Criminogenic Need in Offenders with Intellectual Disability and Personality Disorder

Guidelines for completing the Treatment Need Matrix

Jon Taylor

Contents

Introduction

The last twenty years has seen a steady growth of research and interest into the assessment and treatment of offenders with an intellectual disability (ID). Alongside this the mainstream offender literature has seen substantial progress in the assessment of risk of reoffending. The significance of appropriate risk assessment and the identification of those needs that are related to offending behaviour is described in some detail in the Risk - Need - Responsivity Model (Andrews & Bonta 2006) that has helped to shape the design and delivery of forensic services for the last two decades. Risk assessment has developed to become a guiding influence on sentencing practices, release decisions and effective correctional programming in terms of risk levels (higher intensity treatment for offenders with greater levels of risk) and need (treatments designed to address those needs known to be associated with offending behaviour). However, despite some notable exceptions, there has been little development in relation to the specific criminogenic needs of offenders with a learning or intellectual disability, which by extension, may impact on the quality of treatment and on decisions regarding detention.

Perhaps unsurprisingly the development and dissemination of a range of risk assessments for mainstream offenders has provided a foundation for the assessment of risk in the ID offender population. Briefly, risk is currently conceptualised as comprising two components; static and dynamic. Static risk factors are those aspects of an individual's offending history that cannot change but are known to be empirically related to risk of recidivism. Common items included in actuarial assessments of static risk include age, number of convictions, victim gender and relationship to victim. Actuarial assessments have been tested extensively and the commonly used measures all tend to demonstrate satisfactory predictive validity. However, as they are based on historical details of an individual's offending they provide little in the way of treatment considerations for clinicians. Furthermore, such assessments are based on group reconviction data and therefore do not differentiate those members of a particular group who may or may not reoffend. Dynamic factors, on the other hand, represent long-term and short-term psychological variables that are hypothesised to have a relationship with offending behaviour. Dynamic risk assessments, such as the Structured Risk Assessment (Thornton 2002) and the HCR-20 (Webster, Douglas, Eaves & Hart 1997) clinical scale provide support for clinicians formulating individual treatment needs by classifying factors identified in the literature as relevant to recidivism.

Pragmatically, given the prevalence of ID within the prison population, it seems reasonable to assume that a number of existing actuarial assessments will have been developed with a proportion of the sample population having ID. The STATIC 99 (Hanson & Thornton 2000) for

example, explicitly acknowledges the proportion of ID sex offenders included in the sample population. Similarly, in an evaluation of the Violent Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice & Cournier 1998) the accuracy and predictive validity of the tool was found to be as valid for offenders with ID as it was for offenders without ID (although the ID population included men with an IQ up to 80). In a further investigation into the predictive validity of the VRAG with ID offenders, Quinsey, Book & Skilling (2004) found it to show significant predictive value with medium effect size. Interestingly over 50% of the men included in this study had an additional diagnosis of personality disorder.

Lindsay et al. (2008) investigated the accuracy of the RM2000-C (combined risk) scale and the Static-99 on 212 offenders with ID and found the STATIC-99 to have satisfactory reliability. However, Wilcox, Beech, Markall & Blacker (2009) compared three mainstream risk tools: the RRASOR, Static-99 and RM2000-Sexual on a sample of 27 treated ID sex offenders, and found that the Static-99 had a lower reliability (as measured using AUC) than found in Lindsay's study, though still retained the highest reliability of the three tools.

As mentioned, actuarial assessments only represent one component of the conceptualisation of risk. There is broad recognition that dynamic risk, or criminogenic needs, are equally significant in an assessment of an individual's propensity to relapse and therefore should form a core component of treatment. A particularly good example of this is Thornton's Structured Risk Assessment (SRA) for sex offenders, which identifies risks within four domains of functioning; sexual interests, offence supportive attitudes, relational style and self-management. Thornton recommends that such an assessment of treatment needs is undertaken in conjunction with an actuarial assessment of risk in order to establish a base line for risk judgements.

A number of other assessments have since been developed that combine static and dynamic risk factors in a structured clinical judgement approach to the assessment of risk. The Historical Clinical Risk – 20 and the Sexual Violent Risk - 20 combine static (historical) factors with more clinical and psychological variables (clinical and risk) to support clinicians to develop comprehensive formulation of an individual's risk of future violence or sexual violence and treatment needs. Considerable research has been conducted on the HCR-20 and SVR- 20 in a range of settings and with a range of populations, with findings indicating that the HCR-20 in particular reliably predicts future violence with medium to large effects sizes. It is pertinent, given the focus of this manual for the identification of treatment needs for offenders with ID and PD, to note that in a number of established risk assessments a diagnosis of PD (HCR-20) and a diagnosis of psychopathy (SVR-20, RSVP) would increase the risk estimate for individuals. Coid et al. (2006) found that those people with a diagnosis of a Cluster B personality disorder, namely borderline, anti-social, histrionic and narcissistic, were ten times more likely to have a criminal conviction and eight times more likely to have received a custodial sentence, than people who do not have such a diagnosis. When considering people with a diagnosis of PD who remained

living in the community, Howard, Huband, Duggan, & Mannion (2008), found, that those people having anti-social or borderline PD were more likely than the remainder to have received a conviction for violence and a custodial sentence. They showed higher trait anger and impulsivity and a greater history of aggression, and scored significantly higher on a higher-order "psychopathy" factor. It was concluded that APD/BPD represents a particularly criminogenic blend of traits likely to be overrepresented in high-secure forensic samples. This would suggest that those characteristics of APD and BPD are likely to be areas requiring intervention for offenders with these difficulties (see fig 1).

Table 1: Characteristics of ASPD and BPD

Antisocial Personality Disorder	Borderline Personality Disorder
Since age 15 years	Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5
Failure to confirm to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest	A pattern of unstable and intense interpersonal relationships characterised by alternating between extreme of idealisation and devaluation
Deceitfulness, indicated by repeated lying, use of aliases, conning others for personal profit/pleasure	Identity disturbance: markedly and persistently unstable self-image or sense of self
Impulsivity or failure to plan ahead	Impulsivity in at least two areas that are potential self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour
Irritability and aggressiveness, as indicated by repeated physical fights or assaults	Recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour
Reckless disregard for safety or self or others	Affective, instability due to a marked reactivity of mood (e.g. Intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)
Consistent irresponsibility, indicated by repeated failure to sustain work or financial obligations	Chronic feelings of emptiness
Lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated or stole from another	Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper/anger, recurrent physical fights)
The individual is at least age 18 years	Transient, stress-related paranoid ideation or severe dissociative symptoms

The relevance of PD to the ID population has also become increasingly apparent. Lindsay et al. (2006) examined the prevalence rate of personality disorder in a number of forensic ID settings. Drawing on a range of assessment methodologies they found an average prevalence rate of 39.5 %, rising to 57% in a high secure setting, which compares to prevalence rates found in high secure patients without ID (Blackburn et al. 2003). Anti-social personality disorder was the most frequent diagnosis, though interestingly a formal diagnosis was only recorded in clinical files in almost 23% of cases, suggesting significant under diagnosis.

Subsequently, Lindsay et al. (2007) found a similar factor structure for personality disorder in offenders with ID as has been found for other offender groups (Blackburn et al. 2005), again suggesting that the concept of personality disorder may be a valid construct and useful in the treatment of offenders with ID. Using the same study's data, it was also found that those

with ID and personality disorder presented as significantly higher risk, and with significantly more externalising and internalising problems than those without PD, further validating the diagnosis in a forensic ID population (Johnston & Morrissey, 2010). In a further study examining the relationship between emotional problems and personality disorder, Lindsay et al. (2010) used the Chart of Interpersonal Relationships in Closed Living Environments (CIRCLE; Blackburn, Logan, Renwick & Donnelly, 2003) and the Emotion Problem Scales (Prout & Strohmer, 1991), both of which have been validated on ID populations, and found a number of significant correlations between various sub-scales of the measures and personality disorder.

In the same multi-site study referred to above the relationship between risk and personality disorder was systematically examined in a population of intellectually disabled offenders (Hogue et al. 2006). Using a range of risk assessments (including the HCR-20, VRAG and RM 2000), those men with a diagnosis of PD were consistently found to present greater levels of risk. As may be expected, increasing levels of psychopathic traits were also associated with increased levels of risk, while those men who satisfied the criteria for DSPD presented the greatest risk for both sexual and violent offences. Using the same study's data, it was also found that those with ID and personality disorder presented with significantly more externalising and internalising problems than those without (using ratings independent from the PD ratings), further validating the diagnosis in a forensic ID population (Johnston & Morrissey 2010).

In a review of the literature, Torr (2008) notes that a diagnosis of anti-social personality disorder is associated with placement in higher security settings, serious and repeat offending and poorer long-term outcomes for people with ID. Furthermore, Alexander et al. (2006) found that ID offenders with a personality disorder were nine times more likely to re-offend.

Similarly, Gray et al. (2007) found that the VRAG, PCL-SV and the HCR-20 were all significant predictors of violent reconviction in a sample of offenders with intellectual disabilities, suggesting that these established tools are equally reliable when assessing offenders with ID. Similarly, Taylor et al. (2008) undertook an evaluation of the predictive accuracy of the HCR-20 across a range of ID forensic services and again found it to have reasonable predictive accuracy (AUC 0.72). However, Morrissey et al. (2007) did not find the PCL-R to have similar predictive value for offenders with ID.

Boer, Tough and Haaven (2004) developed the Assessment of Risk Manageability for Intellectually Disabled (sex) Individuals who Offend (ARMIDILO), a checklist containing 30 stable and acute dynamic risk factors, scored in relation to the individual offender and the staff team (see figure 2). Although not empirically tested to date, the ARMADILO contains a number of items drawn from the mainstream offender literature and as such appears to have face validity.

Table 2: ARMIDILO dynamic risk factors	
Stable dynamic	**Acute dynamic**
Attitudes to supervision/treatment Insight into risk factors Sexual self-management Mental health Planning ability Substance abuse Victim selection and acquisition Coping ability Relationship skills Use of violence Impulsiveness Offender specific problems	Changes in social support Substance misuse relapse Sexual preoccupation Poor emotional regulation Increased victim access Reduced compliance Reduced problem solving/relapse plans Changes to routine Offender specific factors

While the ARMIDILO was designed for use with sex offenders with ID, Lindsay et al. (2004) developed a system for the assessment of dynamic risk for ID offenders in general. The Dynamic Risk Assessment and Management System (DRAMS) draws on Thornton's SRA domains to identify broad clusters of risk factors relevant to offenders with ID (see fig 3). In a field trial of the DRAMS Lindsay and colleagues suggested that the instrument may be predictive of institutional aggression with four items (mood, psychotic symptoms, self-regulation and compliance with routine) achieving high reliability and a further two items (antisocial behaviour and thoughts/attitudes) intermediate reliability. A subsequent study (Steptoe, Lindsay, Murphy and Young 2008) found that mood, antisocial behaviour and intolerance had significant predictive values in relation to future incidents of violence.

Table 3: Dynamic Risk Assessment and Management System	
Risk variable	**Specific items**
Mood Antisocial behaviour Thoughts Psychotic symptoms Self-regulation Substance abuse Compliance with routine Renewal of recent relationship Opportunity for victim access	Anger, anxiety, mania, sadness Verbal and non-verbal threats; violence to self, others and property; sexually inappropriate behaviour; lack of consideration for others Aberrant sexual thoughts; suspicious thoughts; criminal thoughts Impulsiveness; sexual impulsiveness Alcohol abuse; drug/solvent abuse Looking after room; looking after self; follow daily routine

The application of a range of actuarial assessments and structured clinical judgement frameworks to offenders with ID would seem to demonstrate the importance and utility of risk assessments to this population. Furthermore,

the predictive validity of both the HCR-20 and the DRAMS would also indicate the importance of dynamic risk factors in the treatment and management of offenders with ID. With this in mind, the framework for assessing criminogenic need in offenders with PD, as used in the Democratic Therapeutic Communities (DTCs) in the UK Prison Service, has been adopted to assess and monitor progress for high risk male offenders with ID and PD.

Forensic Democratic Therapeutic Communities identify treatment needs/risks in four primary domains in addition to psychological functioning (see fig 4). Andrews and Bonta (1994) initially distinguished between major treatment factors, which were considered to be closely associated with recidivism, and minor treatment needs that have less impact on reoffending. However, more recent research has found significant change on a range of measures targeting both offence related risk and psychological health (Shuker and Newton 2008). The authors argue that the two domains of treatment augment and support each other, lending support to the notion that psychological well-being may be viewed as a readiness or responsivity variable. Within each domain there are a number of areas of risk and need in a similar manner to the SRA. However, although the risk items appear to have face validity, and there is clearly overlap with meta-analytic studies that suggest a deviant lifestyle and clinical variables are significant factors for offender treatment (Bonta et al., 1998) it is not clear whether these risk items have been derived from empirical research. Furthermore, there seems to be a lack of research into the validity of the risk items, their predictive value or their relationship to institutional behaviour. Anecdotally, however, men who successfully complete treatment in a prison DTC do demonstrate reduced scores on the items listed in the matrix, and outcome studies from prison TC's show a positive impact on recidivism.

Table 4: Treatment Need Domains

<table>
<tr><td>Antisocial attitudes</td><td>Self-management and problem solving</td><td rowspan="3">Anxiety
Depression
Personal distress
Self – esteem
Insecure/ avoidant attachments</td></tr>
<tr><td>Anti-social attitudes
Anti-authority attitudes
Criminal peer group
Does not accept responsibility
Cognitive deficits
Lack of insight
Lack of empathy</td><td>Difficulties achieving goals
Impulsive decision making
Poor coping and problem solving
Addictive behaviour
Risk taking behaviour and lifestyle
Deficits in management of own risk</td></tr>
<tr><td>Relationship skills</td><td>Emotional management</td></tr>
<tr><td>Aggressive/passive approach to conflict resolution
Controlling/aggressive to others
Deficits in social/interpersonal skills
Hostile, mistrustful, suspicious beliefs
Avoids/dependent in relationships
Lack of empathy
Relationship instability</td><td>Emotionally driven impulsivity
Social/emotional isolation
Volatile behaviour/problems with temper control
Rumination over perceived injustices
Grievant thinking
Sudden fluctuations in mood/temperament</td><td>Psychological & emotional needs</td></tr>
</table>

Camilleri and Quinsey (2011) have suggested that in order to address the specific criminogenic needs of offenders with ID, risk assessments should include the unique characteristics arising from intellectually disabled offenders that both lead to and maintain offending behaviours. In order to develop a tool to identify and monitor dynamic risk in men with ID and PD a number of steps have therefore been taken. In the first instance, the range of risk factors identified in the two large prison DTCs (HMP Grendon and HMP Dovegate) have been combined into one document, with a number of risk items being merged into one broader item. Due to the high levels of psychopathy displayed by the men currently residing on the DTC at the National High Secure Learning Disability Service (one of the sites for whom the tool has been devised), two items have been added to capture some of the interpersonal characteristics of men with high levels of psychopathic traits. The factors have then been compared with items on established risk assessments such as the HCR-20, the VRS and the SRA and with those included on both the ARMIDILO and the DRAMS, again to determine face validity of the items for offenders with ID. All items included in the final matrix were then defined, again on the basis of the definitions existing in the literature, and a scoring system that replicates Thornton's SRA was adopted (with permission).

Once the items were identified a systematic literature review was carried to determine the evidence supporting the relevance of each item for offenders with ID (see evidence base). Papers were reviewed in order to identify those dynamic risk factors reported to have relevance for offenders with ID and the final composition of the tool has been designed to incorporate these factors.

The purpose of this particular tool is therefore to support staff to identify and track changes in dynamic risk in offenders with ID (and personality disorder). The identification of individual need draws on a multi-disciplinary and multi-faceted assessment approach. Psychological measures, direct observations and an analysis of offending behaviour all contribute equally to the process.

A1: Antisocial and anti-authoritarian values and fantasies

Antisocial values and beliefs have been consistently identified as a major factor that contributes to offending behaviour and recidivism. Indeed Andrews and Bonta (2006) identified pro-criminal attitudes as one of the "central eight" risk/need factors and repeated acts of anti-social behaviour is a reliable predictor of on-going antisocial behaviour and relapse for both sexual and violent recidivism (Quinsey, Book & Skilling 2004).

The significance of antisocial attitudes and offence supportive beliefs is reflected in their inclusion in a number of recognised risk assessments. The HCR-20 clinical item *negative attitudes* refers to " a relatively stable pattern of pro-criminal, antisocial and negative attitudes and beliefs towards other people, rules, values, social agencies and institutions, the law and other authorities" (Webster et al. 1997). Similarly, the Violent Risk Scale (Wong & Gordon, 2000) defines *criminal attitudes* as "evidenced by the minimisation of the need for maintaining law and order in society, repeatedly trying to finds ways to circumvent laws or established rules, justifying or rationalising antisocial behaviours and refusing to accept responsibility for ones actions".

Although the relationship between fantasy and behaviour remains uncertain, the role of fantasy is nevertheless regularly cited in offending behaviour and evidence of the role of fantasy in relation to criminal activity, and particularly sexual offending, is therefore included.

Evidence base for Offenders with ID

Although there is little research detailing the role of antisocial attitudes in offending by people with an intellectual disability, recent research into personality disorder in this population may offer some indication for a potential link between such attitudes and offending. For example, Torr (2008) found a diagnosis of antisocial personality disorder, which includes a persistent attitude of irresponsibility and resistance to social norms in both ICD-10 and DSM-IV, to be related to serious and repeat offending. In a pilot study exploring the utility of the Dynamic Risk Assessment and Management System (DRAMS) Lindsay et al. (2004) found that the item labelled "thoughts", which included criminal thinking, to have intermediate reliability for the prediction of institutional aggression. In an exploration of factors predictive of sexual offence recidivism, Lindsay, Elliot and Astell (2004) found antisocial attitudes to be a significant predictive factor and similarly,

Fitzgerald et al. (2011) found that general criminal history was associated in increased rates of recidivism in offenders with ID.

In their recommendations to adaptations to the HCR-20 for offenders with ID, Boer et al. (2010) note that people with ID may appear to hold, or indeed actually hold, antisocial values due to their desire to be accepted by non-disabled peers. However, the authors also note that whether this is the case or not there is no reason to suggest that it would reduce the potency of the item as an area of criminogenic need. In addition, attitudes and beliefs are a key target for interventions based on cognitive behavioural principles and a number of programmes based on these principles have been shown to have positive results for offenders with ID (e.g. Novaco and Taylor 2004; Williams, Wakeling & Webster, 2007).

Numerous studies have also identified the role of beliefs and attitudes in sexual offending within this population. Camilleri and Quinsey (2011) found lower IQ's in sex offenders who exhibit a sexual preference for children, while McGrath et al. (2007) found that both sexual attitudes and sexual interests were significant treatment needs in sex offenders with ID. However, in the same study criminal attitudes were not found to have the same significance, although the authors considered this item to be somewhat more subjectively defined and therefore more problematic to identify. Fitzgerald (2011), on the other hand, found a general criminal history, which would imply a values base supportive of criminal behaviour, was associated with increased rates of recidivism, and using a grounded theory approach Courtney et al. (2006) identified a super-ordinate theme of attitudes and beliefs that was found to impact on every stage of the offence process for offenders with ID.

Based on a review of the empirical and theoretical literature, Langdon, Clare and Murphy (2011) suggested that moral reasoning is likely to be related to intellectual development. They further propose, based on the literature, that lower levels of intellectual functioning would be associated with the first stage of moral development described by Kolberg (1983) and would be likely to obey rules in a unilateral manner and show lower levels of criminality. Stage two of moral development, however, which is demonstrated by an egocentric view characterised by meeting the individuals own needs, is likely to be associated with intelligence in the borderline region. People with borderline levels of intellectual functioning would therefore be more likely than those with lower or higher levels of IQ.

Lindsay et al. (2007b) developed the Questionnaire on attitudes consistent with sex offences (QACSO) and found that the tool reliably distinguished between sex offenders with ID and people with ID who did not engage in sexually abusive behaviour. The scale incorporates attitudes supportive of a range of sexual offences. Using the same assessment, Langton and Talbot found significant differences between treated and untreated sex offenders with ID, suggesting that pro-criminal values are both apparent in ID sex offenders and amenable to treatment.

Furthermore, in a review of repeated administration of the Psychological Inventory of Criminal Thinking Styles (PICTS; Walters 1995) Taylor (in press) found reduced a reduction in antisocial thinking in offenders with ID and PD after twelve months treatment in a residential environment that was based extensively on the principles and practices of DTCs. Although not necessarily associated with this change, incidents of serious violence were also reduced within the same time period.

A2: Criminal Peer Group

As with the previous item, a criminal peer group has been identified in the "what works" literature as a central criminogenic need. A criminal peer group, which may include family members, is likely to influence offending behaviour in two ways. First, pro-criminal peers may encourage further acts of antisocial behaviour and generally condone attitudes that are dismissive of authority and legal processes. Second, a criminal peer group may block opportunities for an individual to behaviour in more acceptable ways and inhibit the development of friendships and relationships that promote a more pro-social value system.

The significance of this item as a risk factor is again reflected in a variety of risk assessment tools. The VRS identifies that violent reoffending may occur directly or indirectly as a result of criminal peers and further notes that during institutionalisation an individual may associate with others who have a negative impact on the residential culture. The HCR-20 item *lack of personal support* refers to the absence of strong support systems consisting of relatives and peers and describes the effect this may have on violent recidivism. It would seem reasonable to assume that if a support system is available but biased towards antisocial values and behaviour then the effect on violent recidivism would be similar.

Evidence base for offenders with ID

In a review of the literature describing the characteristics of people with Intellectual disability who offend Holland, Clare and Mukhopadhyay (2002) found that such individuals are highly likely to have other family members who commit offences. Similarly, Lindsay et al. (2004) found a criminal lifestyle and negative social influences to be highly predictive of recidivism amongst ID offenders, while Camilleri and Quinsey (2011) suggest family criminality has a similar influence.

In terms of peer group influences, Boer et al. (2010) note that the increased suggestibility in this population may also make them more vulnerable to the influence of a criminal peer group, while in a qualitative study of the accounts of offenders with ID Isherwood et al. (2007) note that the association with

criminal peer groups may compensate for a more general sense of isolation for offenders with ID. Similarly, family criminality was included as an item in a dynamic risk scale developed by McGrath et al. (2007) for sex offenders with ID. Although analysis of the scale suggested that the item was not a significant or highly significant treatment need, the authors considered the subjective definition of criminality may have led to an under-rating of the items significance.

A3: Denial or minimisation of responsibility

The justification, rationalisation and denial of offending behaviour is widely considered to represent a major area for treatment intervention. Broadly subsumed under the heading "cognitive distortions" self-statements that facilitate the commission of an offence and post-offence justifications have an established base in the treatment literature. Offence supportive attitudes and beliefs may be related to a more general antisocial lifestyle or may similarly be focussed on specific offence types.

Evidence base for Offenders with ID

Courtney, Rose and Mason (2006) used a grounded theory approach to analyse interview data from sex offenders with ID in an attempt to develop a model for sexual offending within this population. The model developed highlighted the importance of attitudes and beliefs at all stages of the offence process. Four particular types of denial and minimisation were apparent; blaming the victim, denial of offender status (by minimising their role in the offence or denying any recollection of the offence), claims of ignorance concerning relationships and the law and adopting a victim stance. In a review of the literature Lindsay (2002) found denial to be a recurring theme in the academic literature with intellectually disabled sex offenders and in a later study Lindsay et al. (2004) found denial of crime was one of the dynamic factors that was most predictive of relapse in intellectually disabled sex offenders. Furthermore, Lindsay and colleagues (2007) found the QACSO differentiated between sex offenders with ID and non-offenders with ID and a key theme running through the items was concerned with responsibility. Similarly, in a description of a treatment programme for fire setters with ID, Taylor et al. (2002) targeted deviant cognitions in relations to responsibility as a central aspect of treatment, and improvements in responsibility was found post treatment as measured by the Fare Attitude Scale (Muckley 1997).

In a somewhat different approach to denial and minimisation, some studies have shown that staff team attitudes may also have an influence on how an individual offender rationalises his offending behaviour. Lindsay et al. (2004) found some evidence that staff attitudes which make allowances for offence

related behaviour (the offenders behaviour being attributed to the intellectual abilities rather than to criminogenic attitudes) and in the development of the ARMIDILO, Boer et al. (2004) included items covering staff knowledge of sexual offending and staff awareness of individual risk factors for offenders with ID. In a study assessing staff perceptions of risk in sex offenders with ID, Green et al. (2003) found that estimates of risk in staff teams bore no resemblance to the estimates of risk on structured assessment tools (e.g. SCJ mini) and indeed found the presence of child victims was considered to lower risk.

A4: Misreads situations/others behaviour

A tendency to miss-represent the intentions of others and/or situations is thought to be a contributory factor in a range of offending behaviours. Numerous authors (e.g. Novaco 1994) have highlighted interpreting that actions of others as threatening, antagonistic or of personal significance heighten anger arousal. McNeil, Eisner and Binder (2003) proposed that a cognitive style characterised by external hostile attributions increases the risk of violence by mentally ill persons. To evaluate this hypothesis, they administered several self-report measures relevant to the aggressive cognitive style, as well as measures of violent behaviour to 110 psychiatric inpatients. Higher scores on several indicators of the aggressive attribution style were associated with violence. Similarly, Orobio de Castro et al. (2002) found a robust significant association between hostile attribution of intent and aggressive behaviour in children and adolescents with histories of aggression. Sexual offenders may have a tendency to sexualise the behaviour of others and interpret non sexual interactions as having a sexual intent.

Hostile and suspicious thought patterns are cited in a number of different assessments of risk and treatment need. The SRA describes an item termed *women as deceitful* which describes a belief that women are untrustworthy.
A hostile belief system is thought to contribute to a risk of offending by predisposing the individual to misinterpret interpersonal situations and promote hostile attributions. Shuker and Newberry (2010), for example, identified suspiciousness as measured by the Persons Relating to Others Questionnaire (PROQ 3, Birchnell & Evans 2003) to be significantly higher for men admitted to HMP Grendon than the general male population. In a review of violence related cognition Collie, Vess and Murdoch (2007) reviewed the content and structure of violent offender's cognitions. They concluded that the content of offender's cognitions regularly contained a theme that emphasised the hostile nature of the world and the need to use violence as a survival strategy. Similarly, they noted that the research on violent offenders cognitive processing highlighted the tendency for such men to perceive threat and hostility in ambiguous social situations.

Similarly, Nester (2002) suggested that four fundamental personality dimensions operate as clinical risk factors for violence. Alongside impulsivity, narcissism and affect regulation Nester notes that a paranoid cognitive personality style contributes to an individual's propensity for violence.

Evidence base for offenders with ID

Basquill, Nezu, Nezu and Klein (2004) compared people with ID who were aggressive with a matched group who did not display aggression. They found that the aggressive sample were significantly more likely to misinterpret interpersonal situations and significantly less likely to identify interpersonal intent accurately.

A numbers of authors (e.g. Day 1994) have suggested that sex offenders with ID may engage in *inappropriate sexual behaviour* as a result of deficits in socio-sexual knowledge or socio-sexual and legal knowledge (Craig 2010), rather than as a consequence of offence related beliefs or deviancy. In the so-called "counterfeit deviance" model of sexual offending in this population, intellectually disabled sex offenders who produce a PPG profile that is not deviant are considered to offend against children and engage in coercive sexual practices due to deficits in social and sexual, knowledge and limited opportunities, rather than on the basis of sexual preferences. It is therefore possible that some offenders with ID misrepresent situations or behaviour on the basis of lack of knowledge and/or experience rather than on the basis of cognitive interpretations. Nevertheless, the consequences for subsequent behaviour may remain the same and lack of such knowledge would therefore seem to be an appropriate treatment target.

In a small study (n=17) of ID offenders referred for anger management Taylor (2006) found that the men produced significantly higher scores on the hostility sub-scale of the Aggression Questionnaire when compared to the sample population used in the design of the assessment.

Similarly, in an analysis of the first cohort of men transferred to reside in a treatment culture based heavily on the principles of DTCs in the National High Secure Learning Disability Service Taylor et al. (2011) found scores on the paranoid personality disorder sub-scale of the IPDE screen to be second only to borderline PD scores. Furthermore, repeated administration of measures twelve months into treatment revealed significant changes in the paranoid sub-scale of the IPDE screening tool within the same population (Morrissey et al. 2012).

In a subsequent study within the same treatment service, Taylor (in press) found significant changes in relation to fear of change when measured using the PICTS. The apprehension of those men in treatment had been largely related to a belief that others could not be trusted.

A5: Deviant sexual preferences

Deviant sexual preferences have been extensively documented in the non-ID sex offender literature and repeatedly linked to recidivism (Hanson & Morton-Bourgon, 2005). Indeed, Gress and Laws (2009) suggest that the nature of sexual interests is what differentiates repetitive sex offenders from non sex offenders and low risk sex offenders.

Evidence base for offenders with ID

As is the case within the mainstream forensic literature, sexual deviancy has been cited to be significant area of need within the intellectually disabled sex offender population. Craig (2010) suggested that the "counterfeit deviancy" argument proposed by some authors to explain sexual offending in this population is neither sufficient nor adequate to explain sex offending in this population and suggested that the evidence to support it is limited. Boer at al (2004) and Camilleri and Quinsey (2011) have similarly highlighted the role of deviant sexual preferences in the offending behaviour of sex offenders with ID, while Blacker et al. (2011) found a range of assessments tools that incorporate sexual deviancy to demonstrated good predictive validity for ID offenders. In a rare study using phallometric assessment of sexual interests in this population, Rice et al. (2008) compared 69 sex offenders with ID with 69 sex offenders without ID. The ID sex offender group were found to exhibit more deviant preferences for prepubertal children, male children and young children than the comparison group.

The significance of deviant arousal is apparent in the range of treatment programmes that have been developed for sex offenders with ID. In a description of the treatment of intellectually disabled sex offenders in the National Offender Management Service, Williams and Mann (2010) highlight sexual interests as one of your primary treatment domains. Similarly, Lindsay (2009) incorporates sexual fantasy into a treatment protocol for ID sex offenders, while the role of masturbatory fantasy has been included in the treatment of men undertaking the SOTSEC-ID treatment programme (Sinclair, Booth and Murphy, 2002).

Evidence Base Relationship/Interpersonal skills

B1: Poor conflict resolution

Prison service TC's identify difficulties with conflict resolution in terms of an aggressive or a passive approach. Interpersonal conflict may be resolved by the adoption of an aggressive approach where the attempt is to intimidate a third party into compliance. This may or may not be driven by anger. Alternatively, the individual may avoid interpersonal conflict. This pattern may be evident by complete avoidance or by under assertion and compliance with the other party. Either way, the individual does not adopt an interpersonal style that facilitates the effective resolution of conflict.

Evidence base for offenders with ID

Much of the research exploring anger and aggression in offenders with ID (for example, Taylor et al. 2002) suggests that interpersonal conflict is a common antecedent factor for assaultative behaviour. Lindsay et al. (2004) found that a verbally aggressive style, threats and property damage all achieved intermediate reliability when predicting institutional assaults with ID offenders.

In a qualitative study into the offence accounts of offenders with ID, Isherwood et al. (2007) found interpersonal difficulties in offence accounts were associated with anger and violence within individual's domestic environment, suggesting that the inability to manage or tolerate such interpersonal difficulties can contribute to violent behaviour. Similarly, Craig (2010) found low levels of assertiveness to be a dynamic risk factor in sex offenders with ID which would suggest that those offenders who have the skills to assert their position in order to resolve conflict present a lowered degree of risk than those who are unable to manage such conflict. In a study of the predictive validity of the PCL-R, Morrissey et al. (2007) found the Emotional Problem Scales (Prout and Strohmer 1989) to be highly predictive of institutional aggression. The externalising sub-scale was particularly correlated with violence and includes items such as verbal aggression and non-compliance, both of which are suggestive of poor conflict resolution.

B2: Relationship instability

The early work of Andrews and Bonta identified social supports as a central protective factor for offenders and conversely, a lack of supportive

relationships as an area of need. *Lack of emotionally intimate relationships* with adults is identified in the SRA as a risk factor in the relationship style domain, while *relationship problems* are included in both the HCR-20 and the SVR-20, while the PCL-R identifies short-term marital relationships.

Evidence base for offenders with ID

In a series of studies Morrissey (2003, 2006) and Morrissey et al. (2005, 2007a,b, 2010) explored the reliability and validity of the PCL-R (Hare 2003) measure of psychopathy to forensic ID populations. Emerging from these studies was a set of comprehensive guidelines for the use of the PCL-R with ID offenders. These guidelines highlight the difficulty of assessing the PCL-R item *short-term marital relationships* due to the general lack of opportunity that people with ID have to engage in intimate relationships. However, where such relationships have been evident Morrissey recommends that the item be scored in line with the PCL-R guidelines. In suggested adaptations to the HCR-20 for ID offenders, Boer et al. (2010) adopt a more liberal approach to the assessments of relationship stability. Drawing on the notion that the protective value of intimate relationships rests on the support that they can offer the individual, Boer recommends that the assessment should also therefore include a consideration of an individual's general attachment style and therefore incorporate peer and staff relationships. In earlier work Boer et al. (2004) also identified relationship skills as a dynamic risk item in the ARMIDILO assessment.

The quality and stability of family relationships have also been cited as potential sources of risk and need for offenders with ID. In a review of the literature related to the assessment of risk and deviancy in sex offenders with ID Craig (2010) noted that the quality of the maternal relationship was a predictive factor in recidivism, with strong attachments being protective while anxious or ambivalent attachments have the opposite effect. Similarly, in an analysis of factors predictive of relapse in sex offenders with ID, Lindsay et al. (2004) found a poor maternal relationship to be one of the factors that correlated significantly with recidivism. Furthermore, Jackson's (1994) *Only Viable Option* theory of pathological arson in offenders with ID postulates that a range of family difficulties contribute to elevated levels of risk, including high levels of family disruption, poor conflict resolution emotional instability. A number of fire-setter treatment programmes developed from this model (e.g. Murphy & Clare 1996, Taylor et al. 2002) have demonstrated a positive impact of relapse for fire-setters, albeit with low sample sizes. However, Keely et al. (2009) did not find a significant association between fire-setting and unstable family relationships when analysing case notes of ten men with mild ID. On the other hand, Holland and Persson (2011) found family and social support to be a recurring area of need in a large sample of ID prisoners (n = 102).

Isherwood et al. (2007) note that people with ID generally may feel isolated from social groups and it is possible (though not evidenced) that as a consequence may have limited opportunities to develop stable peer

relationships. Affiliation with criminal peer groups (see previous item) has certainly been hypothesised to result from such social exclusion for ID offenders.

Lindsay et al. (2004b) compared sex offenders with ID with non-sexual ID offenders and found relationship problems to be significantly higher in the sex offender group. Similarly, in a controlled comparison between ID and non-ID sex offenders, Blacker et al. (2011) found the ID group to have significantly greater ratings in the psychosocial items of the SVR-20 (Boer et al. 1997). Relationship problems is one of the items included within the psychosocial domain of the SVR-20.

B3: Entitlement

Entitlement is included in Thornton's SRA within the interpersonal domain, while the PCL-R contains a similar item, *Grandiose sense of Self-Worth*, which describes an individual who is opinionated and arrogant. He has an inflated view of his abilities and is likely to see himself as more important than other people. He is likely to be dismissive of a number of the work opportunities offered within secure environments as he sees such opportunities as beneath him.

Evidence base for offenders with ID

In a series of studies investigating the assessment of psychopathy in offenders with ID, Morrissey (2003, 2006) produced practice guidelines. In relation to the *Grandiose Sense of Self-Worth* item a series of issues were highlighted for this population:

- True grandiosity, as per the item description (i.e. belief in own superiority), seems to be relatively rare among people with ID, who more typically present with low self-esteem. In a person with an overestimation of abilities, presenting an inflated self-image may be a defence against feelings of inadequacy, or a result of genuine lack of insight into their own cognitive/adaptive deficits.
- Examples of people with ID who might score positively on this item are those who see themselves as superior to other people with ID (or people with more severe ID), talk about their reputation or status in the institution (or other setting), and have a strong sense of entitlement.
- Psychotic delusions are irrelevant to the scoring of this item unless they are accompanied by the other characteristics associated with the item.

As entitlement, and a concern for one's own needs, is a feature of a number of personality disorders, it is pertinent to note that a number of studies have highlighted the prevalence of personality disorders in the forensic ID population. Lunksy et al. (2011) found an increased diagnosis of Personality Disorder in a cross sectional population of offenders with ID, while Taylor et al. (2012) found high levels of PD in a cohort of men with ID transferred to a developing Therapeutic Community in a high secure ID hospital setting.

B4: Interpersonal Manipulation/impression management

Manipulation is included in both the SRA and the PCL-R as a risk factor for recidivism and a characteristic of psychopathy respectively. The SRA describes a pervasive form of manipulation, referred to as Machiavellianism, and comprising of a view of people as fundamentally weak and an interpersonal strategy that exploits this view. The PCL-R pairs manipulation with a conning and deceitful personal style deigned to exploit others for personal gain. The common feature of these items is an individual who uses other people to satisfy his own needs and pays little regard to the other people's wishes.

Evidence base for offenders with ID

Morrissey's research into the use of the PCL-R for assessment of psychopathy in offenders with ID suggests that the conning/manipulative item remains a valid construct for this population. However, the guidelines developed from this research highlight a number of issues when assessing manipulation in offenders with ID:

- There will be people with ID who do use deception to "con" others, but the methods used are likely to be less sophisticated and more transparent than those described in the manual. For example there are less likely to be convictions evident for fraud and deception.
- However a person with ID may con and use less able patients and be involved in "scams" in the institutional setting involving cigarettes, sexual favours or other goods for personal gain. They may also attempt to manipulate staff to obtain special benefits, although this will be less subtle than with the prototypical psychopath.

In an evaluation of the clinical profile of a cohort or men admitted to a developing TC in Rampton hospital (Taylor et al. 2012), positive impression management was found to be significantly higher than both standardised population scores and high secure hospital patient scores when measured using the EPS – SRI (Prout and Strohmer 1989).

In a study investigating the predictive validity of a range of risk assessment tools, Blacker et al. (2011) found the SVR-20 psychosocial items to be a good predictor of violent recidivism in sex offenders with an IQ below 80 and a strong predictor of sexual recidivism in offenders with an IQ below 75. While the specific items in the psychosocial component of the SVR-2- were not differentiated in the study, psychopathy is included within the domain. It seems probable therefore that the traits associated with psychopathy, which includes a conning and manipulative inter-personal style, increase risk for the ID population.

Self-management, coping & problem solving

Evidence Base

C1: Difficulties achieving pro-social goals

The ability to identify goals, both long and short term, is a recurring feature of daily living. Livesley (2001) identifies the tasks of daily living to be a core aspect of personality functioning and an inability to solve such tasks to be a central feature of personality disorder. A lack of realistic long-term goals is an item in the PCL-R, which has been shown to be a reliable predictor of recidivism. Plans which lack feasibility is also an item in the HCR-20. The HCR-20 recognises that an individual's plans may concern their treatment pathway or their release from custodial settings. In a review of the PCL-R with this population Morrissey (2006) recommends that assessors should take into account what is suitable for the individual given their cognitive and adaptive skills. Boer et al. (2010) similarly recommend that when making assessments with the HCR-20 a wider consideration of feasibility, willingness and ability for offenders with ID.

Evidence base for offenders with ID

In an evaluation of the DRAMS, Lindsay et al. (2004) found poor compliance with routine (which appears to include both day to day routine and a more long-term treatment pathway) to be one of the items most predictive of institutional violence. Boer, Tough and Haaven (2004) also include *time management and planning ability* as a stable dynamic risk item in the ARMADILO.

McGrath et al. (2007) found stage of change (based on DiClemente & Prochaska) to be a significant treatment need for offenders with ID, which would suggest that those men who have difficulties retaining a focus on their long-term goals are more likely to relapse than those who are able to remain engaged in their treatment pathway. Similarly, non-compliance with treatment has been consistently found to be a significant predictor of both relapse and problematic institutional behaviour (Quinsey, Book and Skilling 2004; Camilleri and Quinsey 2011; Lindsey 2002; Lindsay et al. 2004). Furthermore, in a study exploring risk factors associated with recidivism in intellectually disabled sex offenders, Lindsay et al. (2004) found erratic treatment attendance to be a significant predictor of re-offending. Clearly, erratic attendance implies some difficulties with an individual's ability to sustain a focussed approach to long-term goals.

Alternatively, however, some offenders may demonstrate an ability to pursue goals but their goals have an antisocial component, either in terms of the outcome or in terms of the methods used to obtain an outcome. For example, Courtney et al. (2006) found that sex offenders with ID were able to identify clear goals from their offending (usually sexual satisfaction) but clearly used antisocial and harmful methods to achieve their goals.

C2: **Poor problem solving**

Numerous studies have highlighted the link between poor problem-solving skills and offending behaviour (e.g. Antonowicz & Ross, 2005). Some studies have linked social problem solving deficits and offending (D'Zurilla, et al., 2004) while other studies have linked deficits in problem recognition to offenders (McMurran, Blair & Egan, 2002). Poor problem solving skills have been linked directly to hostility and aggression (Ramadan & McMurran, 2005), substance misuse (Herrick &Elliot, 2001) and other psychological and behavioural problems (Cassidy & Long, 1996; Londahl, Tverskoy & D'Zurilla, 2005).

Problem solving has been defined as comprising a number of stages: problem identification, problem specification, goal setting and solution generation. Offenders have been consistently found to have deficits in one or more of these areas (McMurran et al. 2002).

Evidence base for offenders with ID

Lindsay et al. (2011) describe the development of a problem solving group for offenders with ID, based heavily on the "Stop and Think" programme, and aims to promote both problem recognition and problem solving. They report on the overall difficulties that offenders with ID experience with social problem solving and suggest that it is a primary area of need and risk for such individuals. Boer at al (2004) describe the reduced use of coping strategies as being a short term dynamic risk factor that exacerbates risk of relapse, while Kelly et al. (2009) found a significant association between a perceived inability to effect change in personal circumstances and offending within a small sample of arsonists with ID, and Taylor et al. (2002) also cited problem solving as a central treatment component for intellectually disabled arsonists and for offenders with ID who presented with violent behaviour (Taylor et al. 2005).

On the basis of an expert consensus, McGrath et al. (2007) incorporated an item referred to as *application of risk knowledge* into a dynamic risk assessment for offenders with ID. The item refers to the ability of an individual to apply their knowledge of risk factors (including personal states and situational circumstances) in a manner that manages risk effectively. The tool, which contains twenty-five items in total, was found to have a

significant relationship with levels of supervision/security deemed necessary on the basis of the seriousness of index offences. Furthermore, problem solving as a more general item was included within the same tool and was found to be a significant treatment need.

Using a qualitative methodology, Isherwood et al. (2007) found a small sample of offenders with ID attributed a lack of routine and daily structure as an antecedent condition to offending, which implies that the men involved in the study lacked the problem solving skills to develop a structure for themselves.

C3: Impulsivity

Impulsivity is included in the VRS, HCR-20, SRA and PCL-R. Although defined somewhat differently in each assessment tool a common theme refers to a tendency to "act on the spur of the moment". Impulsive individuals tend to react to situations with little regard for anything beyond the immediate consequences of his or her behaviour. Impulsive acts are likely to be associated with negative consequences for the individual, others or both.

Evidence base for offenders with ID

In a comparison of impulsivity between sex offenders with ID, non-sexual offenders with ID and non-offenders with ID, Parry and Lindsay (2003) found higher levels of impulsivity among the non-sexual offender group, perhaps reflecting the ability of (some) sexual offenders to engage in delayed gratification in order to facilitate access to a suitable victim. Despite the lower levels of impulsivity in this study, Boer at al (2004) nevertheless includes impulsivity within the ARMIDILO assessment framework. In an investigation of the predictive validity of a range of assessments Blacker et al. (2011) compared sex offenders with and without ID. For the ID group stable dynamic factors, which included impulsivity, were found to be highly predictive of recidivism (AUC 0.86). Similarly, McGrath et al. (2007) found impulsivity to be an area of significant treatment need for intellectually disabled sex offenders, and in a recent evaluation of a problem solving group for offenders with ID, Lindsay et al. (2011) found reduced levels of impulsivity following successful completion of the programme.

Although there seems to be some inconsistency in relation to the significance of impulsivity as a dynamic risk factor, it seems plausible that there may be difference across offence typologies, with some offences (e.g. child sexual abuse, armed robbery) requiring some degree of planning and self-regulation, while others (e.g. violent assault) may be more influenced by impulsivity. Indeed, Courtney et al. (2006) analysed offence accounts of intellectually disabled sex offenders and highlighted the differing strategies

that were employed by the same individual across different offences. At times men were found to engage in considerable levels of planning and self-control in order to facilitate access to a victim, while at other times the men engaged in highly impulsive and opportunistic offending.

Despite these inconsistencies, impulsivity is one of the clinical items included within the HCR-20 (Webster et al. 1997) and studies exploring the viability of the HCR-20 with ID offenders have found the clinical scale to have good predictive validity (with an AUC of 0.68)

C4: Addictive behaviour

Substance abuse was identified by Bonta and Andrews (2007) as a major area of criminogenic need. In a review of the relationship between substance misuse and criminal behaviour, Singleton, Farrell, M. & Meltzer (2003) found that 43% of sentenced male prisoners reported a serious drug misuse problem in the year prior to their incarceration. Similarly, 63% of male prisoners reported problematic drinking habits prior to arrest and 30% reported alcohol dependency. McMurran (2007) notes that the prevalence of problematic drinkers and drug users in correctional services of England and Wales is high, with implications not only for the health of prisoners, but also for substance-related crime. For most illicit drug users, the biggest criminological concern is acquisitive offending to fund the habit, whereas with alcohol it is violence and disorder.

Evidence base for offenders with ID

In a review of the literature relating to substance misuse and ID Sturmey *et al.* (2003) estimated prevalence rates of alcohol misuse to be between 0.5%−2%. Winter, Holland and Collins (1997) compared a sample of individuals with ID both with and without involvement in forensic services and found that those with forensic involvement were more likely to have a history of illicit drug use. McGillivray and Moore (2001) compared the rate of self-reported alcohol and other drug use in a sample of adult offenders with mild intellectual disability with a matched comparison group of non-offenders. The results indicated that many individuals with mild intellectual disability regularly consumed alcohol and used illicit drugs. Furthermore, the data suggest a possible link between substance abuse and offending behaviour in this population. Individuals who had offended reported greater use of both legal and illicit drugs than their non-offending counterparts and many reported that they had been under the influence of alcohol or illicit drugs at the time of committing the offence. Similarly, in a comparison of the demographic characteristics of people with mild ID living in the community and those admitted into secure psychiatric accommodation, Doody,

Thomson, Miller and Johnstone (2000) found those in secure accommodation to be more likely to have a substance misuse problem.

Ishwerwood et al. (2007) found exposure to destabilisers was regularly cited in offence accounts of men with ID, while Fitzgerald et al. (2011) used drug and alcohol misuse as an indicator of a deviant lifestyle and found that offenders who were reconvicted were significantly more likely to have a history of drug and alcohol misuse. In a rare controlled comparison study in this population Winter et al. (1997) found a higher rate of abuse of non-prescription drugs among suspected offenders with ID than a broadly matched comparison group, while Chapman and Wu (2012), in a systematic review of the empirical literature, note that criminal activity is a repeatedly identified correlate of substance abuse for people with ID.

Evidence base

Emotional management & Functioning

D1: Emotional regulation

The focus of this item is on an individual's general ability to regulate their emotional state. Whether they experience a positive or negative emotional state they are likely to present as somewhat exaggerated in their expression. Emotional regulation is cited as a factor in a number of recognised risk and need assessments. The VRS describes emotional regulation/control as being insufficient or over controlled. Over-controlled individuals are likely to be unassertive and bottle up their feelings until they are no longer able to contain themselves and may react in a dramatic fashion to a slight provocation. Sex offenders may show evidence of poor emotional regulation and offend as a self-soothing strategy. Pithers et al. (1988) found anxiety, depression and poor self-esteem to be common precursors to incidents of aggression.

Evidence base for offenders with ID

Lindsay et al.'s (2004) research into the DRAMS found mood to be have significant predictive value in relation to institutional violence, while Boer et al. (2004) incorporate changes in emotional regulation into the ARMIDILO. In an analysis of motivation in people with ID who set fires, Murphy and Clare (1996) found both anger and depression to be regular antecedents to offending. Langton, Maxted and Murphy (2007) found Ward and Hudson's self-regulation theory (1998) of the offence process to be applicable to offenders with ID. The self-regulation model identifies avoidant goals as a primary motivation for some sex offenders and a recent study by Lindsay et al. (2008) supported Langton et al.'s findings, suggesting that some sex offenders with ID are likely to be motivated to offend in order to manage negative emotional states.

Emotional coping skills generally and fluctuations in emotional coping skills are both included as client related items in the ARMIDILO assessment. The acute factors of the assessment have been found to be good predictors of sexual recidivism in sex offenders with an IQ below 80, while the stable dynamic factors have been found to be a significant predictor of relapse in sex offenders with ID (IQ<75).

Camilleri and Quinsey (2011) have reported self-esteem as an important factor in relapse for offenders with ID and the relationship between self-esteem and low mood is widely documented. Furthermore, the EPS

internalising scale, which is an aggregate scale comprising anxiety, depression and self-esteem, has been found to have significant predictive value in relation to institutional aggression (Morrissey et al. 2007, Lindsay et al. 2008). Given that the EPS is completed on the basis of an individual's presentation over a four week period it suggests that the composite sub-scales are important considerations of dynamic risk. Emotional management was also found to be one of eleven items that were considered to represent areas of considerable or very considerable need in sex offenders with ID (McGrath et al. 2007). In a small scale study evaluating the effectiveness of Dialectic Behaviour Therapy with offenders with ID, Sakdala et al. (2010) recorded significant changes on the Short Term Assessment of Risk and Treatability (START, Webster at al 2004). The DBT programme incorporated a substantial piece of work covering distress tolerance and emotional regulation. Post treatment improvement would suggest that these areas benefitted from intervention as measured by the START. Finally, in a controlled study, Winter et al. (1997) found a recent significant life event differentiated between the experience of suspected offenders with ID and a matched comparison group. The life events described in the study are likely to have caused significant emotional distress and therefore imply that the emotional regulation skills of those who were suspected of offending were limited.

D2: Volatile behaviour/anger regulation

Poor anger control has been consistently related to incidents of aggression and violent assault within the literature for some time (e.g. Hanson and Harris 2002). Anger has similarly been associated with rape and sexual assault.

Evidence base for offenders with ID

Novaco & Taylor (2002) found that almost half the male forensic population of a specialist forensic service for people with intellectual disabilities had been physically assaultive following admission, and anger, as assessed by patient self-report and by staff ratings, was found to be significantly related to patient history of aggression. Significant treatment effects were found for men who completed anger treatment, which included an emphasis on the acquisition of anger regulation skills. This would suggest that knowledge and ability to implement anger regulating strategies represents an area of criminogenic need for violent offenders with ID. Similarly, Lindsay's (2002, 2004) research into the DRAMS found mood, which includes an item on anger, to be have significant predictive value in relation to institutional violence.

In an analysis of fire setting behaviour in offenders with ID Murphy and Clare (1996) found anger to be the most common antecedent emotion. In a description of group treatment for arsonists with ID, Taylor et al. (2002) also found high levels of anger, as measured by the Novaco Anger Scale (NAS; Novaco 1994). Post treatment evaluation revealed statistically significant reductions on the NAS total score. Similarly, Isherwood et al. (2007) found that strong emotions were regularly cited in accounts of offending.

In a comparison of sexual and non-sexual offenders with ID, Lindsay et al. (2004) found problems with anger to be a significant difference between the two groups and a feature of the non-sex offender groups in over 50% of men referred to services.

D3: Rumination over perceived injustices

Grievance thinking is defined by difficulty seeing other people's point of view, believing that others have wronged you and are likely to do so again, angry rumination over past wrongs, suspiciousness of others, a sense of having a grievance against the world and others, and vengefulness. The key issues seem to be angry rumination, vengefulness and poor perspective taking in the sense of denying the legitimacy of other people's point of view.

Offenders with a grievance stance tend to be behaviorally aggressive rather than submissive or assertive. They tend not to see or accept others' points of view but try to impose their own perspective. This can be viewed as a form of cognitive aggression. It also serves to entrench their sense of being wronged. They view other people with suspicion, expecting that others will try to wrong them. They dwell angrily on occasions when they believe they have been wronged, and seem unable or unwilling to let go of these events. They show an actively aggressive response to perceived wrongs and in particular are inclined to seek revenge.

Evidence base for offenders with ID

In a pilot study into anger treatment for offenders with ID Taylor, Novaco, Gilmer and Thorne (2002) found group members to have similar scores on the Provocation Index as has been found in non-ID offender populations. One of the sub-scales of this assessment evaluates a tendency for individuals to perceive a sense of unfairness/injustice. In a subsequent study, Taylor et al. (2005) the unfairness/injustice component of the Provocation index was significantly reduced. It is notable that the treatment protocol explicitly targeted attentional focus which is concerned with a pervasive preoccupation with anger arousing situations.

Although not concerned with offenders per se, Jahoda et al. (1998) compared the responses of people with ID with and without histories of aggression, on a sentence completion tasks designed to explore responses to stressful social situations. Participants with histories of aggression were found to produce a significantly greater proportion of aggressive responses (Mann Whitney, $p<0.01$). A follow up study that investigated the salience of stressful situations also found that the group with histories of aggression were significantly more likely to perceive that they were being treated in a derogatory manner and particularly in relation to their disability ($p<0.01$). Isherwood et al. (2007) identified themes of resentment of others and retaliation to others in offence accounts of people with ID.

Although not clearly linked to injustice, Taylor et al. (2002) noted that fire-setters with ID reported a preoccupation with fire and feelings of anger in relation to not being listened to as a precursor to their offending.

D4: Perspective taking & empathy

The significance of empathy and perspective taking as mediators of offending behaviour has a significant evidence base. Scully (1988) and Elliott et al. (1995) indicate that approximately half of all sex offenders report that they had not perceived the emotional state of their victim at the time of the offence. Similarly, Scott and Wolfe (2000) noted that male perpetrators of domestic violence had deficits in empathy and adolescent sex offenders were found to have lower empathy than non-offending adolescents (Lindsey, Carlozzi and Eelis 2001). D'Orazio (2002) found that offenders who had deficits in perspective taking tended to engage in more serious offending and were more likely to begin their criminal careers at a younger age. Joliffe and Farrington (2004) identify perspective-taking as a central treatment target for violent offenders, while Mohr et al. (2007) found that individuals with higher perspective-taking abilities report less outward expression and inward suppression of anger alongside greater use of adaptive anger regulation strategies. Wells (2001) reported reduced convictions for both violent and non-violent offending amongst a group of juvenile offenders following social perspective taking.

In a review of factors that offenders considered to contribute to successful treatment Scott and Wolfe (2000) found that the development of empathy was one of the most regularly endorsed items.

Evidence base for offenders with ID

Joliffe and Farrington (2004) found a link between empathic expression and intelligence suggesting that those individuals with lower intelligence

experience greater difficulties with empathy. Generalising the findings from the mainstream literature, this may suggest the people with ID are less likely to be inhibited by empathic feelings than their non-disabled counterparts. Taylor (2001) found offenders with ID to have significantly greater difficulties with emotional recognition and perspective taking than non-offenders with ID. However, Proctor and Beail (2007) found offenders with ID to perform better on second order theory of mind tasks than non-offenders with ID. Conversely, Courtney et al. (2006) found a lack of empathy and a "poor me" stance to be a recurring theme in accounts of sex offenders with ID.

In addition, a number of studies (e.g. Reed et al. 2004, Lindsay et al. 2006) point to the high prevalence of antisocial personality disorder in secure ID settings. Given that one of the central diagnostic criteria for antisocial PD is concerned with remorse it would seem reasonable to suggest that a number of offenders with ID may be indifferent to the harm caused by their offending.

In a study investigating the discriminative properties of the QACSO, Steptoe et al. (2008) found that seven of the sub-scales discriminated between sex offenders with ID and other offenders with ID (with one standard deviation between the two groups means scores), leading the authors to suggest that the assessment provides a valid and reliable measure of the cognitive distortions held by intellectually disabled sex offenders. All items in the assessment were designed to measure one of three themes in relation to a range of sexual offences; intent, responsibility or victim awareness. The inclusion of victim awareness items, along with the discriminative properties of the tool, would suggest that sex offenders with ID have poorer levels of perspective-taking, empathy or remorse than their non sex offending peers and than non-offenders with ID.

Reliability and Validity

The current version of the TNM has been developed and adapted from the framework used to identify risks and needs in Prison based Democratic Therapeutic Communities. The prison service document identifies a number of risks within four domains (see fig 4). However, the items included in the original document appear to have been developed by expert consensus and, despite having face validity, no studies appear to have been undertaken to demonstrate predictive validity.

In order to establish the validity of the tool for offenders with intellectual disability and personality disorder the following steps have been taken:

Item Definition

No definitions were available for the original items included in the prison service matrix. To reduce subjectivity and establish a consensus view of each item definitions were developed from existing assessment tools in addition to the literature. A small group of staff (n = 5) then scored a case study on the basis of the definitions. Scores were discussed amongst the raters in order to identify any confusion arising from the definitions. A number of definitions were clarified on the basis of the feedback from these raters.

Systematic Literature Review: Item relevance

As the tool was developed in order to identify the criminogenic needs of offenders with ID and PD it was necessary to establish the typical needs of such a population. In order to identify relevant areas of need a systematic literature review was undertaken. Databases searched for the purpose included Psychinfo, Medline, Embase and Web of Science. Review papers identified in the search were perused for additional relevant literature. More papers were identified through this process than relevant hits in the systematic review, a situation described previously by Lindsay (2002). Details of these papers are provided later.

A hierarchy of search terms were used to assist the identification of suitable literature:

6. Offender* OR crimin*
7. Learning disab* OR intellectual* disab* OR mental* retard* OR mental* handicap*
8. Personality disorder*
9. Dynamic risk* OR criminogenic need* Or risk* factor* OR treatment need*
10. 1 and 2 and 3 and 4
11. 1 and 2 and 4

Only one paper was returned from the original search and a pragmatic decision to repeat the search without the PD term was taken due to the general under diagnosing of PD in forensic ID services. It was assumed that studies looking at the criminogenic needs of offenders with ID would still include a number of offenders with PD. Papers included in the review were identified using the usual acronym PICO:

Population
As the study aimed to identify the psychological and criminogenic needs of offenders with an intellectual disability and personality disorder, the population was a broad spectrum of offenders with intellectual disability, regardless of their offence type. All studies included in the review were therefore required to identify the presence of an intellectual disability by a recognised method. Similarly, papers were required to demonstrate the "forensic" nature of the population. However, due to the policy of diverting people with intellectual disabilities from the criminal system the use of convictions/charges was unreliable. Instead, the nature of the behaviours described in the population were used to make judgement. If behaviours described in a study would be likely to be criminal in people without an intellectual disability studies were retained. Due to the limited number of papers returned from the original population search

Intervention:
As with the population the intervention was broadly defined. The aim of the search was to identify those psychological variables that were targeted by treatment providers and could be demonstrated to be responsive to treatment and/or have a relationship with recidivism. Studies considering a range of treatments were therefore included along with studies examining predictive validity of assessment tools.

Comparator:
As has been identified in previous systematic reviews (e.g. Duggan, Huband, Smailagic, Ferriter & Adams, 2007), this proved problematic. Many interventions were compared against a treatment as usual condition, waiting list controls or pre/post treatment designs. Papers based on single case designs or the author's opinion were not included in the final analysis. Similarly, papers that did not provide a clear methodology were excluded

Outcome :
Outcome was similarly problematic to define. Studies identified during preliminary scooping exercises used a wide variety of outcome measures and many relied on frequency of certain behaviours rather than changes in the psychological factors underlying the behaviour. As offending behaviours may occur infrequently or may be inhibited by placements in custodial environments a reliance on observed behaviour clearly raises problems for determining the value of an intervention.

Assessment of Methodological Quality

Methodological quality was determined from a comparison of studies against the different levels that are considered by the National Institute of Clinical evidence:

- Level A: Consistent Randomised Controlled Clinical Trial, cohort study, all or none (see note below), clinical decision rule validated in different populations.
- Level B: Consistent Retrospective Cohort, Exploratory Cohort, Ecological Study, Outcomes Research, case-control study; or extrapolations from level A studies.
- Level C: Case-series study or extrapolations from level B studies.
- Level D: Expert opinion without explicit critical appraisal, or based on physiology, bench research or first principles.

The search returned no results that would satisfy the criteria for randomised control trials. The majority of papers returned from the overall search strategy were therefore located at level B. The papers (n = 41) identified have been used to establish the relevance of the items included in the final tool. Each item included within the TNM was identified as a salient treatment need in a minimum of three independent studies.

Reliability Studies

A number of steps have been taken in order to determine the reliability of the Treatment Need matrix:

- Five members of staff with experience of working in a forensic ID setting rated a fictitious case study. Their answers were used to explore the usefulness and clarity of the definitions. A number of revisions were subsequently made to the item definitions.
- Three experts rated two case studies in order to establish a gold standard score.
- Fifteen members of staff then scored the same two case studies in order to obtain data for inter-rater reliability studies.
- Ten members of staff repeated scoring for the case studies for a second time in order to establish intra-rater reliability.

Early data suggests a high level of agreement between expert raters on a number of case study and generally positive qualitative ratings of intra-class correlations for a large sample (n = 66) of previously untrained raters (see table 5).

Table 5	Qualitative ratings of ICC values
Disagreement	Denial (offence). Poor conflict resolution (general), Poor problem solving (general), Self-management domain total
Poor agreement	Difficulties achieving goals
Fair agreement	Anti-social attitudes (general), Misreads situations (offence), Poor conflict resolution (general), Impulsivity (offence), Rumination (general))
Good agreement	Denial (general)
Excellent agreement	Criminal peer group (offence), Misreads situations (general), Antisocial values domain total (general). Antisocial values domain total (offence), Relationship instability (general), Relationship instability (offence), Entitlement (general), Entitlement (offence), Impression management (general), Impression management (general), Interpersonal relating (general), Interpersonal relating (offence), Difficulty achieving goals (offence), Problem solving (general), Impulsivity (general), Addictive behaviour (general), Addictive behaviour (offence), Self-management total (offence), Poor emotional regulation (general), Poor emotional regulation (offence), Volatile behaviour (general), Volatile behaviour (offence) ,Rumination (offence), Perspective taking (general), Perspective taking (offence), Emotional regulation (general), Emotional regulation (offence)

The test-retest reliability of the TNM has also been investigated during the development of the tool with domain and total ratings all being in excess of the recommended 0.7 value for minimum (see table 6) .

Table 6	Test-retest correlations for domains and total TNM scores			
			Test	Retest
TNM total	Test	Pearson Correlation Sig (2-tailed)	1	.852** .000
	Retest	Pearson Correlation Sig (2-tailed)	.852** .000	1
Antisocial values	Test	Pearson Correlation Sig (2-tailed)	1	.898** .000
	Retest	Pearson Correlation Sig (2-tailed)	.898** .000	1
Interpersonal relating	Test	Pearson Correlation Sig (2-tailed)	1	.864** .000
	Retest	Pearson Correlation Sig (2-tailed)	.864** .000	1
Self-Management	Test	Pearson Correlation Sig (2-tailed)	1	,712** .000
	Retest	Pearson Correlation Sig (2-tailed)	.712** .000	1
Emotional management	Test	Pearson Correlation Sig (2-tailed)	1	.861** .000
	Retest	Pearson Correlation Sig (2-tailed	.861** .000	1

Finally, cohen's kappa values were calculated to allow a comparison of raters scores with an "expert consensus" score for each case study. Kappa values are likely to provide an underestimate of the true reliability of scores as precise agreement is measured rather than consistency of agreement between individual raters and the expert score. Nevertheless, the distribution of kappa values across the sample of raters participating in the reliability studies show a moderate to good overall reliability (see fig 1)

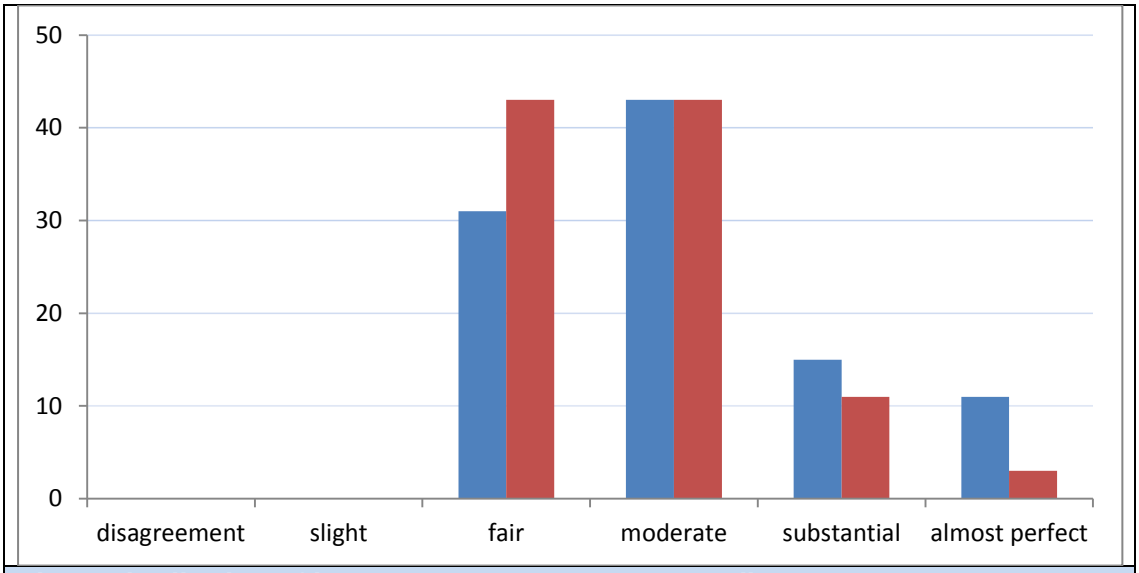

Fig 1: Distribution of kappa scores across case studies.

Treatment Need Analysis: User qualifications

The Treatment Need Matrix is designed to support staff to identify the criminogenic needs of offenders with ID and PD and thus is intended to be both user friendly and amenable to a wide range of professional staff members.

However, as with all assessments that use empirical research in order to guide structured clinical judgement some caution is required to ensure that judgements are accurate and subsequently inform clinical decision making. There was some evidence, though not statistically significant, that those receiving training produced a TNM profile closer to the expert profile on the second case study that they scored, regardless of which case study was actually scored second. It is therefore recommended that all users complete training in the administration of the TNM which provides an overview of the research, item definitions and the opportunity to score a number of case studies.

Professionals who have received training in the use of similar assessment tools (in particular the SARN/SRA) would not require this training but would nevertheless be advised to familiarise themselves with the item definitions and scoring practices prior to use within a clinical setting. New users of the tool are also advised to complete five cases with colleagues in order to promote inter-rater reliability.

Treatment Need Analysis: Scoring Procedure

Scoring items draws on Structured Clinical Judgement methodology that is apparent in a number of established risk and need assessment tools, including the PCL-R, HCR-20, SVR-20 and ID specific assessments such as the ARMIDILO, in which clinicians gather evidence to establish the relevance of any one item to a particular individual.

The Treatment Need Matrix classifies needs in a manner adopted from the Structured Risk Assessment for sex offenders (developed by David Thornton and adopted with permission), which allows for a more holistic exploration of needs by considering each item in relation to general lifestyle functioning as well as the offence chain. Two variables are therefore considered when establishing primary treatment targets:

- Generality: has the need been a general and persistent feature of this individuals functioning.
- Centrality: has the need played a central role in the sequence of decisions that lead to at least one offence committed by the individual.

Major Treatment Needs are those long-term vulnerabilities that show both generality and centrality.

Reliability studies highlighted the importance of applying the definition and the strict criteria for scoring generality and offence chain. Most scoring errors during the reliability studies were due to raters failing to apply these criteria or misrepresenting the definition.

Coding generality

Generality refers to the factor being a general and persistent feature of the offender's life. Note that this means that the factor does NOT need to be apparent in his current behavior. However, for a factor to be rated as Strongly Characteristic there must be evidence of its having been expressed either in his last five years in the community or during his subsequent time in institutions.

Assessors should distinguish between circumstances where they have insufficient information to assess a long term vulnerability and circumstances where the evidence indicates that the factor is not applicable. In the latter case a 0 should be scored while in the former they should record "unable to score".

Strongly characteristic (2)	The factor shows generality over **time** and **context**. Generality over Time requires that the factor is expressed in incidents more than 6 months apart (The risk factor does not have to be evidenced constantly, but incidents should be spread over a period of greater than six months). Generality over Context requires the factor being expressed in at least two non-offending contexts or being central to two or more offences plus one non offending context. Contexts include interactions with parents, with romantic partners, social, and work situations. Psychometric evidence of a risk factor also indicates generality.
Present but not strongly characteristic (1)	There is positive evidence of the factor being present, but only over a narrow time period (less than 6 months) or in narrow circumstances (e.g. one relationship). It is also important to consider whether the circumstance(s) in which the risk factor has been observed are contexts which would be unlikely to occur again after release (e.g. was the risk factor only observable with a specific person who is now estranged from the offender?). If a risk factor is evidenced in offences against 2 victims, and not in non-offending contexts, then you can score 1.
Not present (0)	There is no evidence for this factor being generally present, or the client typically manifests opposite characteristics, or minor and uncertain evidence of the factor is outweighed by clear evidence of opposite functioning. If a risk factor is only evidenced in offences against one victim, and not in any non-offending context, then you should score 0.

Coding the offence chain:

The offence chain refers to the sequence of decisions that led to an offence. These offence-chains are usefully characterised as each decision involving a situation, thoughts that occurred in that situation, and the resulting feelings and behaviors. In considering centrality you should consider both features of the currently prevailing lifestyle that made the offence-chain more likely to start and elements that occurred during the chain itself. The crucial issue for scoring is not just *presence* of the factor in the chain, but the *centrality* of the factor in the commission of the offence. If the client has committed more than one offence, consider all and any chains in scoring.

Not present	No evidence that the factor played any part in any of the offence-chains.
Present but not central to offence	The factor played a role in at least one offence chain; if the factor had not been present, the offence would have been less likely.
Central to offence	The factor played a major role in at least one offence chain; if the factor had been absent the offence would probably not have happened.

Given that a considerable proportion of men detained in forensic learning disability services have been incarcerated for some time, their ability to manage situations (including thoughts and feelings) that resemble those present in the offence chain should also be taken into consideration. In other

words, offence paralleling behaviours will need to be considered and a formulation of offence parallel behaviours will therefore need to be developed.

Information to guide scoring (in both areas) can be derived from interviewing the offender, file information, offence-accounts, treatment reports, police reports, victim statements etc. Psychometric tests administered as part of the pre and post treatment assessment battery can also appropriately be considered. Additional information from collateral contacts (people who know the offender) can be sought (as is recommended for ID offenders, Clare & Murphy 1988).

It is important when scoring to consider the opinions of the whole staff team and not locate the identification of needs/risks in specific professional groups. It is recommended that scoring is therefore completed within a team discussion where differences of opinion between team members can be explored.

Item Definitions

Offence supportive attitudes and beliefs

A:1	**Antisocial (offence supportive) and anti-authoritarian values, attitudes and fantasies**
Definition	A relatively stable pattern of pro-criminal, antisocial and negative attitudes and beliefs towards other people, rules, values, social agencies and institutions, the law and other authorities. These values may be generalised to support an antisocial lifestyle or they can be specific to one particular type of offence (for example child abuse supportive beliefs).

Generality
To determine the generality of this item it is important to consider how an individual's attitude and value system operates across a range of domains; relationships, employment/school and institutional behaviour. Persistent rule breaking and a clear lack of respect for authority across these domains would indicate a highly characteristic feature for the individual concerned. People with a strong antisocial value system are likely to have an extensive criminal record and engage in a variety of crimes. They are likely to hold a view that "crime pays" and may demonstrate some pride in their criminality. However, their values will also be evident in non-criminal ways, for example persistent breaking of rules at work/school, failing to follow direction or supervisory conditions within institutions. For a strongly characteristic rating there also needs to be evidence that such values are persistent and have therefore been apparent for a minimum of six months.

Offence chain
Antisocial values can be evident in an offence chain in a number of ways. They may be a central feature in the planning of an offence or in creating an opportunity to offend. Pro-criminal/offence values are likely to be a driving feature of offences to be considered highly characteristic. Examples are likely to be evident in offence accounts in the form of statements that give permission for the subsequent behaviour. Similarly, they are likely to be evident following a crime and enable the individual to justify their behaviour in a variety of ways.

Psychometric evidence
High scores on the Power Orientation of the PICTS indicate poor social conformity and a need to obtain control an authority over others.
High scores on the antisocial PD scale of the IPDE screening assessment.
PCL-R criminal versatility
EPS – BRS non-compliance
HCR -20 Negative attitudes

A:2	Criminal Peer Group
Definition	A criminal peer group is defined as a primary group (friends or family) who the individual chooses to spend time with, and who advocate criminal activity (in a manner similar to that described in the previous item). Within institutional settings, where opportunities to engage in friendships groups are compromised, a criminal peer group can still be apparent in the particular associations that an individual chooses to sustain.

Generality
Generality over time and context are particularly important for an individual to be rated as *highly characteristic*. Generality over context may be difficult to assess for people with ID and assessors may need to consider their peer group within their current residential setting in addition to any evidence of peer associations in the community. Negative relationships with staff members may also be indicative of a desire for pro-criminal relationships. It is also important when considering generality to explore family relationships and whether the individual has a family who are generally associated with crime.

Offence chain
Evidence for the relevance of criminal peers in the offence chain is most likely to be found in the account of the offence or official records. Offenders who commit crimes within a group or with a co-accused are likely to score highly on this item, though with co-accused it would be important to determine which party was most dominant and influential. Evidence can also be found for people who commit offences alone but do so to achieve some social standing or recognition with others. Individual who repeatedly commit offences alone would not score on this item.

Psychometric evidence
HCR – 20: lack of personal support. (Although primarily concerned with the availability of positive supportive relationships it may also be appropriate to consider exposure to social relationships that are pro-criminal as a risk management item and a potential destabilising influence).

A:3	Denial or minimization of responsibility
Definition	Denial and minimisation refers to a range of processes that a person may engage in to reduce the level of responsibility that they accept for their behaviour. Usually apparent in the form of statements used to describe the factors that contributed to the offence, an individual may suggest that they were not fully responsible for a number of reasons, including alcohol or drug intoxication and provocation. Statements that imply someone other than the offender is responsible are also examples of this item (she didn't say no), along with comments that fail to acknowledge the impact the offence may have had (they will get over it, the insurance will pay). Palliative comparisons (eg "I'm not as bad as...") are another example of minimisation along with claims of a "false consensus" (anyone would have done the same).

Generality
For evidence of generality assessors need to consider the individuals habitual patterns when challenged about their behaviour. Individuals who demonstrate high levels of generality are likely to discuss events in their life in a passive manner, suggesting that other people were responsible for those events. Where they do accept responsibility they may qualify this with various statements that limit the true extent of that responsibility. A pattern of denial and minimisation is also likely to be evident in a range of contexts, including work/education, personal relationships and leisure. For individuals with ID their circumstances and living arrangements will need to be taken into consideration. They may talk about the breakdown of residential placements as being out of their control, may describe difficult relationships with staff whilst blaming staff.

Offence chain
Within the offence chain denial, justification, rationalisation or minimisation may be evident before or after the offence, or both. An individual's offence analysis may reveal exposure to high risk situations that they dismiss as chance or bad luck. They may have actively engaged in encouraging self-talk (e.g. it won't hurt, they want me to really) or may have made numerous excuses for their actions (she didn't say no, I didn't use force, they were looking at me in a funny way, I didn't really punch him).

Psychometric evidence
High scores on various sub-scales of the PICTS; Superoptimism (a denial of the harm of offending behaviour for oneself) and Mollification (a tendency to externalise blame and make excuses for ones behaviour).

A:4	Misreads situations/others behaviour
Definition	The misrepresentation or misunderstanding of situations or other people's behaviour is the central component of this item. An individual may misrepresent a situation as a consequence of their experiences and therefore react in a manner that seems excessive or out of context (for example hostile or suspicious attributions). Alternatively, misunderstandings may result from lack of knowledge or experience. If misrepresentation appears to be a deliberate and conscious act then that is more reflective of the previous item (rationalisation of offending), for example when an individual chooses to interpret someone's behaviour in a manner that justifies their reaction to them (for example child sex offenders seeing a child's behaviour as being sexually provocative).

Generality

Generality will be evidenced by a long term tendency to mis-represent the intentions and actions of others in a number of differing contexts and with a wide range of people. The individual may be known for taking things personally over-reacting to seemingly neutral comments. Alternatively, an individual may be known sexualising situations, failing to notice peoples anxiety/distress and consequently responding inappropriately. A hostile belief system would be evident in a number of relationships and would be a characteristic pattern over time. The beliefs will be evident in a range of relationships and within different contexts (e.g. work, peer, leisure, intimate). The individual is likely to see other people as deliberately antagonistic and may personalise seemingly innocuous interactions. A persistent but exclusive pattern of hostility would not qualify as a general feature of an individual's lifestyle. If the hostile belief structure is only evident in relationships with authority figures then this should be scored under anti-authoritarian values.

Offence chain

An analysis of the offence will reveal the salience of hostile beliefs in the offence chain. For violent offenders it is helpful to examine a number of episodes of violence in order to see whether hostile attributions and a mistrust of other people is a recurring feature. Institutional violence should also be considered. An offence analysis would need to reveal clear misrepresentation of others people's behaviour or intentions for this item to be considered strongly characteristic. Furthermore, these attribution errors would need to be significant factors in the commission of the offence. For sex offenders such attributions are likely to sexualise the victim's behaviour or imply consent to sexual activity. For violent offenders, attributions are likely to justify violence by implying impending hostility or threats.

Psychometric evidence

High scores on the IPDE paranoid sub-scale would suggest an individual holds suspicious and mistrustful beliefs about others.

Prominent mistrust/abuse schema as measured by the Young Schema Questionnaire.

CIRCLE hostility sub-scale

PICTS interpersonal hostility

A:5	Deviant sexual preferences.
Definition	Sexual deviancy is defined as sexual arousal to non-consensual sexual activity involving either adults or children. As measurement of sexual deviancy is problematic within the ID population, preference may be inferred from behaviours. Offender who sexually abuse children can be assumed to have at least some degree of preference (or at least arousal) towards children. For men who offend against other adults a preference for violence will be apparent from the excessive use of violence during an assault. A preference for coercion will need to be considered carefully and not confused with the use of force to enable the offence to occur (i.e. coercion as an instrumental factor in the offence rather than as a component of the sexual preference).

Generality
Sexual deviancy is measured by the enduring presence of sexual arousal to children or forced sexual activity with adults. As with all generality codes, the preference will need to be apparent over time (minimum six months) and be apparent on a number of occasions. Some caution is required when determine the strength of generality as there is some evidence that offenders with ID tend to offend against a broader range of victim types in comparison to non-ID sex offenders.

Offence chain
Sexual preoccupation may show as repeated sexualization of other people's behaviors. The offender appeared to be seeking evidence for a sexual component to his interactions. He is likely to feels he "has to have sex" and his thinking was dominated by sexual thoughts (and circumstances did not cause any distraction). Sexual preoccupation is also indicated in the chain by the number of sexual acts that he perpetrated during the offence, such as raping more than once, varying the sexual act or raping more than one person in a short period of time. Sexual deviancy is coded in the offence chain if any non consensual activity took place with an adult where it is clear that the man was not misunderstanding the social cues in the situation. Given the evidence that men with ID offend against a broad range of victims, any sexual activity with a child would be coded as strongly present. Excessive violence during an offence is likely to indicate a sexual preference for violence and would also be coded as strongly present.

Item Definitions

Relationship/interpersonal skills

B:1	Poor Conflict Resolution
Definition	Poor conflict resolution refers to an individual's inability to manage disagreements or arguments in a manner that attempts to lead to resolution. Poor conflict resolution may be evident in a number of ways; an individual may resort to an aggressive approach to close down disagreements by inducing fear, may seek to pacify another party rather than asserting oneself or may avoid conflicts altogether.

Generality
The VRS identifies interpersonal aggression as a dynamic factor associated with risk of violent recidivism. For a maximum rating the individual is expected to habitually display an aggressive interpersonal style which may include violence to property but not necessarily violence to others. The individual is likely to use threatening and abusive language when experiencing interpersonal conflict and generally use strategies that are more likely to inflame the situation rather than achieve a successful resolution.
A passive approach is likely to be manifest by a tendency to acquiesce to the demands and opinions of others or avoidance of people with whom there has been conflict. Whichever style is adopted it will be evident in a range of settings and with a range of other people. Individuals who adopt an aggressive approach but only with certain people (e.g. those in authority) should not be scored in this item.

Offence chain
Where anger is identified as a factor in the adoption of an aggressive approach to conflict resolution it is important that the assessor determines the source of the anger. If the individual becomes angry as a result of hostile interpretations of others behaviour, or reacts to a difference in opinion because it is a threat to narcissism and entitlement then the individual should be scored in the appropriate risk item rather than here.

Psychometric evidence
High scores on the Cognitive Indolence scale of the PICTS suggest poor critical reasoning skills and poor problem solving.
EPS verbal and physical aggression
CIRCLE dominant and hostile sub-scales

B:2	Relationship instability
Definition	Relationship instability is concerned with the ability of an individual to develop and sustain relationships that can be a source of support. However, some caution is necessary when assessing offenders with ID due to their often limited ability to engage in intimate relationships. A broader consideration of family and peer relationships is therefore required.

Generality
On the basis of the recommendations for offenders with ID, generality should include a consideration of an individual's pervasive relationship style. Frequent short-term sexual relationships would be evidence of relationship instability, as would evidence of conflicted family relationships. In addition, however, frequent episodes of conflict with peers in institutional settings, which may be interspersed with attempts to repair relationships, would also be evidence of generality. Similarly, volatile relationships with staff members would also constitute evidence. To score as highly characteristic these disturbances in relationships should be evident in a number of contexts (e.g. family, intimate, peers, staff) and across a time span.

Offence chain
Relationship instability may be evident in the offence chain whether directly or indirectly. An argument or the ending of a relationship may precipitate an offence directly against the other person, whether violent or sexual. Similarly, a disagreement may lead to damage of another person's property or theft of property. Indirectly, relationship instability may contribute to an offence chain as a precursor to the offence. An individual may engage in criminal behaviour following the breakdown of a relationship in an attempt to self-soothe.

Psychometric evidence
PICTS power orientation
IPDE borderline personality disorder

B:3	Entitlement
Definition	The SRA identifies an excessive sense of entitlement as comprising four components: • The belief that "my needs are more important than other people's rights"; • A sense of owning other people; • A sense that he is special and so entitled to special treatment • An inflated sense of what he is entitled to relative to other's expectations.

Generality
The SRA provides explicit guidelines for determining the generality of entitlement. Evidence of generality could come from any setting in which his desires can come into conflict with other people's sense of the limits to what he is entitled to. An excessive sense of entitlement is then displayed (a) by his giving priority to his desires over other people's sense of the limits to what he is entitled to (b) his showing some sense of outrage when other people seek to limit his getting what he wants on the basis of their sense of the limits of what he is entitled to.

This entitled behavior pattern might be displayed in the commission of a range of offences, in his disregarding rules, in his disregarding other's expressed wishes, in his disregarding other's attempts to set limits for him. Equally where his ability to do what he wants has been restrained by others, an excessive sense of entitlement may be displayed by expressions of outrage or anger, a reluctance to accept the legitimacy of the constraint placed on him.

Offence chain
Thornton suggests that Entitlement beliefs can contribute to offending in a number of ways. Put most generally, it makes it easier for the offender to give himself permission to offend since he specifically feels he is entitled to. Additionally it may activate other risk factors as a consequence of the individual's sense of grandiosity and entitlement is thwarted.

Psychometric evidence
PCL-R - grandiosity
PICTS entitlement sub-scale

B:4	Impression management
Definition	The central feature of this item is concerned with an attempt to exert influence over others in order to achieve personal gain and often with little regard to the impact on other parties. The nature of this may, however, vary considerably. On the one hand, an individual may attempt to portray himself in a positive manner and therefore create an impression on the mind of others that he is reliable, honest and trustworthy. On the other hand, strategies may be more coercive and involve direct threats and intimidation. Strong counter evidence encapsulated by the phrase "what you see is what you get", where an individual is transparent and open about their activities and motives.

Generality
A manipulative interpersonal style will be a core component of an individual's interpersonal interactions. Their relationships will be characterised by a disregard for the feelings of others. In a non-offending context the individual is likely to lie to others and cheat in order to secure personal gain. The individual may have a reputation as a conman and may have a history of deception and fraudulent activity. Relationships will typically seem to offer little to other people and once a person has got what they wanted they may move on to another relationship. For men who are incarcerated relationships with staff are just as likely to include this interpersonal style, though the individual is more likely to use manipulation with authority figures in order to present himself in a positive manner. However, it is also equally likely that an individual may attempt to manipulate different members of staff in different ways, thus causing a split amongst a team.

Offence chain
Within the offence chain manipulation is likely to have been a central part of the planning process, either of the victim or of others who may have provided some protection for the victim. Within an institutional context an individual may presents themselves to staff members in a particular manner while other patients describe the person in a highly contrasting manner.
The SRA notes that setting up offences by using interpersonal manipulation should be distinguished from using force or the immediate threat of force to create the opportunity to offend, and from opportunistic offenses.
Manipulation or impression management may also be apparent in an offence chain if an individual's attempts to manipulate are exposed or thwarted and they respond to this with criminal activity.

Psychometric evidence
PCL-R – conning and manipulative
CIRCLE
EPS – SRI positive impression scale

Item Definitions | Self management, coping and problem solving

C:1	Difficulties achieving goals
Definition	This item is concerned with an individual's ability to pursue and satisfy pro-social goals. An individual will need to be able to demonstrate the ability to identify a goal and the stages required to achieve that goal consistently in order to be considered to be uncharacteristic in relation to this item. Goals may be in relation to educational programmes, offending behaviour work, financial management as well as shorter term targets. Alternatively, however, some offenders may demonstrate an ability to pursue goals but their goals have an antisocial component, either in terms of the outcome or in terms of the methods used to obtain an outcome. Such goals would be considered to demonstrate a high level of need in relation to this item.

Generality
The PCL-R describes this item as being characterised by an individual who seems unable or unwilling to both develop and pursue plans. The person is likely to live day by day and may demonstrate frequent and marked changes in plans and aspirations. Research using the DRAMS may indicate that poor compliance with medication is indicative of difficulties achieving goals. A score of two needs evidence of habitual difficulties with satisfactory problem solving over time and across contexts. An individual who has a history of starting but not completing a range of tasks over a sustained period of time and across contexts would be considered to show generality. Individuals who repeatedly generate anti-social goals and demonstrate the ability to pursue these would also be considered to display generality.

Offence chain
Poor goal attainment may be evident in the offence chain in two ways. First, an individual may demonstrate poor adherence to relapse prevention strategies. A key factor in such an offence would be that the individual elected to behave in a manner that jeopardised their abstinence from crime rather than reacting impulsively or due to a lack of insight. Second, some individuals may identify goals that have an antisocial focus, the problem here being their goal selection rather than goal attainment.

Psychometric evidence
PICTS cut off scale
PCL-R tem 15/PCL-SV lacks goals

HCR-20 employment item

C:2	Poor problem solving
Definition	Problem solving has been defined as comprising a number of stages: problem identification, problem specification, goal setting and solution generation. When assessing this item difficulties may be present in one of more of these stages, the emphasis being on the inability to ultimately solve the problem in a pro-social manner. In addition, some individuals may be adept at problem solving, but elect to utilise antisocial methods.

Generality
Examine multiple areas of the offender life for examples of him responding to stress/problems with poorly chosen strategies that are self-defeating immediately or in the longer term. To meet criteria for generality this problem-solving deficit will need to be apparent in multiple settings and persistent over time. The fact that an individual has repeatedly been punished for offending is NOT sufficient to attribute poor problem-solving. Individuals who are unable to identify the relapse signatures in relation to their mental health, where their mental health is a feature of their offending behaviour, would also be considered to have poor problem-solving if they repeatedly fail to recognize a deterioration in their mental health.

Offence chain
Look in the chain for presence of problems to which the offender responded with a poorly chosen or unsuitable strategy. Examples would include dealing with emotional problems by getting drunk, dealing with relationship stress by looking for a sexual encounter, dealing with work stress by taking it out on partner, etc. look for examples of avoidance or emotional coping instead of problem-focused coping.

Psychometric evidence
Social problem solving inventory

C:3	Impulsivity
Definition	Impulsivity is defined in a similar manner to that employed in the PCL-R. A person who is impulsive acts with little regard for the potential consequences of their actions and fails to consider the advantages or disadvantages of a particular course of action. Alternatively, he may be aware of the consequences but dismisses them and behaves recklessly. Such a person is known for acting "on the spur of the moment" Impulsivity as defined here is not concerned with impulsive acts driven by high levels of emotional arousal; rather this would be considered under poor emotional regulation (D:1) or poor anger control (D:2). Pre-mediation and planning in the offence chain are illustrations of strong counter evidence.

Generality
For a strongly characteristic rating an individual will need to display impulsivity in a range of settings and not solely in relation to offending behaviour. In the PCL-R item description it is noted that pervasive impulsivity may be seen in relationships, employment, sudden changes in plans and in accommodation. Assessors should identify evidence of impulsivity in two or more of these contexts for the higher rating.

Offence chain
The SRA notes that impulsivity can be related to the offence chain by bringing offenders into high risk situations; the tendency to dismiss negative consequences of one's actions and decisions inhibits an individual from careful consideration of their behaviour. Sex offenders who demonstrate impulsivity in their offence chain are likely to follow the approach-automatic pathway.

Psychometric evidence
PCL-R impulsivity item
YSQ insufficient self-control
EPS – SRI impulse control
EPS – BRS hyperactivity

C:4	Addictive behaviour
Definition	A pattern of substance use that is causing damage to health. The damage may be physical or psychological. A dependency, as characterised by a strong desire to take the drug (or alcohol), difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. Similar addiction to gambling, where financial resources are stretched or obtained illegally would be counted in this item.

Generality
For a strongly characteristic rating an individual would need to show long-term substance misuse problems that are likely to have interfered with daily functioning. A single episode of drug addiction where the individual engaged and responded to treatment would not qualify for a strongly characteristic rating. However, numerous episodes of short-term drug use and relapse would qualify the individual.

Offence chain
Evidence for the role of substance misuse on the offence chain will come from a detailed analysis of the individuals offending history. Substance misuse may be related to the offence chain in one of two ways. First, the individual may engage in acquisitive offences in order to obtain the resources to satisfy a drug or alcohol habit. Second, the person may commit offences whilst under the influence of drugs or alcohol. In either case, the item should be rated as strongly characteristic if the offence is unlikely to have taken place without the relationship to substance misuse difficulties.

Psychometric evidence

HCR – 20: Substance Use problems
PCL-R Item 3 (need for stimulation), clarify content to establish whether drugs used to generate stimulation and ameliorate boredom.

Item Definitions

Emotional management and functioning

D1	Poor emotional regulation
Definition	Poor emotional regulation is concerned with the ability of the individual to tolerate and contain high levels of a range of emotions. Although generally associated with anxiety or depression, poor control of positive emotions can also lead to regulatory problems.

Generality
Poor emotional regulation will be scored as highly characteristic if it is characteristic over both time and emotional context. As the item refers to a general inability to self-regulate it should be evident in relation to two or more emotions. As the next item refers to anger regulation specifically, anger is only used as evidence to support scoring of this item if there is clear evidence for one emotion (e.g. anxiety) and partial evidence for a second emotion. Anger can then be used as supplementary evidence. If impaired emotional regulation is apparent for only one emotion other than anger then the item should be scored as partially characteristic.
Frequent episodes of self-harm and brief episodes of depression are likely to be indicative of generality. The person is likely to demonstrate rapid and marked shifts in mood. He may present as settled and content at one moment and then angry/upset the next, and there may seem to be little apparent reason for the change. Emotional outbursts may be short lived.

Offence chain
As with the generality rating, the concern within the offence chain is with an individual's general inability to regulate a range of emotions other than anger. For this item to be considered highly characteristic of the offence chain there would need to be evidence that the individual experienced an intense emotion in the build up to the offence. This emotion may have contributed directly to the offence or the individual may have taken action to manage the emotion that led them into high-risk situations.

Psychometric evidence
IPDE borderline PD sub-scale
PCL-R poor behavioural controls
EPS internalising/externalising scale

D:2	Volatile behaviour/poor anger control
Definition	This item is concerned specifically with an individual's ability to regulate their anger and manage their behaviour accordingly. A person who experiences difficulty with this item will be known as short tempered, likely to fly off the handle and has a reputation for engaging in a variety of inappropriate behaviours when angry (verbal and physical aggression, property destruction etc).

Generality
Poor anger control and volatile behaviour is considered strongly characteristic of an offender if it has been a feature of their life over a number of years and has been apparent within a range of living environments. The individual is likely to be known as short-tempered and hot headed. They may often over react to situations. It is important to recognise that violence is not the only indicator of volatile behaviour and such things as swearing at others, storming off, property damage and self-harm may all be the result of poor anger control. However, both features of the item are necessary, i.e. poor anger control and inappropriate behaviour.

Offence chain
Thornton describes poor anger control (in the context of poor emotional control) in the offence chain as "Poor control over emotions may also play a central role in overly (gratuitously) violent acts or unnecessarily coercive strategies during offending through these behaviors can also be explained by sadistic interest (sexual interests domain). Often acting out of poor emotional control produces behaviors which are grossly beyond what was required to secure the victim's submission."

Psychometric evidence
STAXI trait anger scores
EPS – BRS verbal and psychical aggression
IPDE antisocial PD scale

D:3	Rumination over perceived injustices/grievant thinking
Definition	Grievance thinking is defined by difficulty seeing other people's point of view, believing that others have wronged you and are likely to do so again, angry rumination over past wrongs, suspiciousness of others, a sense of having a grievance against the world and others, and vengefulness. The key issues seem to be angry rumination, vengefulness and poor perspective taking in the sense of denying the legitimacy of other people's point of view. It is important to look for the cognitive content of grievance, the process of rumination, and difficulty accepting other people's point of view, rather than just the presence of anger.

Generality
Look for Grievance thinking being displayed in multiple contexts and over time. Evidence of this should be fairly easy to elicit either through records that display behavior that appears to be based on a sense of grievance or, more compellingly, by asking the offender to recount what happened to him over a period of time in the context you are investigating. Offenders who are markedly prone to grievance thinking will typically find it hard not to express this when talking about how they have been treated. Sometimes, however, you may have individuals who are very controlled and polite in their routine interactions but who occasionally have outbursts that indicate that they must have been covertly ruminating about the topic for an extended period of time.

Coping logs or processing of current events in treatment groups can be valuable sources of information in assessing the generality of Grievance Thinking.

Offence chain

Grievance can be seen in the offence chain in a number of ways. The offender may have:

- Offended or engaged in offence-related fantasy as a way of gratifying his need for revenge;
- Expressed, through the offence, his grievances against people in the past who he believes injured him.
- Over-reacted to a minor provocation because he broods so much on injustice;
- Alienated others because of his suspicion and belligerence and this separation from others may have contributed to his offending.

Psychometric evidence
IPDE: paranoid PD sub-scale (clarify which items endorsed)

D:4	Perspective taking/empathy
Definition	This item is concerned with both the ability of the individual to appreciate the perspective of another person, and their ability to generate an appropriate emotional response to the experience of that person. For some offenders it is possible that they will have the ability to recognise another person's emotional state but may be indifferent to that person and/or experience some degree of satisfaction or pleasure from another person's distress. Difficulties with either component of the item are sufficient to score the item. However, given the focus on treatment it is important that raters distinguish where the difficulty of the individual lies.

Generality
Evidence of generality of empathy and perspective-taking deficits would need to be seen as a pervasive feature of an individual's inter-personal functioning. For this item to be considered strongly characteristic the individual is likely to be known as somewhat selfish and self-centred. They are unlikely to show consideration for others and may appear to be unconcerned by the impact their behaviour has on others. Within an institutional context such individuals may regularly fail to complete tasks that are shared out within the residential setting (for example cleaning jobs). Similarly, it is likely that fellow residents will complain about them behaving in antisocial manner by playing music too loud, talking when others are trying to watch television etc.

Offence chain
Within the offence chain a lack of empathy and perspective taking is likely to be evidenced by a disregard for the emotional state of the victim. Sex offenders may continue to use threats despite their victim displaying obvious compliance and distress. Acquisitive offenders may dismissive that their robberies may cause distress and make references to the wealth of their victims or insurance claims.

Psychometric evidence
PCL-R items empathy

Individual Items | Item Definitions

While the items in the TNM have been degenerated from a systematic literature, it is inevitable that individuals will have their own idiosyncratic needs. The TNM includes a fifth domain that allows clinicians to record areas of need, areas of risk and potentially protective factors in order to support individual offenders in their treatment and rehabilitation.

Although the items recorded in this domain are individualised, it is nevertheless important for teams working with individuals to establish a clear working definition of the item that they are recording, For some of these items they may be defined on the basis of formal measures or diagnoses (eg psychotic illnesses, depression as measured by he Beck Depression Inventory etc), but the relevance of these to the persons vulnerability to risk and reoffending should nevertheless be clear,

A: Antisocial Beliefs, Attitudes and Values (Offence Supportive Beliefs & Fantasies)			
Risk Factors	**Evidence**	**Counter Evidence**	**Rating**
Anti-social/anti-authoritarian values and attitudes			0 1 2 (G) 0 1 2 (O)
Criminal peer group			0 1 2 (G) 0 1 2 (O)
Denial or minimisation of responsibility			0 1 2 (G) 0 1 2 (O)
Misreads situations / other's behaviour			0 1 2 (G) 0 1 2 (O)
Sexual deviancy and preoccupation			0 1 2 (G) 0 1 2 (O)

B: Interpersonal Relating / Relationship Skill Deficits Management and Functioning			
Risk Factors	**Evidence**	**Counter Evidence**	**Rating**
Poor conflict resolution			0 1 2 (G) 0 1 2 (O)
Relationship instability			0 1 2 (G) 0 1 2 (O)
Entitlement			0 1 2 (G) 0 1 2 (O)
Interpersonal manipulation			0 1 2 (G) 0 1 2 (O)

C: Deficits in Self-Management Coping and Problem Solving			
Risk Factor/Need	**Evidence**	**Counter Evidence**	**Rating**
Difficulties achieving goals			0 1 2 (G) 0 1 2 (O)
Poor problem solving			0 1 2 (G) 0 1 2 (O)
Impulsivity			0 1 2 (G) 0 1 2 (O)
Addictive behaviour			0 1 2 (G) 0 1 2 (O)

D: Emotional Management and Functioning			
Risk Factor/Need	**Evidence**	**Counter Evidence**	**Rating**
Poor emotional regulation			0 1 2 (G) 0 1 2 (O)
Volatile behaviour / poor anger control			0 1 2 (G) 0 1 2 (O)
Rumination over perceived injustices/ grievant thinking			0 1 2 (G) 0 1 2 (O)
Perspective taking/empathy			0 1 2 (G) 0 1 2 (O)

E: Individual specific needs			
Risk Factor/Need	**Evidence**	**Counter Evidence**	**Rating**
			0 1 2 (G) 0 1 2 (O)
			0 1 2 (G) 0 1 2 (O)
			0 1 2 (G) 0 1 2 (O)
			0 1 2 (G) 0 1 2 (O)
			0 1 2 (G) 0 1 2 (O)

Summary of Treatment Needs	
Primary Treatment Needs	**Secondary Treatment Needs**

Community Care Plan	
Priority Treatment Needs	**Strategy to Meet Needs**

Date	**EPS - BRS**																
	TBD	VA	PA	SM	NC	HY	DS	AX	SC	WD	SE	EB	IB				
Date	**EPS - SRI**																
	PI	TD	IC	AX	DP	SE	TP										
Date	**PICTS**																
	CF	DF	MO	CO	EN	PO	SE	SO	CI	DC	CC	HC	PA	IH	SA	DH	FC

Date	**YSQ**																
	Ed	AB	MA	SI	DF	FA	DP	VU	EM	EN	IS	SU	SS	EI	US		
Date	**CIRCLE/PROQ3**																
Date	**PCL-SV**																
	SU	GR	DE	RE	EM	RE	IM	BE	LG	IR	AB	AD					

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APPENDIX TWO
TRAINING CASES

Mr M

Mr. M is a 32 year old man serving a life sentence for murder with a minimum tariff of 18 years. He remained a cat A prisoner for the first six years of his sentence due to persistent assaults on staff and other prisoners. He has numerous adjudications dating back to this time and also spent long periods of time in segregation units. He had three adjudications for brewing hooch during the first two years of his sentence but has had none since. He was reclassified as a cat B prisoner two years prior to coming to the TC.

History

Family

Mr M. is the second child of Mr M (sen) and Ms W. His parents separated prior to his first birthday and Mr M lived with his father, while his older sister lived with his mother. Ms W. reported to social services that she had been the victim of domestic violence, though Mr. M (sen) strongly denied this claim and Mr. M has since reported that while he recalls arguments following the separation of his parents, he does not remember witnessing any violence between them. Social service reports indicate that there were numerous concerns throughout Mr M's childhood in relation to his general welfare and his name was entered on the at risk register on three separate occasions during his pre-teen years. Mr. M (sen) is reported to have been highly critical of his son and relied on punitive and possible physical methods of discipline.

Mr M. (sen) had a number of convictions, primarily for acquisitive offences and fraud, though did receive a short custodial sentence for ABH when Mr M was 12. During this time Mr M went to live with his mother and older sister and

seemed to struggle to accommodate into the family home (despite having had regular contact with both throughout his childhood). Ms W twice approached social services to place Mr. M in care (within a six month period), citing his defiance and threatening behavior as her primary concern. Whilst social services provided support to the family, Mr M was not accommodated despite making numerous allegations that his mother would hit him and was regularly abusing alcohol.

Education

Mr M had an uneventful infant school career but began to have difficulties after his move to junior school. His year three school report highlighted some emerging behavioural difficulties. By the end of year six Mr M reports that he had been suspended from school on a number of occasions for bullying other children and a number of fights. He spent a period of time in an exclusion unit towards the end of year six.

Mr. M's secondary school career showed a steady deterioration. He was excluded prior to the end of his first year after hospitalsing another student. After moving to an alternative school at the beginning of year eight Mr M was again excluded, this time for being "sexually aggressive" to a female student in the year below. Mr M says that he does not recall the details of this incident but believes he had asked her out and she had turned him down.

Employment

Appears to have had difficulty maintaining a stable period of employment and describes a large number of different jobs. Official records indicate that Mr M has never paid income tax and has received benefits throughout his adult life. Periods of employment that he has had, have run in parallel to ongoing benefit claims.

Indicated in his assessment pack that he has used the injuries to his arm to falsify disability allowance claims.

Relationships

Mr. M reports having had a number of transient sexual partners. He claims to have had two more enduring relationships, one of which resulted in his conviction for burglary in 2005 (following the end of the relationship) and the second of which involved his current murder conviction. He claims that the first of these relationships lasted almost a year and the second about 18 months. He claims to have been largely faithful in both cases but did not elaborate on this in his assessment application.

Mr. M has extensive scarring to his left arm caused when he was attempting to build a bomb which exploded. He has been reported to have told a previous cell mate that he was manufacturing the bomb to attack the home of a former employer who had sacked him for stealing.

Whilst a cat A prisoner Mr M was regular described as a loner in lifer reports and his relationships with other prisoners were often considered to be tense. Whilst at HMP F he was attacked by three other inmates and sustained a serious facial injury after being slashed with a manufactured weapon. After refusing to move wings for his own safety Mr M was subsequently adjudicated for attacking one of his assailants. During a cell search while he was in segregation a dairy documenting the attack and plans to extract revenge were found in his cell.

Offending Behaviour

Reports that M had thoughts of wanting to get revenge on P (girlfriend) on the morning of the offence because she woke him at 5:30 am. It also states that he had a grudge against P because he felt she had become pregnant in an “underhand” way and that he had planned and fantasised about killing her then himself previously.

Forensic evidence indicates that Mr M strangled his partner, most likely whilst standing or kneeling over her. The injuries sustained to her throat suggest a very considerable degree of force. There were no signs of resistance, though

injuries to her wrists suggest that her hands had been bound behind her back at the time of her death. Burns marks on her breasts and torso are consistent with cigarette burns, which were made before death. There was evidence of sexual assault and Mr. M's disclosure to the police would suggest that he raped the victim on a number of occasions post mortem.

Mr M has a number of juvenile convictions for criminal damage and theft. He received a custodial sentence at the age of sixteen for assault. Although information is limited, it is understood that Mr M assaulted a friend over a disagreement. Mr M is reported to have hit his friend over the head with a wooden object and kicked him a number of times in the face and upper body.

Mr M received a second custodial sentence for burglary and criminal damage in 2005. Mr M broke into the house of a former girlfriend and stole a number of electrical items. Considerable damage was caused to the house during the break-in including graffiti aimed at his former girlfriend sprayed on the outside of the house.

He has spoken about having been involved in fights regularly during his youth and has suggested that at the time he doesn't consider violence to be unacceptable. In his application pack he describes living in a hostel where he had problems with a man and "ended up back in jail for GBH" – he commented that he considered the man in question "got what he deserved".

When Mr M has spoken about his offending behavior in the small groups he has suggested that at the time he rarely considers anyone else and tends to believe that he is justified in his actions or that his victims are deserving of the consequences of his behavior.

Community behaviour

Mr M has been resident on the TC for 14 months. During the first few months Mr M presented as hostile and argumentative. He regularly raised issues in

business meeting, demanding that staff pursue various issues for him (property from his previous prison, legal appointments, medical appointments etc) and was usually impatient for a response. His attendance at small groups and community meetings was erratic, though did not result in a “commitment vote” by other residents.

However, since this time his attendance has been exemplary and he has gradually engaged more with the process, tolerating being put on the agenda and beginning to discuss things in his small groups.

M was approached by two residents following a difficult small group so they could offer him support but responded aggressively to this. When asked about this in a community meeting he said that he had not wanted them to see him upset so was aggressive in order to ensure they left him quickly. M also structured his use of group time very clearly and at times presented as uncomfortable being asked questions as it took him away from the topic he had been speaking about. At times he responded in a way which may be perceived as fairly aggressive to some of the questions he was asked particularly when he said that the person asking the question was not being clear. This may be seen as a need to control the group time. This was not the case however when other residents were using the group.

M commented in small groups about having difficulties trusting people and that this will take time for him. He said that although the group were not displaying this he thinks that people were amused by what he was saying. In addition when asked a question he was uncomfortable with by a staff member he said that he felt he was being deceived, conned and that he could not trust her anymore. M felt that the two staff members present smiled at each other when the question was asked and as a result was unwilling to speak further within the group. Following the small group M asked for support but was unwilling to speak to a staff member as he said he was unable to trust any of the staff team and would only speak to a peer support worked who was not available at the time. Further evidence for mistrustful beliefs was observed

when M completed one of the psychometrics and made comments about being “stitched up” with the questionnaire.

M stated in his assessment paperwork that he finds it difficult speaking in small groups when experiencing paranoia and speaking to people he still has “trust issues” with. Furthermore the summary of his discussion with the psychiatrist states that he often feels misunderstood and unsupported. It also says that he described high demands and tests for people in the early stage of learning to trust them.

There is no evidence of current substance misuse. M self reports having stopped using drugs 2 years before coming to prison and there are no records of him having had a positive drug test during this sentence, which supports his claim. He has discussed using a range of substances pior to this sentence including heroin and crack cocaine. He has indicated that he used substances to “escape” and has began to disclose that he was escaping from his feelings of anger, mistrust and worthlessness. He concedes that his drug use had been problematic and that he engaged in some acquisitive offences in order to support his habit.

In small groups M stated that he is unaffected by screaming as he holds a belief that compassion and emotion are weakness as they might prevent you from doing something. He said he would feel weak if he stopped doing something because a person was screaming if he was the one causing the individual to scream and he felt they deserved his actions. In his diary M noted that when he is angry he struggles to hear or think about others which suggests that experiences of limited empathy may be linked to emotional arousal for him. He also commented that he felt compassion towards another resident who spoke in small groups which suggests that he is able to experience empathy towards others in some situations.

placed another resident on the agenda for staring at him and took this as confrontational. The other resident stated that he had not been aware this had occurred. There are possible links between this and an incident in a previous

establishment in which M assaulted another prisoner with boiling water and reportedly claimed this was due to the prisoner having been staring at him

During his time on assessment M has shown a tendency to expect immediate gratification regarding his perceived wants and needs.

Psychometric Summary

Psychological Inventory of Criminal Thinking Styles

High Cutoff (Co) score in addition to a high current criminal thinking score on the PICTS suggests that that M may respond impulsively to situations and may have a self destruct button which may eliminate one of the common deterrents to committing crimes. In other words, he may urge himself on to commit crimes by minimizing the likely consequences for both himself or others. Alternatively he may dismiss any concerns in relation to these consequences (eg "I'm not bothered"). A current criminal thinking score of 67 suggests that M may associate with some anti social values and attitudes.

SCALE	DESCRIPTION
Confusion[a]	High scores indicate psychological distress, mental confusion, poor reading ability, or a deliberate attempt to portray one of the above. Low scores donate a lack of distress, confusion or deception.
Defensiveness[a]	High scores indicate a defensive test taking style, where an attempt is being made to conceal minor difficulties or deficiencies. Low scores indicate a willingness to acknowledge the existence of any limitations.
Mollification	High scores reflect a tendency to externalise blame for the consequences of offending and offer rationalisations and excuses for committing crimes. Low scores reflect a greater willingness to take responsibility for ones behaviour.
Cut-off	High scores indicate a low frustration tolerance and a tendency to remove deterrents to criminal behaviour with drugs, mental impairment or short phrases (e.g. "fuck it"). Low scores denote good emotional coping skills.
Entitlement	High scores reflect an attitude of privilege or ownership, often including a tendency to misidentify wants as needs. Low scores reflect a consideration of others perspectives and an ability to discriminate between wants and needs.
Power Orientation	High scores indicate a need to achieve a sense of control and authority over others. Low scores reflect social conformity.
Sentimentality	High scores denote a belief that one is a "good person", despite the destructive consequences caused by involvement in criminal behaviour. Low scores indicate a more realistic view of the impact of ones criminal behaviour on other people.

Superoptimism	High scores indicate a belief that the negative consequences of criminal behaviour can be avoided indefinitely. Low scores reflect a more realistic view of the effect criminal behaviour has on oneself.
Cognitive Indolenc	High scores reflect poor critical reasoning and an over reliance on cognitive short cuts in dealing with social problems. Low scores reflect adequate planning and reasoning skills.
Discontinuity	High scores denote inconsistency in thinking and behaviour. Low scores indicate an ability to follow intentions through into behaviour.

High Cognitive Indolence (Ci)score in addition to a high current criminal thinking score on the PICTS suggests that M is likely to take short-cuts or easy ways around problems. Problem solving skills are likely to be limited and the individual is likely to take the easy route to problem resolution, despite the potential consequences of this.

Emotional Problem Scales

Percentile scores provide a percentage comparison with the sample population. For example, a percentile score of 82 means that Mr M scored higher than 82% of the population.

EPS-BRS Subscales	Percentile Scores
Thought/behaviour Disorder	66
Verbal Aggression	82
Physical Aggression	79
Sexual Maladjustment	28
Non-compliance	69
Hyperactivity	76
Distractibility	62
Anxiety	42
Somatic Concerns	69
Withdrawal	76
Depression	62
Low Self-esteem	42
Externalising Behaviour	76
Internalising Behaviour	46

Particularly prominent scores for M included verbal and physical aggression, hyperactivity and withdrawal. Individuals with high verbal aggression scores report feeling agitated and tend to have difficulty making considered decisions. They also report being easily angered and regularly engage in

arguments and threats. They may also be highly provocative to others, regularly teasing or ridiculing their peers.

High scores on the physical aggression sub-scale are associated with bullying and physical provocation. Individuals are likely to hit out, push and "bump" into other people. They may have a reputation for being a "hothead" and others are likely to be intimidated by them.

High hyperactivity scores are associated with individuals who tend to be impatient and impulsive. They often report having difficulties thinking things through and struggle to stay on task and pursue goals.

High withdrawal scores are associated with individuals who often appear aloof and disinterested in others. They are often socially isolated and spend long periods of time alone. They rarely try to establish friendships and will suggest that others don't find them interesting.

Chart of Interpersonal Relationships in Closed Living Environments (CIRCLE)

The CIRCLE determines the interpersonal style of individuals living in closed environments. It seeks to identify their typical style of mixing with other people around them. The assessment asks people who are familiar with the individual being assessed, to rate the frequency of certain behaviours that have been demonstrated by the patient, within the last 30 days. Mr M's CIRCLE was completed by his personal officer along with another member of the community staff team. The results are shown below.

Subscales	TC Assessment Means (all)	Lower Typical Range	High Secure Norms	Upper Typical Range	M
Dominant	8.8	2.1	5.7	9.3	8
Gregarious	7.4	3.9	7.2	10.5	7
Nurturant	6.2	6.2	11	15.8	7
Compliant	11.5	6.3	9.6	12.9	11

Submissive	5.9	3.2	5.7	8.2	3
Withdrawn	5.7	3.9	6.6	9.3	5
Hostile	8.5	4.2	8.4	12.6	12
Coercive	13.5	4.7	9.5	14.3	15

Notable ratings of Mr Ms behaviour on the CIRCLE include the coercive scale. Mr M scored above the range typically found in high security suggesting that he is observed to be argumentative, hostile, threatening and impulsive.

Interpersonal style	Descriptor	Items
Dominant	Confident, assertive, forceful, and opinionated	**Voices strong opinions, dominates conversations, has something to talk about, boasts about his achievements, tries to organise or influence others**
Coercive	Arrogant, argumentative, demanding, rebellious aggressive	**Lies easily, threatens others with physical violence, demands attention to his own rights and needs, acts impulsively, on the spur of the moment, impatient over delays or frustrations, gets involved in heated arguments, blames others when things go wrong, insulting and abusive towards other patients.**
Hostile	Suspicious, sullen, unfriendly, uncooperative, and unreliable	**starts fights, does what is necessary without being told (R), shirks obligations or responsibilities, refuses to comply with requests or instructions, responds to kindness or trust (R), sullen and resistive to staff suggestions, clothes are soiled and disarranged, expression is hostile and unfriendly**
Withdrawn	Isolated, inactive, and withdrawn	**Inactive unless directed to do something, sits alone or keeps to himself, mixes with many others (R), finds something to occupy himself (R).**
Submissive	Meek, passive, unassertive, avoidant, indecisive	**attends social functions (R), timid or cautious with people he doesn't know, expresses lack of confidence in his abilities, is boisterous and excited (R**
Compliant	Conforming, respectful, docile	**abuses or swears at nurses (R), accepts the rules, respectful to people in authority, easily annoyed or irritated (R), complains about changes in routine (R).**
Nurturant	Helpful, friendly, concerned and approachable	**does ward duties as well as is able, shows genuine affection for at least one person, has to be reminded what to do (R), takes a sympathetic interest in the problems of others, helpful to other patients, expresses concern about upsetting or hurting others, pleased and willing to do things for staff**
Gregarious	**Sociable, talkative, cheerful**	**joins in group activities, comes to staff for advice or approval, makes jokes and cheerful comments, starts conversations, talks enthusiastically about interests or plans**

International Personality Disorder Examination IPDE (screen)

The IPDE screen is a seventy-two item self report questionnaire in which a respondent is required to simply answer true/false to a statement.

IPDE1	M
Paranoid	3
Schizoid	0
Schizotypal	1
Antisocial	4
Borderline	1
Histrionic	1
Narcissistic	2
Avoidant	1
Dependent	4
Obsessive	0

A score of 3 or above suggests a possible diagnosis of PD. Where this is apparent it is important to identify the specific traits the individual has and how these may influence their daily behavior and their offending behavior. Mr M scored above the threshold for a possible diagnosis (and therefore requires further assessment) on the paranoid and anti-social sub-scales of the IPDE. Paranoid personalities are characterized by suspiciousness, a feeling that other people are being nasty to you (even when evidence shows this isn't the case) , a tendency to feel easily rejected and a tendency to hold grudges.

Antisocial personality disorder on the other hand is characterised a lack of regard for the feelings of others, low frustration tolerance, aggression and impulsivity, criminal activity, lack of guilt or remorse and a tendency not to learn from the negative consequences of such behaviours.

PCL-R/PCL-SV

The PCL-R is a structured assessment to determine the presence of traits associated with psychopathy, while the PCL-SV is a screening version of the tool. Items are rated as being present, partially present or not present.

Item	
Superficial	0

grandiose	2
deceitful	1
remorse	2
empathy	2
responsibility	2
impulsive	2
behavioural controls	2
lacks goals	1
irresponsible	2
adolescent behaviour	2
adult behaviour	2
SV score	20

A score of 2 indicates that an item is highly characteristic of the individual and traits are generally considered to be enduring patterns of behaving or relating to others.

Relevant PCL-R definitions are as follows:

Grandiose sense of self worth: an inflated view of one's abilities and self-worth. Such an individual is likely to present as opinionated and cocky as well as coming across as self-assured. He will show little concern for his current legal difficulties, will tend to view his difficulties as being the result of bad luck or unfairness/incompetence by his legal representatives. He is also likely to consider a number of activities provided within the custodial environment as being beneath him. Within LD settings true grandiosity is often rare, though may be seen in those who consider themselves to be superior to other people with LD, talk about their reputation or status and have a strong sense of entitlement.

Deceitful: This item relates to a presentation where deceit is a pervasive part of interactions with others. Where people with ID are concerned there needs to be clear evidence that there is a deliberate attempt to deceive rather than a genuine confusion or lack of memory of details.

Remorse: Describes an individual who shows a general lack of concern for the negative consequences of his actions and is more concerned about the consequences for himself. He may state that he is not concerned about the effects of his behavior or may claim to be concerned but his behavior does not match up to these claims. In ID settings it is important to be clear that the person has the capacity to know that his behavior can cause harm to others.

Empathy: A profound disregard for the rights, feelings and welfare of others. The person will be concerned with himself and views others as objects. He is likely to tease others and may have a history of mistreatment to animals.

Fails to take responsibility: An inability or unwillingness to accept personal responsibility for his actions. Typically the person will make numerous and varied excuses for their actions, blaming others, external circumstances or mental state (or ID).

Impulsive: Refers to people who do not think before they act and often do things on the spur of the moment or because they feel like it.

Poor behavioural controls: This item is concerned with lack of control of angry aggression rather than behavioural controls in general. The person is often described as a hot head and short tempered. They are likely to become angry over minor things and their anger is often short lived. They are likely to have numerous records of verbal and physical attacks on staff, other residents and property.

Lacks goals: An inability or unwillingness to formulate and carry out long-term (and realistic) plans. For people with ID this item should be considered in the context of the person's level of functioning and living context (for example, some residential establishments may limit the opportunity for a person with ID to make plans). Positive scoring is relevant when a person lives day to day, develops unrealistic plans or changes their mind frequently.

Irresponsibility: this item refers to an individual who habitually fails to honour his obligations and commitments. In ID settings these obligations may relate to managing finances, completing work and domestic duties.

Adolescent behavior: refers to an individual with a serious history of antisocial behavior as an adolescent (aged 17 and below). For ID it is important to include behaviours that may not have lead to a formal charge or conviction, but would have done had the ID not been present. A persistent and varied history of juvenile offending scores 2.

Adult behavior: this item refers to a varied and extensive criminal history as an adult. In ID it is suggested that all reliable recorded criminal activity is included whether resulting in charges of convictions or not.

Blame Attribution Inventory

The blame attribution scale measures an individual's perception of their responsibility on three sub-scales:

- Mental; blaming responsibility for crimes on mental illness or weak self-control
- External; blaming crimes on social circumstances, the victims or society
- Guilt; feelings of regret or remorse for the crimes

Mr M scored below the range typically found in prisoners at HMP Grendon on guilt sub-scale (suggesting that he feels little remorse for his crimes) and scored above the Grendon range on the scale measuring external, suggesting that he tends to externalize blame (particularly onto his victims).

Mr K

Mr. K is a 26 year old serving an IPP sentence with a five year tariff for wounding with intent. His index offence took place in a city centre after he had spent a night out with some friends. They had become involved in an altercation with another group of men in a night club and had eventually been removed from the club by the bouncers. Mr. K reported feeling a strong sense of grievance following this and has suggested that the other group of men had triggered the incident by knocking a drink out of Mr K's hand while he was stood at the bar. During the trial he indicated that he considered that this had been a deliberate act and believed that one particular man had been "looking for trouble" because he had been looking over at Mr K earlier on in the evening.

After being ejected from the nightclub, Mr K and his friends moved on to another pub in the town and continued drinking. Mr K reported that he could not move on from the incident and kept thinking about the sequence of events that had led up to being thrown out of the club. During a sentence planning interview he said that the bouncers had no right to remove him and that he felt belittled. He went on to say that he felt obliged to "teach people a lesson" and wanted to stand up for himself and put people in their place.

Mr K says that he discussed getting his own back with his friends, but says that they "didn't have what it takes". He told one interviewer that he had a reputation to uphold and could let others think that someone had got the better of him. After trying to convince his friends to return to the club with him Mr K says that he decided that he would "show them who's boss". He left his friends and went to a near by shopping area of the town. He smashed a local hardware shop window and stole a hammer and screw driver. He said that he knew he would be confronted a group of people and therefore needed some "friends".

Mr K reports having waited for approximately 45 minutes until he saw a group of three men leave the club and recognized one of them as the person who he said had "shown me disrespect". He said he followed them down the street for a while until they were away from the more populated areas and then approached the group from behind and struck one of the men over the head with the hammer. Mr K described this scene as "he went down like the sack of shit he is". He said that the two other men began shouting at him and asking why he had done it. He says that he calmly said that he was teaching them a lesson and that they would know to never mess with him again. He said at this point that one of the men recognized him from the club and came towards him. He says he stepped towards the other man and stabbed him in the stomach with the screw driver.

Mr K says that he was aware at the time that he could have killed both of his victims but considered that he was unlikely to get caught. However, he has also indicated that even if he had believed that he would get caught he would have continued, suggesting that other than being separated from his family he does not struggle with prison life.

History

Family

Mr K is the youngest of six children. He grew up in a deprived area of a city and both parents were unemployed for large proportions of their life. Two of his older brothers have both served a number of prison sentences and his father has served a number of community sentences for acquisitive offences. Both parents are reported to have had alcohol and substance misuse problems and the names of all of the children were placed on the at risk register on a number of occasions throughout their childhood. However, none of the children were ever taken into care and the parents were reported in a social service report to be "committed to their children though lacking in capacities to nourish their children without ongoing support from welfare teams".

Parents described Mr K as their “little prince” and were reported to be unable to manage boundaries and regulate his behavior. Furthermore, reports from parenting classes highlighted their unwillingness to impose consequences on the children’s behavior. A referral to a child psychiatrist resulted in a diagnosis of oppositional defiance and ADHD, though trials of Ritalin were reported to have little impact on Mr K’s behavior.

Shortly after Mr K’s 12th birthday the family were referred for family therapy after Mr K had assaulted a teacher at secondary school. Reports at the time suggested that Mr K had reacted angrily to be told off in the class room. He had reportedly told a friend that he would “show the twat” and manufactured a weapon by breaking a fence in the school grounds. He then persuaded two friends to keep a look out while he waited for the teacher to come out of the school at the end of the day. On seeing the teacher leave his class he walked over to the teacherscar and smashed the windscreen with the wood that he had removed from the fence. As the teacher approached to challenge Mr. K he hit the teacher around the head with the wood causing a nasty head injury requiring hospital treatment. Mr K then smashed both wing mirrors while saying “that will teach you who’s in charge here”.

Mr K has always received regular visits from his parents, sisters and his partner during his prison sentences and describes strong loyalty for all his family members.

Education

Mr K attended his local primary school that had been attended by all of his older siblings. Although both of his brothers were reported to present with behavioural difficulties Mr K’s teachers reported particular concerns with his beahviour, even from a young age. He was described by his head teacher at the end of year three (aged 8) to be defiant and disruptive. She went on to indicate that Mr K appeared to have an inflated expectation that other children would bow to his demands and showed little regard for the authority of teaching staff.

Mr K was excluded from secondary school following a violent assault on a teacher and was placed in a pupil referral unit. Despite better staffing levels and increased psychological input Mr K continued to cause concern. Reports suggest that he “always wanted to be top dog” and exerted a considerable influence over other pupils.

Whilst in the pupil referral unit Mr K completed a WISC assessment and was found to have a mild to borderline IQ and was subsequently referred to a local special school. His behavior continued to cause concern in this establishment and he regularly damaged staff cars if he considered that he had been mistreated by staff – though reports indicate that his idea of mistreatment was usually when someone reprimanded him or held a boundary around his behavior. However, it was also noted that Mr K appeared to like being in the school and commented often that he was brighter and better than the other “cabbages”.

Employment

Mr K has had a number of periods of employment. Following the completion of a college course he was offered an apprenticeship in a local building firm. Although Mr K was reported to be a good worker (and he reports having enjoyed the manual labour) he was dismissed for theft of tools from a building site, although charges were not brought against him. Mr K says that he regrets loosing this job but needed money to buy a birthday present for his girlfriend.

Mr K secured a second period of employment in a paint factory. He says he left this job because the supervisor treated everyone “like a retard”.

Relationships

Mr K describes himself as a sociable and friendly person. He says that once he has formed a friendship he remains loyal to his friends and would do anything for them.

Mr K claims to have had five or six brief sexual relationship during his teenage years, but says that his only long-term relationship is his current partner. He says that they met when he was on a college placement from school (aged 16) and that their relationship soon progressed to be sexual. Mr K says that his partner became pregnant when she was 19, over three years after they had started seeing each other. Their second child was born when Mr K was 22 and he says they have always remained commitment and faithful to each other. Mrs K and the children visit regularly and Mr K clearly looks forward to seeing them.

Offending Behaviour

In addition to the index offence Mr K has an extensive criminal history dating back to his early teens. Mr K has had the following convictions:

- Drunk and disorderly
- Possession of class A drugs
- Burglary x 3
- Possessing and selling stolen property
- Benefit fraud
- Car theft x 4 (all with co-accused)
- Assault and GBH x 3
- Failure to comply with bail conditions

Mr K acknowledges that he committed all of these offences and has boasted that he has got away with far more than he has been caught for. He has suggested that his acquisitive offences and benefit fraud were committed to support his family. On the other hand he describes car thefts as having been

impulsive acts, often influenced by alcohol or drug consumption and were “for a buzz with mates”.

On two separate occasions Mr K has been sectioned under the Mental Health Act and detained in medium secure services for people with a learning disability. On both occasions his discharge was planned and involved clear behavioural contracts for his reintegration back into the community. On both occasions Mr K was unable to follow these agreements (one of which included employment).

During his prison sentences Mr K is reported to have formed friendships with other problematic prisoners and appears to take pride in the anti-authority stance of these groups. He has received numerous adjudications for disobeying orders and for the possession and supply of illegal substances.

Mr K has also been adjudicated for numerous offences on other prisoners and staff. He had additional time added to a previous sentence for an assault on a staff members after he believed the staff member had been “disrespectful”, by which he meant that the staff member ignored a request that he had made in relation to an application.

During one prison sentence Mr K was relocated to a wing where his oldest brother was also housed. Although never proven they were suspected of having carried out an extremely violent assault on another prisoner who himself had been adjudicated for an assault on their other brother. The victim of this assault had one ear cut off and had the initials of the middle brother carved into the back of his neck. Despite some other prisoners reporting this assault to staff and naming Mr K and his older brother, none of them were prepared to give evidence against the two.

Community behaviour

Mr K has been resident on the TC for 4 months. During the first few months Mr K presented a number of challenges. Although he attended meetings he

rarely contributed to the content. Mr K was placed on the agenda on a couple of occasions during his first month in the community and was hostile and threatening towards the peer who placed him on the agenda. He argued that on both occasions the peer had misunderstood him or was making something out of nothing. It is notable that Mr K has not been placed on the agenda since this time.

During assessment Mr K attended all small groups and community meetings. Although his openness was somewhat limited he did tell his peers that he wanted to be successful for his family. Subjective staff reports indicated that Mr K was quite emotional when talking about his partner and children and seemed to genuinely want to be able to spend more time with his children while they were still young. In one group he stated that he didn't want them to grow up without anyone to care and control them and suggested that although his own parents were caring, they never imposed limits on him. He also said that he continues to behave without limits. Mr K has not been able to discuss this any further to date.

In another small group Mr K discussed his index offence. Mr K indicated that he knew his behavior was wrong (unlawful) but nevertheless felt justified in his actions. He appeared at times to gain some satisfaction from knowing the harm he had caused – indeed he stated that he could "see the fear in their eyes". When asked by other group members he said that he felt nothing for his victims.

At the end of his assessment period, staff were split over whether or not to vote him on to the community and were perhaps swayed by overwhelming support from his peers for his inclusion as a permanent community member. Mr K, did however, use some small groups to discuss his behavior during the assessment period. He described himself as a wild child, who was never able to obey rules. He said that he has always felt that he should be able to get hisn own way and that he can use violence to influence others. He described most of his violent offending as being "righting wrongs" and when challenged over this became hostile to other group members. He has said that while he

can get angry quickly, he tends not to lose his temper and rather claims that he channels it until “the time is right”.

Mr K has described using his own way to solve problems in both community meetings and small groups. He has referred to his own way as the “way of the streets”

Mr K has been subjected to commitment votes on three occasions since arriving on the community. One of these votes was in relation to attendance at groups while the other two followed episodes of threats on the community. On both occasions it was notable that Mr K. received considerable support from the wider community with no one suggesting that he should be voted off. Indeed, on both of these votes the alleged victims of his threats were largely denigrated by Mr K and his friends and there was a strong suspicion that Mr K had encouraged his friends to intimidate other members of the community.

Mr K has refused one mandatory drug test since being on the community and refuses to take part in the voluntary drug testing programme.

M stated in his assessment paperwork that although he had always felt justified in his behavior he also realized that he caused distress to his partner and children and didn’t want to keep spending time away from them. He also indicated that his primary goal for treatment is to both convince a parole board that his risk has been lowered but also to be a father to his children. He indicated that his own father was often absent to his way of life and hi doesn’t want his own children to grow up feeling that they were not important to him.

In his diary/personal log Mr K has began to record his feelings and it has been noted that he rarely identifies any emotion other than anger.

To date Mr K has not placed anyone on the agenda and has commented a number of times that he is not a grass.

M commented in small groups that he doesn't know what to say. He has said that he is not used to talking about himself or about his feelings and doesn't know how to start using them. He has also, however, said that he does want to learn to talk and that when he is with his children or his partner he feels comfortable telling them how much he loves them.

Mr K continues to struggle with the more creative half of the themed groups that are integral to the TC + regime. He has walked out of these groups on a number of occasions stating that they are like being at school. However, he has also shown some consideration for others during these groups and has helped other community members to think about how they want to use creative therapies to enhance their time on TC+. Furthermore, when the creative therapies are more action base (for example constructing objects rather than drawing/art or music he has remained engaged throughout the session. Similarly, Mr K has joined in with education classes and is pursuing an NVQ in plumbing. He has attended all sessions to date and has been described by the tutors as a conscientious and hard working.

Mr K is a prominent member of the community generally. He is generally gregarious and has become involved in a number of community activities. He plays football with his peers and has also volunteered to organize competitive sports within the community.

When Mr K is discussed in staff debrief meetings, there is a general consensus of opinion between the staff members. Indeed, staff regularly report that Mr K is very honest and open about himself

Psychometric Summary

Psychological Inventory of Criminal Thinking Styles

Mr K produced high scores on a number of sub-scales of the PICTS. He produced elevated scores on both historical criminal thinking and current criminal thinking, suggesting that he has an active anti-social belief system. He also scored significantly above means on the Mollification sub-scale, entitlement, power orientation and superoptimism.

SCALE	DESCRIPTION
Confusion[a]	High scores indicate psychological distress, mental confusion, poor reading ability, or a deliberate attempt to portray one of the above. Low scores donate a lack of distress, confusion or deception.
Defensiveness[a]	High scores indicate a defensive test taking style, where an attempt is being made to conceal minor difficulties or deficiencies. Low scores indicate a willingness to acknowledge the existence of any limitations.
Mollification	High scores reflect a tendency to externalise blame for the consequences of offending and offer rationalisations and excuses for committing crimes. Low scores reflect a greater willingness to take responsibility for ones behaviour.
Cut-off	High scores indicate a low frustration tolerance and a tendency to remove deterrents to criminal behaviour with drugs, mental impairment or short phrases (e.g. “fuck it”). Low scores denote good emotional coping skills.
Entitlement	High scores reflect an attitude of privilege or ownership, often including a tendency to misidentify wants as needs. Low scores reflect a consideration of others perspectives and an ability to discriminate between wants and needs.
Power Orientation	High scores indicate a need to achieve a sense of control and authority over others. Low scores reflect social conformity.
Sentimentality	High scores denote a belief that one is a “good person”, despite the destructive consequences caused by involvement in criminal behaviour. Low scores indicate a more realistic view of the impact of ones criminal behaviour on other people.
Superoptimism	High scores indicate a belief that the negative consequences of criminal behaviour can be avoided indefinitely. Low scores reflect a more realistic view of the effect criminal behaviour has on oneself.
Cognitive Indolenc	High scores reflect poor critical reasoning and an over reliance on cognitive short cuts in dealing with social problems. Low scores reflect adequate planning and reasoning skills.
Discontinuity	High scores denote inconsistency in thinking and behaviour. Low scores indicate an ability to follow intentions through into behaviour.

Emotional Problem Scales

Percentile scores provide a percentage comparison with the sample population. For example, a percentile score of 88 means that Mr K scored higher than 88% of the population.

EPS-BRS Subscales	Percentile Scores
Thought/behaviour Disorder	46
Verbal Aggression	88
Physical Aggression	86
Sexual Maladjustment	28
Non-compliance	74
Hyperactivity	76
Distractibility	62
Anxiety	42
Somatic Concerns	38
Withdrawal	45
Depression	42
Low Self-esteem	40
Externalising Behaviour	82
Internalising Behaviour	46

Particularly prominent scores for Mr K included verbal and physical aggression, hyperactivity and non-compliance. Individuals with high verbal aggression scores report feeling agitated and tend to have difficulty making considered decisions. They also report being easily angered and regularly engage in arguments and threats. They may also be highly provocative to others, regularly teasing or ridiculing their peers.

High scores on the physical aggression sub-scale are associated with bullying and physical provocation. Individuals are likely to hit out, push and “bump” into other people. They may have a reputation for being a “hothead” and others are likely to be intimidated by them.

High hyperactivity scores are associated with individuals who tend to be impatient and impulsive. They often report having difficulties thinking things through and struggle to stay on task and pursue goals.

High scores on the non-compliance scale are associated with individuals who are rebellious, stubborn and uncooperative. They tend to show little respect for authority and violate rules. They tend to do things their own way and have little respect for the rights of others.

Chart of Interpersonal Relationships in Closed Living Environments (CIRCLE)

The CIRCLE determines the interpersonal style of individuals living in closed environments. It seeks to identify their typical style of mixing with other people around them. The assessment asks people who are familiar with the individual being assessed, to rate the frequency of certain behaviours that have been demonstrated by the patient, within the last 30 days. Mr K's CIRCLE was completed by his personal officer along with another member of the community staff team. The results are shown below.

Subscales	TC Assessment Means (all)	Lower Typical Range	High Secure Norms	Upper Typical Range	K
Dominant	8.8	2.1	5.7	9.3	10
Gregarious	7.4	3.9	7.2	10.5	7
Nurturant	6.2	6.2	11	15.8	5
Compliant	11.5	6.3	9.6	12.9	6
Submissive	5.9	3.2	5.7	8.2	3
Withdrawn	5.7	3.9	6.6	9.3	5
Hostile	8.5	4.2	8.4	12.6	12
Coercive	13.5	4.7	9.5	14.3	15

Notable ratings of Mr Ks behaviour on the CIRCLE include the coercive, hostile and dominant scales.

Interpersonal style	Descriptor	Items
Dominant	Confident, assertive, forceful, and opinionated	**Voices strong opinions, dominates conversations, has something to talk about, boasts about his achievements, tries to organise or influence others**
Coercive	Arrogant, argumentative, demanding, rebellious aggressive	**Lies easily, threatens others with physical violence, demands attention to his own rights and needs, acts impulsively, on the spur of the moment, impatient over delays or frustrations, gets involved in heated arguments, blames others when things go wrong, insulting and abusive towards other patients.**
Hostile	Suspicious, sullen, unfriendly, uncooperative, and unreliable	**starts fights, does what is necessary without being told (R), shirks obligations or responsibilities, refuses to comply with requests or instructions, responds to kindness or trust (R), sullen and resistive to staff suggestions, clothes are soiled and disarranged,**

		expression is hostile and unfriendly
Withdrawn	Isolated, inactive, and withdrawn	**Inactive unless directed to do something, sits alone or keeps to himself, mixes with many others (R), finds something to occupy himself (R).**
Submissive	Meek, passive, unassertive, avoidant, indecisive	**attends social functions (R), timid or cautious with people he doesn't know, expresses lack of confidence in his abilities, is boisterous and excited (R**
Compliant	Conforming, respectful, docile	**abuses or swears at nurses (R), accepts the rules, respectful to people in authority, easily annoyed or irritated (R), complains about changes in routine (R).**
Nurturant	Helpful, friendly, concerned and approachable	**does ward duties as well as is able, shows genuine affection for at least one person, has to be reminded what to do (R), takes a sympathetic interest in the problems of others, helpful to other patients, expresses concern about upsetting or hurting others, pleased and willing to do things for staff**
Gregarious	**Sociable, talkative, cheerful**	**joins in group activities, comes to staff for advice or approval, makes jokes and cheerful comments, starts conversations, talks enthusiastically about interests or plans**

International Personality Disorder Examination IPDE (screen)

The IPDE screen is a seventy-two item self report questionnaire in which a respondent is required to simply answer true/false to a statement.

IPDE1	**M**
Paranoid	3
Schizoid	0
Schizotypal	1
Antisocial	5
Borderline	1
Histrionic	1
Narcissistic	4
Avoidant	1
Dependent	0
Obsessive	0

A score of 3 or above suggests a possible diagnosis of PD. Where this is apparent it is important to identify the specific traits the individual has and how these may influence their daily behavior and their offending behavior. Mr K scored above the threshold for a possible diagnosis (and therefore requires further assessment) on the paranoid, narcissistic and anti-social sub-scales of the IPDE. Paranoid personalities are characterized by suspiciousness, a feeling that other people are being nasty to you (even when evidence shows

this isn't the case) , a tendency to feel easily rejected and a tendency to hold grudges. Narcissistic PD is characterized by

Antisocial personality disorder on the other hand is characterised a lack of regard for the feelings of others, low frustration tolerance, aggression and impulsivity, criminal activity, lack of guilt or remorse and a tendency not to learn from the negative consequences of such behaviours.

PCL-R/PCL-SV

The PCL-R is a structured assessment to determine the presence of traits associated with psychopathy, while the PCL-SV is a screening version of the tool. Items are rated as being present, partially present or not present.

Item	
Superficial	0
grandiose	2
deceitful	1
remorse	2
empathy	2
responsibility	2
impulsive	0
behavioural controls	0
lacks goals	1
irresponsible	1
adolescent behaviour	2
adult behaviour	2
SV score	15

A score of 2 indicates that an item is highly characteristic of the individual and traits are generally considered to be enduring patterns of behaving or relating to others.

Relevant PCL-R definitions are as follows:

Grandiose sense of self worth: an inflated view of one's abilities and self-worth. Such an individual is likely to present as opinionated and cocky as well as coming across as self-assured. He will show little concern for his current legal difficulties, will tend to view his difficulties as being the result of bad luck or unfairness/incompetence by his legal representatives. He is also likely to consider a number of activities provided within the custodial environment as being beneath him. Within LD settings true grandiosity is often rare, though may be seen in those who consider themselves to be superior to other people with LD, talk about their reputation or status and have a strong sense of entitlement.

Deceitful: This item relates to a presentation where deceit is a pervasive part of interactions with others. Where people with ID are concerned there needs to be clear evidence that there is a deliberate attempt to deceive rather than a genuine confusion or lack of memory of details.

Remorse: Describes an individual who shows a general lack of concern for the negative consequences of his actions and is more concerned about the consequences for himself. He may state that he is not concerned about the effects of his behavior or may claim to be concerned but his behavior does not match up to these claims. In ID settings it is important to be clear that the person has the capacity to know that his behavior can cause harm to others.

Empathy: A profound disregard for the rights, feelings and welfare of others. The person will be concerned with himself and views others as objects. He is likely to tease others and may have a history of mistreatment to animals.

Fails to take responsibility: An inability or unwillingness to accept personal responsibility for his actions. Typically the person will make numerous and varied excuses for their actions, blaming others, external circumstances or mental state (or ID). Mr K's PCL-SV identifies his externalization of balme onto others as being highly salient.

Lacks goals: An inability or unwillingness to formulate and carry out long-term (and realistic) plans. For people with ID this item should be considered in the context of the person's level of functioning and living context (for example, some residential establishments may limit the opportunity for a person with ID to make plans). Positive scoring is relevant when a person lives day to day, develops unrealistic plans or changes their mind frequently.

Irresponsibility: this item refers to an individual who habitually fails to honour his obligations and commitments. In ID settings these obligations may relate to managing finances, completing work and domestic duties.

Adolescent behavior: refers to an individual with a serious history of antisocial behavior as an adolescent (aged 17 and below). For ID it is important to include behaviours that may not have lead to a formal charge or conviction, but would have done had the ID not been present. A persistent and varied history of juvenile offending scores 2.

Adult behavior: this item refers to a varied and extensive criminal history as an adult. In ID it is suggested that all reliable recorded criminal activity is included whether resulting in charges of convictions or not.

Blame Attribution Inventory

The blame attribution scale measures an individual's perception of their responsibility on three sub-scales:

- Mental; blaming responsibility for crimes on mental illness or weak self-control
- External; blaming crimes on social circumstances, the victims or society
- Guilt; feelings of regret or remorse for the crimes

Mr M scored below the range typically found in prisoners at HMP Grendon on guilt sub-scale (suggesting that he feels little remorse for his crimes) and scored above the Grendon range on the scale measuring external, suggesting that he tends to externalize blame (particularly onto his victims).

APPENDIX THREE
PARTICIPANT INFORMATION & CONSENT

The Treatment Need Matrix (TNM) has been used to support the identification of criminogenic need for the men living on the TC and is likely to be used in the two Prison TC's due to open soon. The TNM was developed from a framework used in Prison TC's and includes items considered to be risk factors. These items were selected by an "expert consensus" for prisoners with personality disorder. The items were not described and the relevance of the items for offenders with LD had not been established.

In order to help staff complete the assessment all of the items have been defined and a scoring procedure has been established. Similarly, the relevance of the items have been checked for offenders with LD by undertaking an extensive review of the literature.

This training has been developed to support members of the multi-disciplinary team to identify areas of need (and risk) in order to inform individual treatment plans for those resident on the TC.

The training will provide an overview of the definitions for each of the items included in the TNM and guidelines for rating the presence of each item in two domains: general lifestyle functioning and the offence chain. A fictitious case study is used so that all staff attending the workshop can practice scoring a TNM.

This training is available as a one-day workshop for all members of staff.

In order to improve the TNM it is necessary to perform a number of tasks . We need to establish that the TNM measures what we want it to measure (ie risk and needs) and we need to make sure that it measures these needs consistently.

In order to check that the TNM measures risks consistently we need to know whether different people come to similar conclusions about the presence of risk/need factors. One way of doing this is to ask a number of staff to complete the TNM and then compare their scores (study one).

We also need to check that the TNM measures risks/needs consistently over time. To find this out we need to ask some staff to complete a TNM on the same case study in about three months time (study two). If you are happy to take part in these studies I will need you to complete the enclosed consent form. I will need you to put your name on the TNM forms for both studies so that your second score can be compared with your first score.

You do not have to agree to take part in the research to have a place on the workshop and if you decide not to take part in the research your decision will be kept confidential. If you have any questions about the research you can contact me on the e mail address below.

If you agree to take part in the research when you attend the workshop, you can still withdraw your consent at any point up until two weeks after the second set of TNM forms have been completed. After this point all scores will be entered on a database anonymously and original forms will be destroyed.

All completed TNM forms will be stored securely and will be kept confidential.

Data collected and analysed from both of these studies may be written up for publication. Personally identifiable information will not be used in any such publications.

Please note that you can attend the workshop and practice using the TNM without taking part in either study. Similarly, you may consent to taking part in the study but later decide to withdraw your consent. In such an instance your completed forms will be destroyed. No one will be informed if you choose not to take part in the research.

Many Thanks

Jon Taylor
J

I have read the information sheet describing the purpose and procedures of the research investigating the reliability of the TNM. I will complete the TNM during the training workshop and agree to having my completed form kept for analysis. I understand that my name will be on the form and that the form will be kept in a secure location.

Name: Signed: Date:

I also agree to complete a TNM form on a second occasion for use in the intra-rater reliability investigation (study two). I am aware that my name will be on the form and that my completed scores will be compared with the TNM that I completed during the training workshop.

Name: Signed: Date:

I understand that data collected and analysed from both of these studies may be written up for publication. Personally identifiable information will not be used in any such publications.

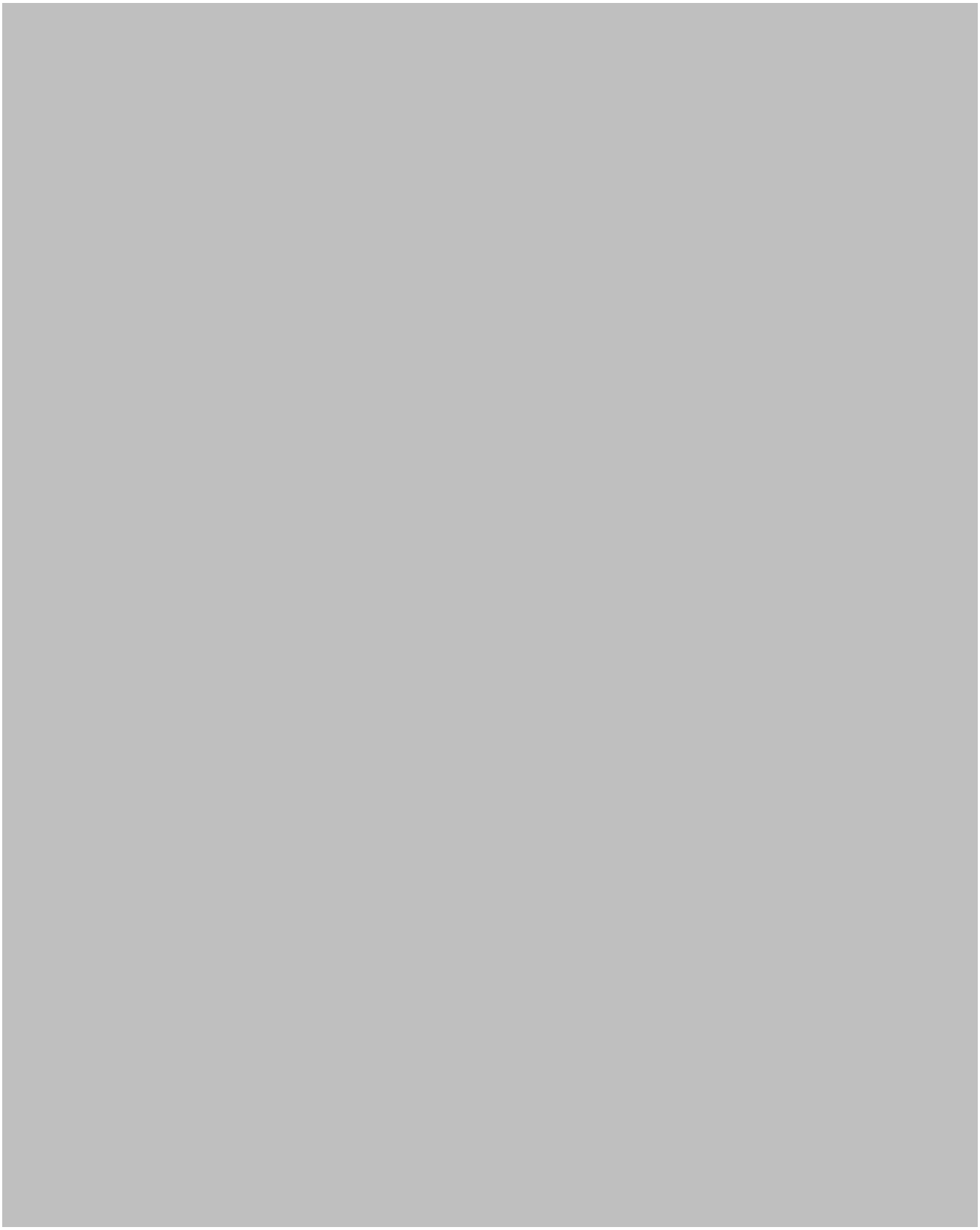
Name: Signed: Date:

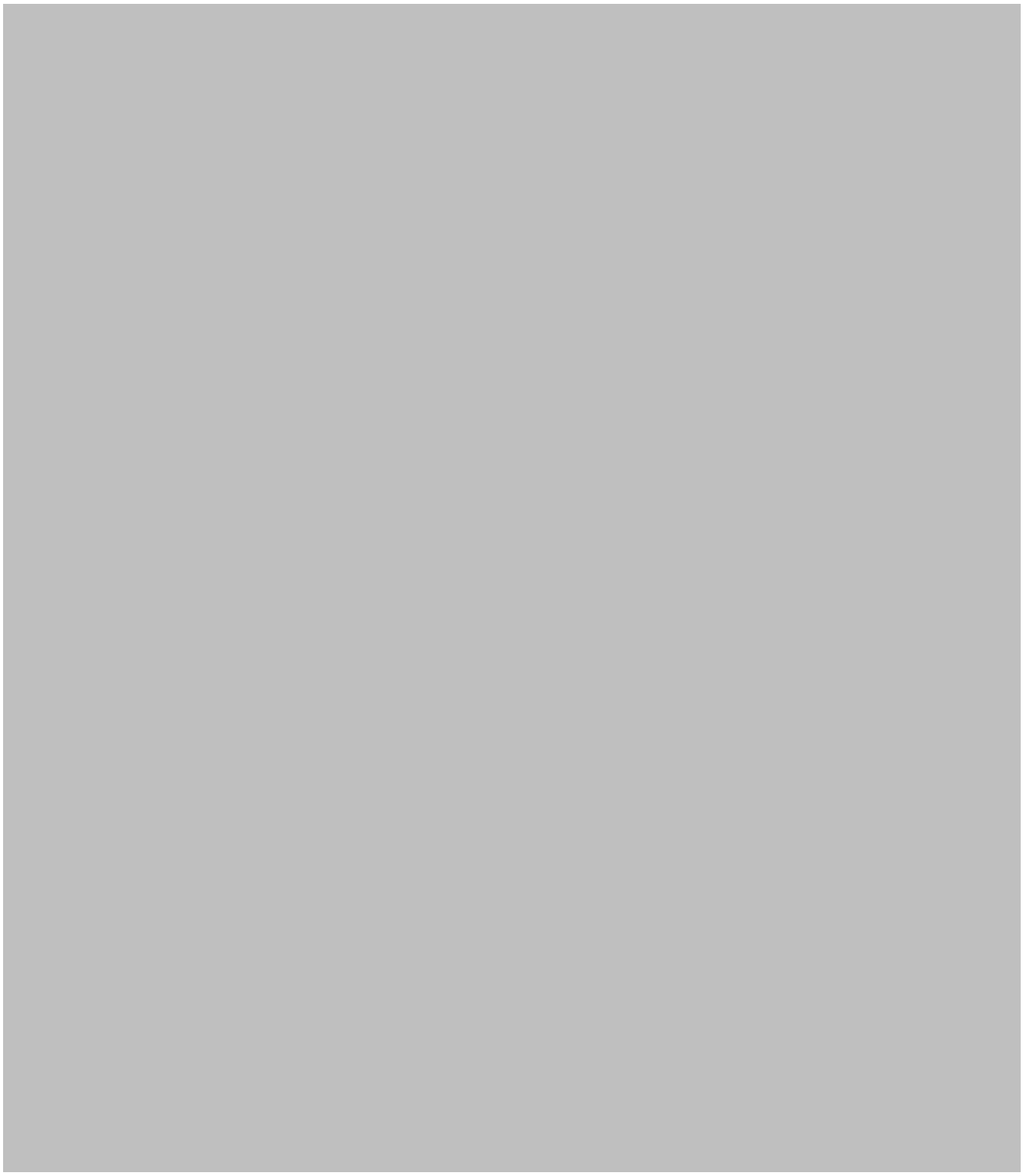
Please note that you can attend the workshop and practice using the TNM without taking part in either study. Similarly, you may consent to taking part in the study but later decide to withdraw your consent. You can withdraw your consent up to two weeks after the second time you complete the TNM. In such an instance your completed forms will be destroyed. No one will be informed if you choose not to take part in the research.

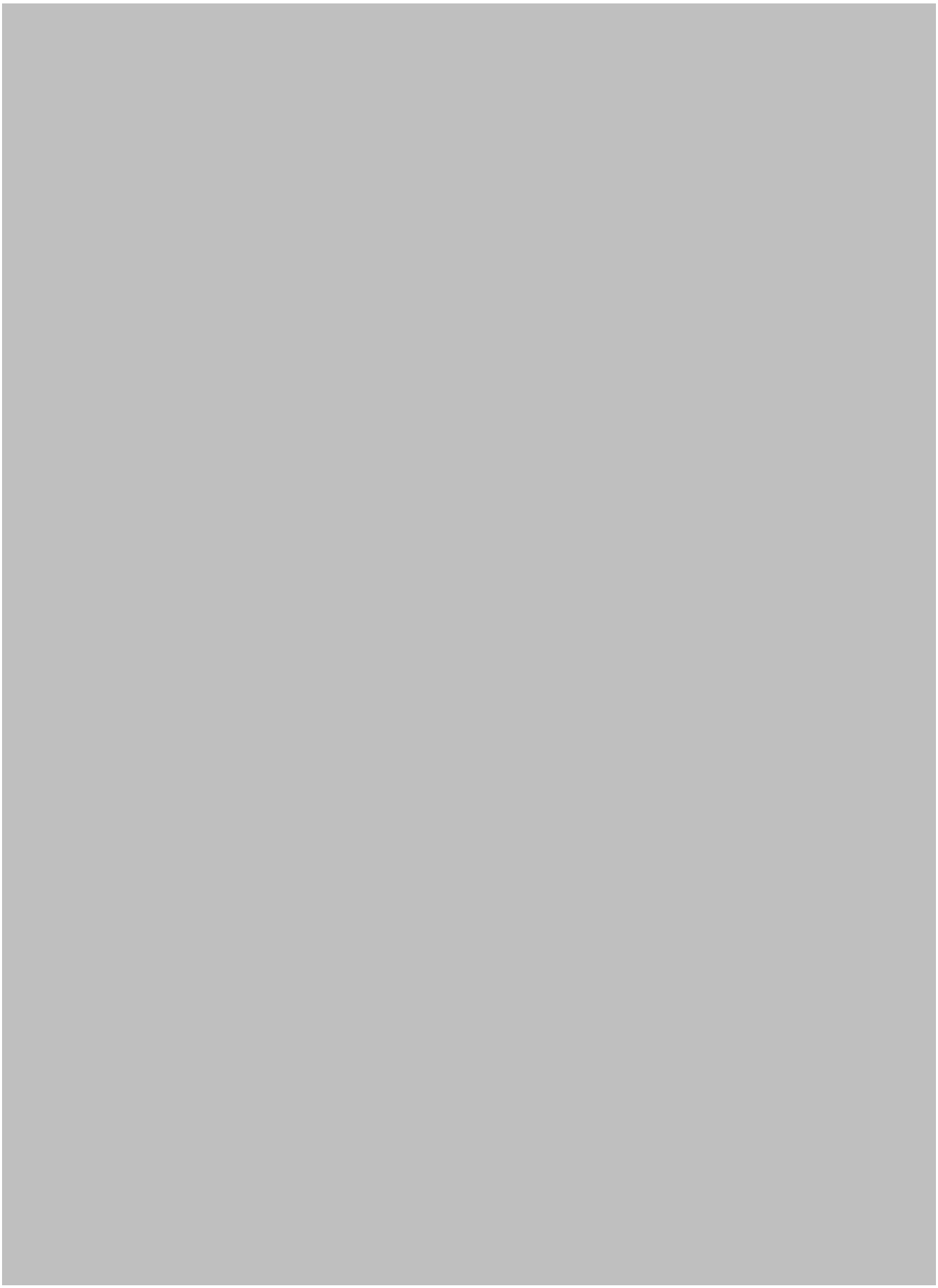
Many Thanks

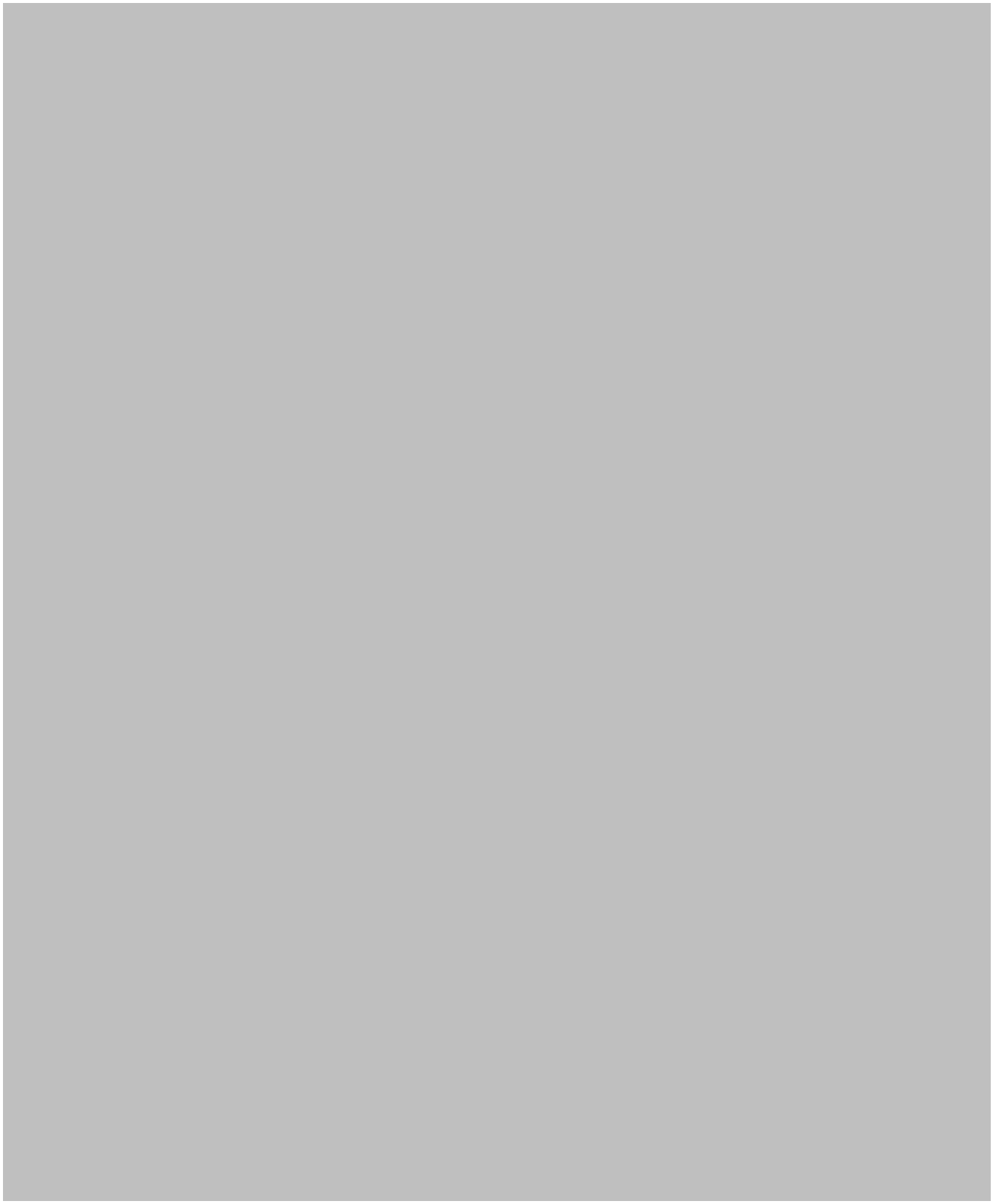
Jon Taylor

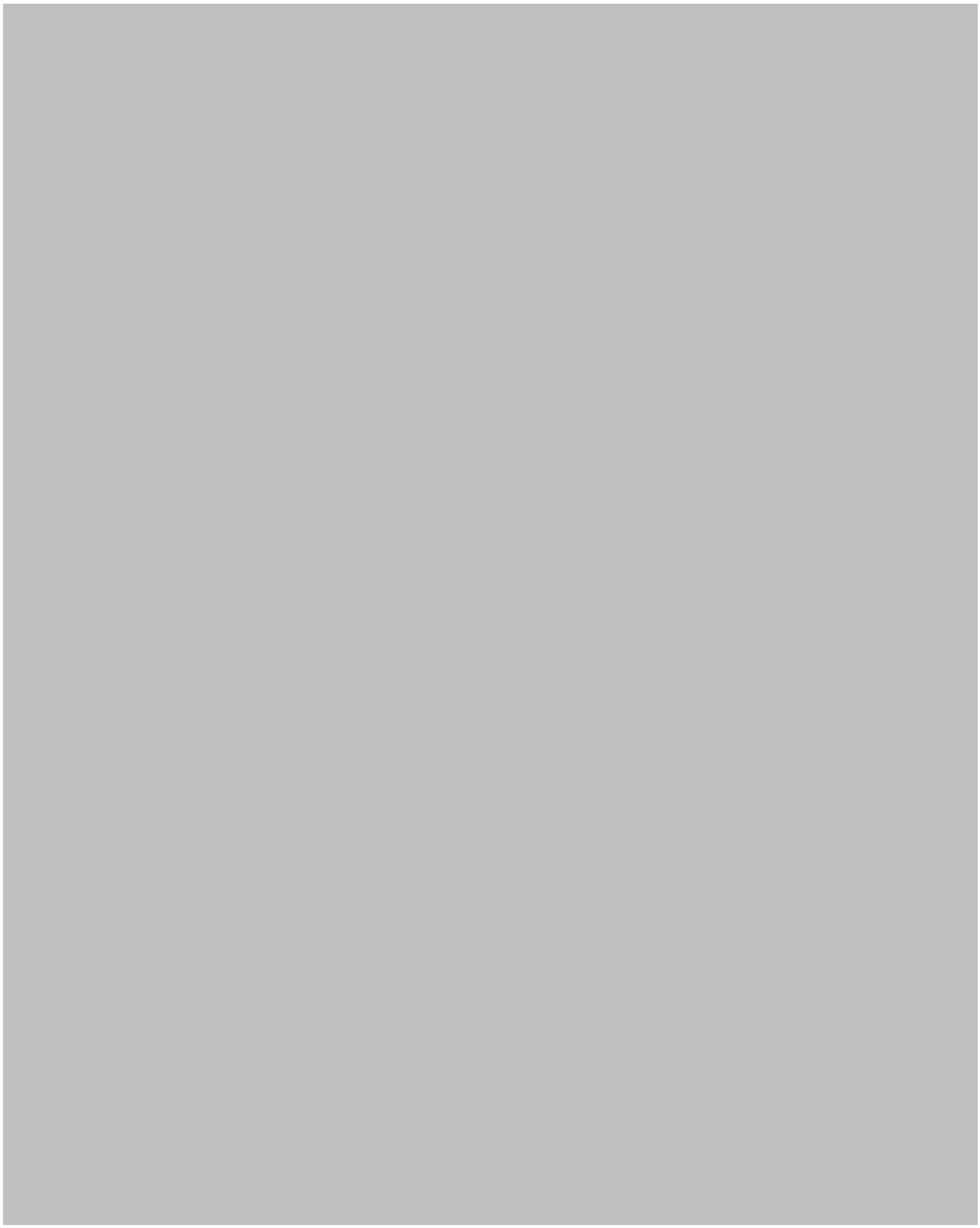
APPENDIX FOUR
ETHICAL APPROVAL

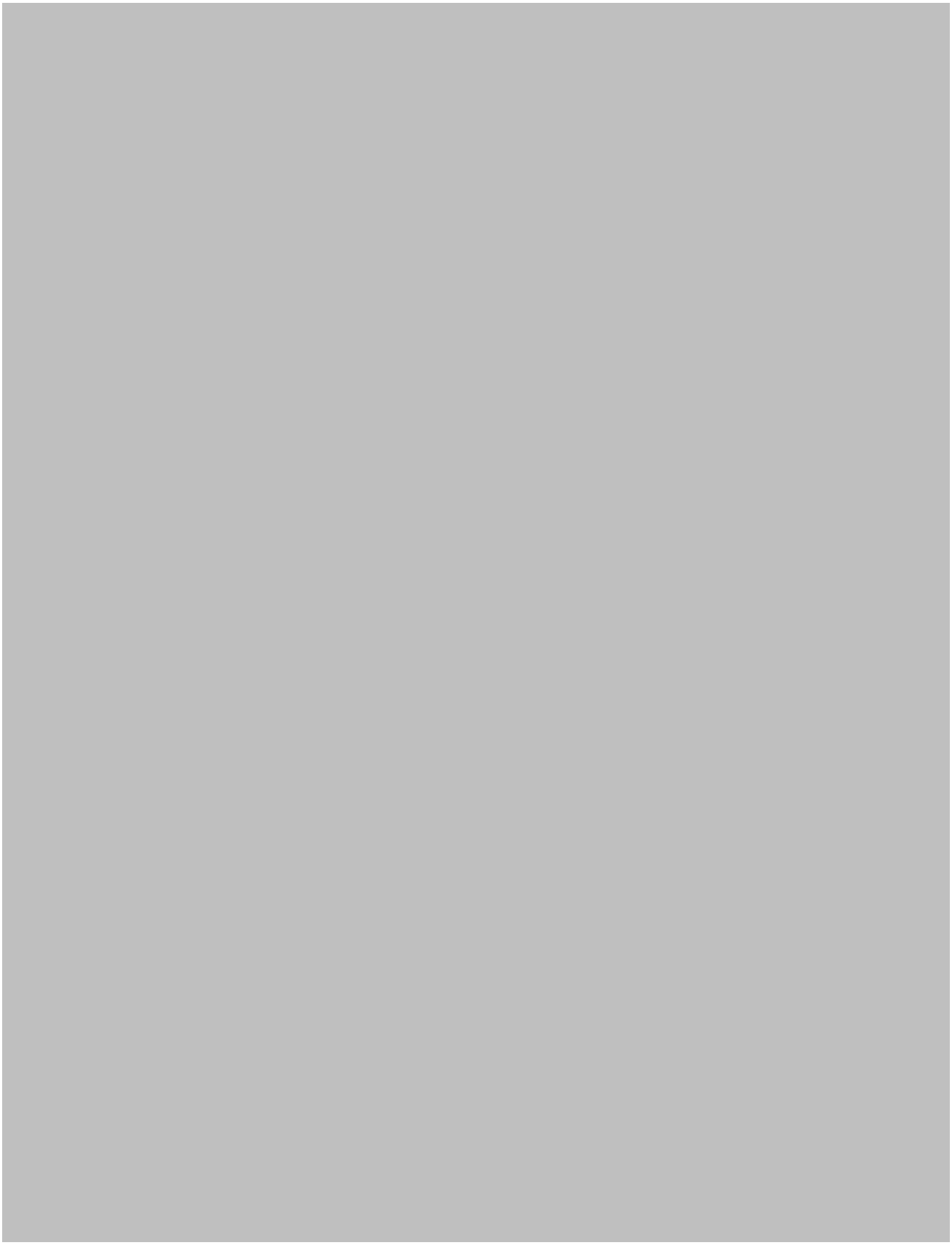




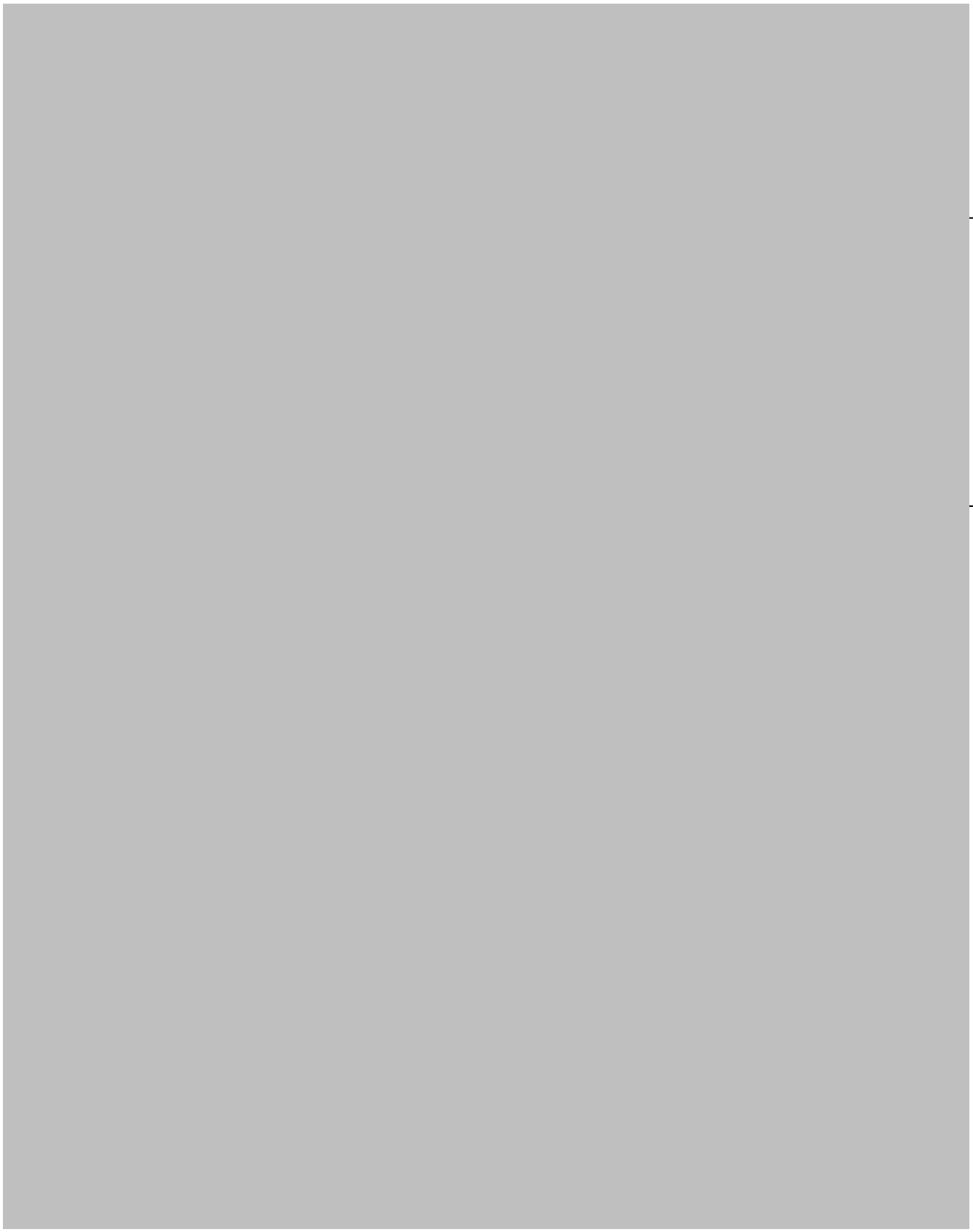


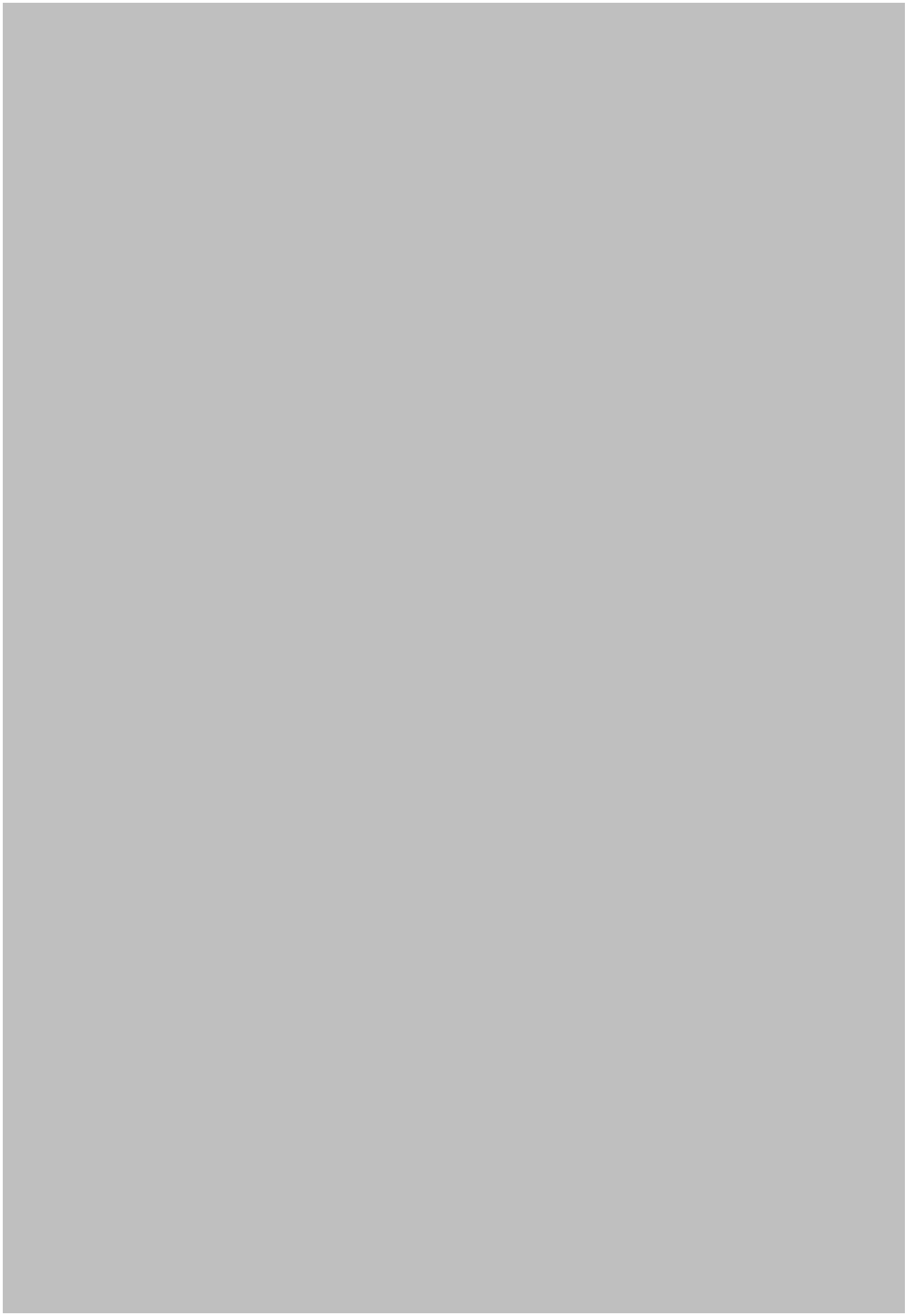


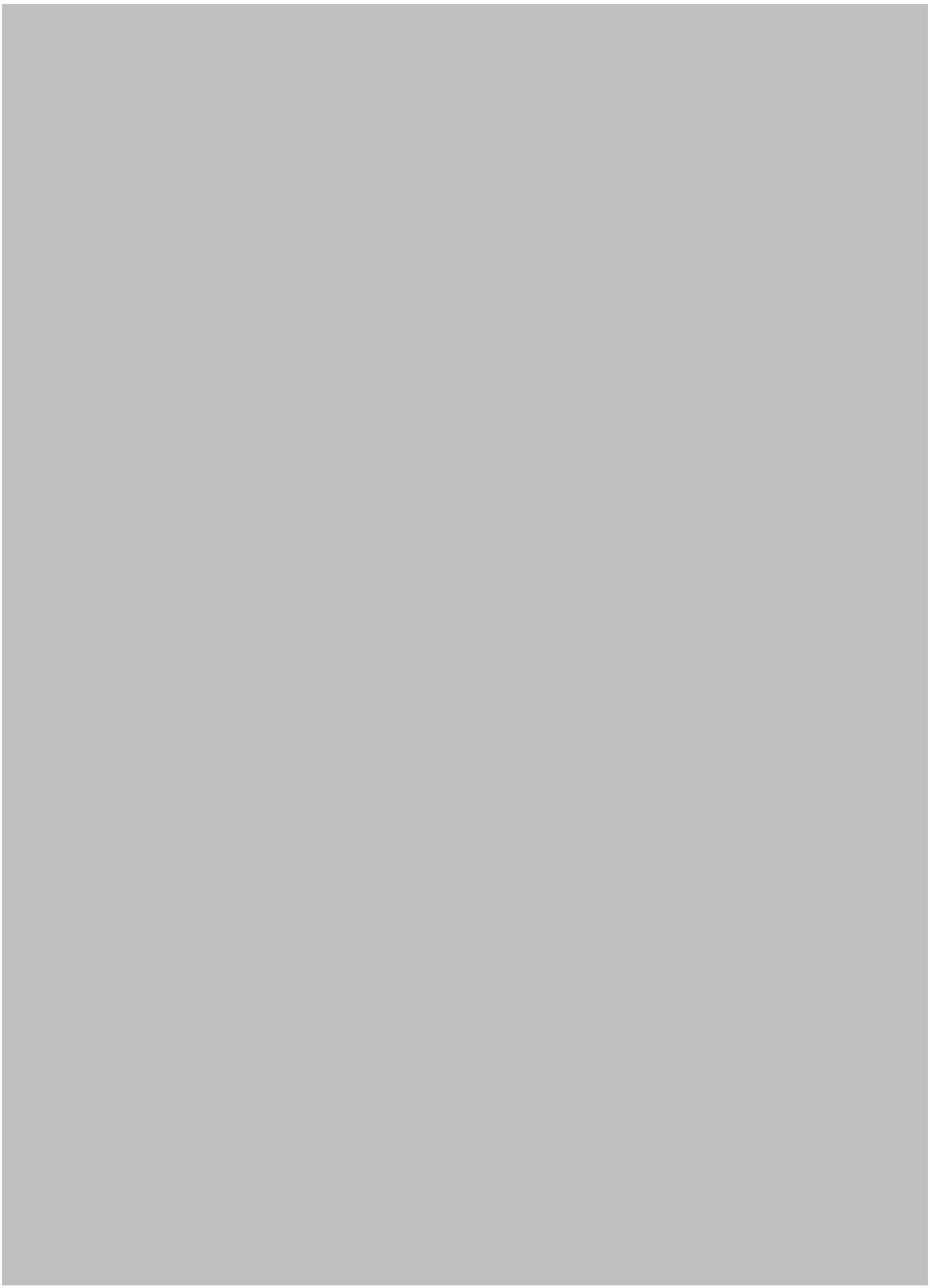




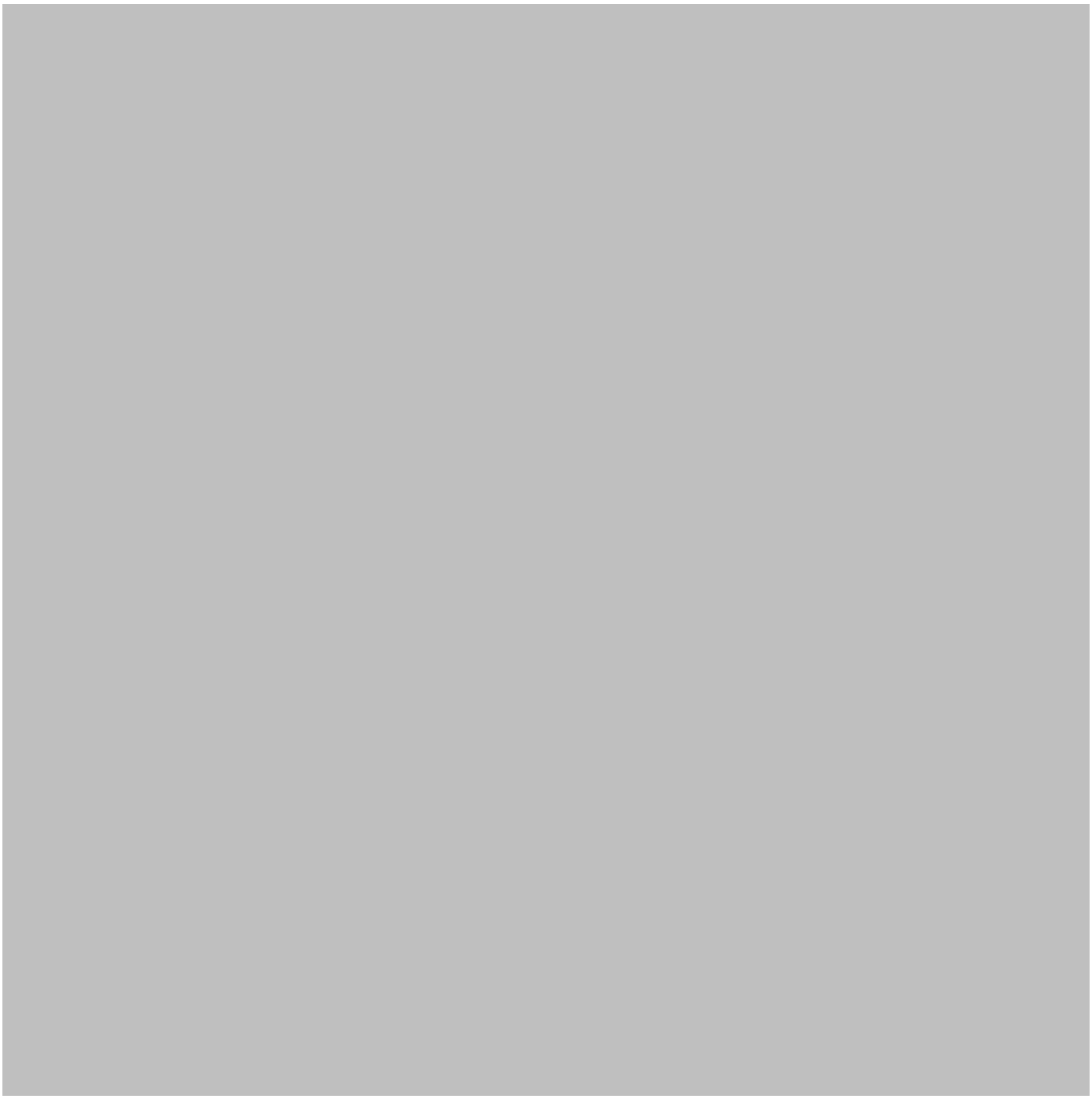
APPENDIX FIVE
ADAPTED PSYCHOMETRIC MEASURES

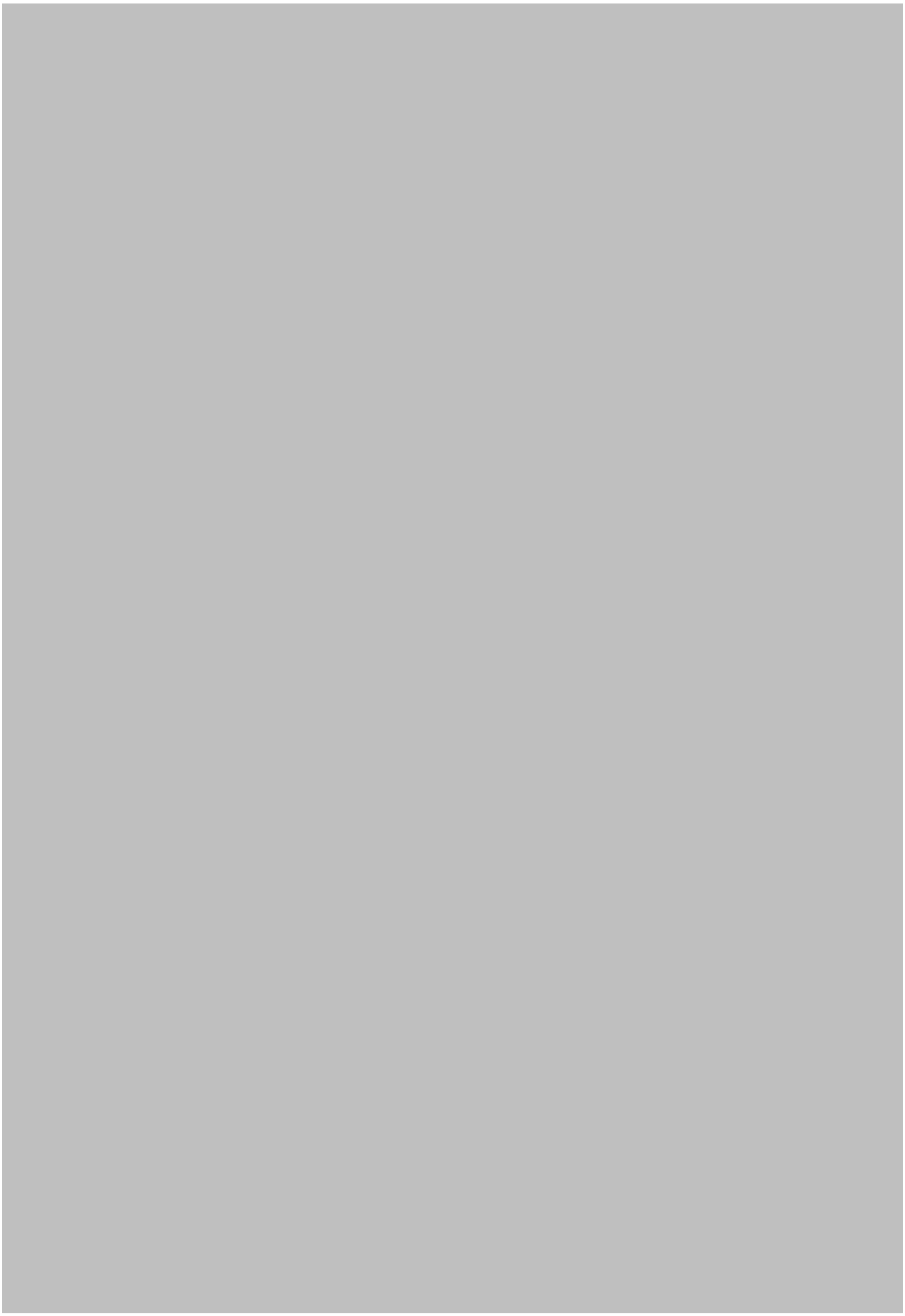


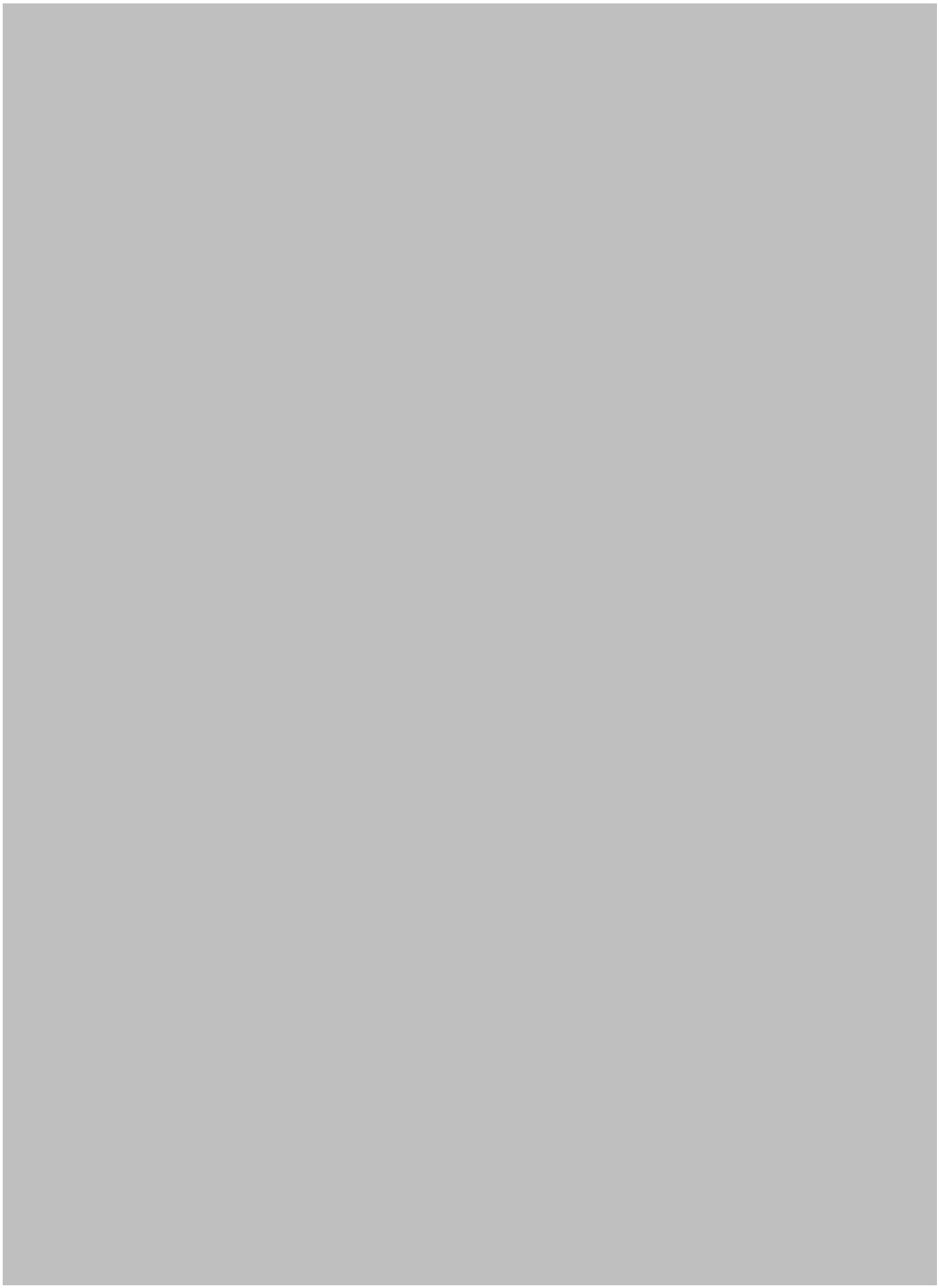




Blame Attribution Inventory (ID)







PROQ3

THE PERSON'S RELATING TO OTHERS QUESTIONNAIRE (ID)

Name:	
Number:	
Date of assessment:	
Interviewer:	

PLEASE READ THIS TO THE INTERVIEWEE BEFORE YOU START

A lot of people who commit crimes find that their behavior can get in the way of other things – as well as getting them into to trouble. It can stop them holding down a job and can cause problems in their relationships.

We are trying to find out how you get on with other people. This will help us to think about the work you need to do while you are in the TC.

I'm going to read out some things that talk about relationships. I want you to imagine I'm talking about you. And you can decide if the thing I read is true or not.

Try to be really honest.

	True (always)	True (a lot)	True (a bit)	false
1. I keep myself to myself (prompt: *I don't mix with others much*)				
2. I give in to what other people want				
3. I make sure my needs are met (*prompt: give an example of a need, eg affection, and ask if he will try to get other people to meet that need*)				
4. I hold on to people too much (*prompt: I try to keep friends and stop girlfriends/boyfriends from leaving me*)				
5. I'm ok telling people what to do				
6. I don't feel that people really love me				
7. I try hard to get what I want				
8. I do not let people get too close to me				
9. I like to be the one in control (*prompt: I don't like to think can get me to do things*)				
10. I prefer other people to take the lead (*prompt: sort things out for me, tell me what to do)*				
11. I have a tendency to cling to people (*prompt: have any of your partners said you want too much time with them*)				
12. I keep my feelings to myself				
13. I look after people close to me				
14. I get scared of people leaving me				
15. I can ignore other people's feelings				
16. I am more of a follower than a leader				
17. I try to keep people for myself				
18. When people I like go away I cant wait to see them again				
19. It annoys me when people will not do what I want				
20. I'm happy to do what people tell me				
21. I get my own back if people annoy me				

22. I hate being on my own				
23. I prefer it when someone else is in control				
24. I get clingy (*prompt: want to stay near them*) if my partner seems to fancy someone else				
25. I like it when others tell me what to do				
26. I do not let people get away with insulting me				
27. I expect people to do what I tell them				
28. I'm never sure that people really like me				
29. I let other people make decisions (choices)				
30. I find it easy to show I care about someone				
31. I don't like others to know too much about me				
32. I back off from arguments				
33. When I like someone I try to keep them close				
34. I put people in their place (*prompt: I tell them what I think of them. I don't let people think they are important*)				
35. I don't like it if things aren't done the way I want				
36. I know that there are people I can get help from				
37. If I can't do something I find someone else who can show me				
38. I try to arrange things so that people do what I want				
39. I try to make sure that someone I like does not get too interested in other people				
40. When people try to intimidate me I retreat				
41. I am afraid that people are going to lose interest (*get bored*) in me				
42. I try to keep people close to me				
43. I get so close to people I can't bare to let go of them				
44. When things go wrong I think it's my fault				
45. When I am put under pressure I back off				
46. I like my own space				
47. I prefer to keep people at a safe distance				
48. When people are bossy I back off (*prompt: I don't like to be with bossy people*)				