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Current Practices for Forensic Assessments of Offenders

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Walden University

College of Psychology and Community Services

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Garet Bradford

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Walden University
2023

Abstract

Current Practices for Forensic Assessments of Offenders

by

Garet Bradford

MA, University of Cincinnati, 2017

BA, University of Nevada, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

Walden University

August 2023

Abstract

Examining the validity, reliability, and predictive accuracy of tools used to calculate risk of recidivism in forensic health settings is important to ensure that assessments are accurate and credible. Furthermore, the inclusion of additional information or approaches in offender assessment, such as index offense work or index offense analysis, has been noted to enhance forensic practitioners' assessment of violent offenders. These tools have also been shown to enhance the predictive accuracy of existing tools; however, they are currently not commonly used within forensic practice as a whole. This qualitative study explored several different approaches in violent offender assessment, focusing specifically on their clinical utility in forensic mental health settings. The study addressed the validity and subsequent use of the violent offender assessment tools currently adopted by forensic practitioners in a forensic setting, a state hospital that supports criminally violent offenders. The findings shed light on the lack of consistency in their use and the outcomes of practitioners' experiences, affording an understanding of what tools should be used and when to use them (if at all). These findings may have a direct impact on how forensic practitioners use these tools, how various jurisdictions set policies, and how future courts weigh their use in offender adjudication.

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Dedication

I dedicate this study to my family (2 dogs and 2 cats). Unbeknownst to them, my perseverance and diligence will one day reap them the reward of feasting on gourmet pet food.

Acknowledgments

I wish to thank my Advisor, Dr. Eric Hickey, and my Editor Professor, Dr. Glenn Phillips, for being patient with my never-ending petulance concerning this life-draining project.

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Chapter 1: Introduction to the Study

Introduction

Effective predictive assessment has become a critical aspect of offender treatment both in terms of accurately assessing an individual's risk and appropriately directing their treatment pathway. The assessment of offenders is a core skill used by forensic and clinical psychologists; it requires them to systematically collate a wide variety of information relating to the characteristics of an individual and their offenses. Wood et al. (2020) highlighted that assessments carried out by psychologists are increasingly used to inform parole decisions and criminal appeals. Furthermore, Heilbrun (2001) emphasized that clinicians' conclusions will be scrutinized by the legal system, and, therefore, it is their responsibility to provide accurate information. For these reasons, assessments are of the utmost importance and need to be as accurate as possible. Despite this, Singh et al. (2018), in his risk assessment review, suggested that a growing number of psychologists are limited in their ability to conduct in-depth assessments of offenders. It is possible that this could be for a variety of factors including the limited availability of accurate assessment tools, limited access to offender information, and a lack of clear guidelines pertaining to the assessment process.

The U.S. Department of Justice's (USSC, 2020) most recently published reoffending rates show that between October 2015 and October 2016, 412,731 incarcerated adult offenders were released from custody by 30 U.S. states, with 64% (264,148) of those released being categorized as "violent." Statistics highlight that these individuals reoffend at a high rate (79%) within 5 years of their release (USSC, 2020).

These recidivism rates further clarify the need for assessments to be accurate and robust. Effective assessments can promote public protection by ensuring that offenders address their risk factors through appropriate intervention to reduce the potential for future violence. Assessment, therefore, is more than just part of a practitioner's role; it is a big responsibility that impacts the wider society. Research has driven the development of approaches to assessment, and within this, psychology has developed a variety of tools and models to assist clinicians in understanding and assessing offenders' complex difficulties.

Understanding what led to an individual's offense requires practitioners to understand the person, including their life, attitudes, coping strategies, and core beliefs. Researchers and practitioners have developed approaches for achieving this, including formulation or functional analysis (Hart et al., 2011). More formal models have also been developed for offender assessment and interventions, such as the risk-need-responsivity model (RNR; Andrews et al., 2006) and the good lives model (GLM; Ward & Stewart, 2003). Such models were developed to assist practitioners in taking a broader and more holistic view of offenders, including their strengths and weaknesses. Despite this, Singh et al. (2018) highlighted that use of the best and most current offender assessment instruments is not widespread.

Background

Approaches for achieving greater accuracy in predicting future violence have been developed, such as formulation or functional analysis (Hart et al., 2011), as well as more formal models like RNR and GLM. Bonta (2010), along with Singh and his

colleagues (2018), highlighted that the use of the best and most current offender assessment instruments is not widespread.

The “risk principle” that is the focus of this study highlights the importance of the accurate assessment of offenders’ risk, as to appropriately design interventions to address the massive challenge in deterring/eliminating future offender violence (Singh et al., 2018). While the efficacy of risk assessment relies on the ability of assessments to accurately predict future behavior (Hatcher, 2012), the framework suggests that interventions only focus on targeting noncriminogenic needs (Henwood et al., 2015). Given the often-complex nature of offenders, particularly those in forensic mental health settings who present an array of difficulties, focusing only on criminogenic needs both during assessment and intervention seems inappropriate (Tangney et al., 2012). This study focused on a broader, more pragmatic approach that forensic practitioners can use to improve the overall risk assessment process currently used by most of the jurisdictions within the U.S. criminal justice system (Monahan & Skeem, 2016). This change can end the longstanding and ongoing controversy surrounding the ability of practitioners to predict future offender violence (Van der Put et al., 2019). Collecting information from the experiences of forensic practitioners in using these risk assessments is a crucial step in sorting out these controversies.

Current Model of Offender Assessment

The overall aim of the predictive models is to target dynamic risk factors through treatment to reduce recidivism rates, and the predictive models do this through three key principles (see Table 1). This philosophical approach has been the main impetus for

directing the development and implementation of various predictive future offender violence assessment tools utilized within the criminal justice system (Bonta & Andrews, 2010).

Table 1

Summary of the Key Principles of the Risk Assessment Models

Risk principle	Need principle	Responsivity principle
The intervention should be equivalent and appropriate to meet the offenders' level of risk Offenders who pose a greater risk should receive higher levels of intervention and resources Accurate assessments of offenders' risks are required for practitioners to appropriately allocate them to treatment	Focus on treatment targets Interventions should target needs/risk factors (criminogenic needs), which are subject to change Treatment should target factors that are relevant to each individual offender (e.g., violent supportive attitudes and antisocial peers)	Interventions that meet an offender's preferred learning style and method of delivery will be most effective To result in the greatest level of therapeutic change, it should consider cognitive ability, motivation, maturity, and personal/interpersonal characteristics Interventions therefore must be responsive to offenders' needs

As Table 1 indicates, the risk principle highlights the importance of the accurate assessment of offenders' risk to appropriately design interventions to address risk. While the efficacy of risk assessment relies on the ability of assessments to accurately predict future behavior (Hatcher, 2012), conducting accurate and robust assessments is also the responsibility of clinicians working within the field. Clinician action, however, is dependent on the information that is available to conduct such assessments. As Hatcher

(2012) asserted, the consequence of incorrect prediction can be problematic. For example, someone who is assessed as unlikely to recidivate may be released from custody. If this prediction is incorrect and the offender goes on to reoffend, this has a real and detrimental impact upon society and the offender.

The framework suggests that interventions that focus on targeting noncriminogenic needs—self-esteem or communication skills, for example—are nonessential and should be secondary to criminogenic needs. Given the often-complex nature of offenders, particularly those in forensic mental health settings who present with an array of difficulties, focusing only on criminogenic needs both during assessment and intervention seems inappropriate. The focus on risk and criminogenic needs as opposed to broader needs is likely to demotivate the offender. While the RNR model does provide guidance on dynamic risk factors and, therefore, indicates what clinicians should be targeting via assessment and intervention, it does not provide practitioners with information regarding how to incorporate such factors into clinical formulations, treatment plans, and intervention designs (Polascheck, 2012). Such factors support the notion that more needs to be known about tools and processes utilized, to ensure that offenders are assessed and treated according to their needs, thereby reducing their risk.

Problem Statement

As statistics suggest higher recidivism (USSC, 2020), risk assessment for future violence will be a crucial component of the criminal justice system. Currently, more than 200 violence risk assessment tools, often integrated with clinical-actuarial instruments, have been developed to predict violent, antisocial, and sexual behavior, and their use is

increasing in criminal justice settings (Singh et al., 2018). The central aim of these methods is to identify high-risk and low-risk offenders correctly.

There remains a longstanding controversy about the ability of mental health professionals to assess and particularly predict risk of future offender violence (Monahan et al., 2014), such that even a high-profile case referenced the challenge:

> It is, of course, not easy to predict future behavior. The fact that such a determination is difficult, however, does not mean that it cannot be made. Indeed, prediction of future criminal conduct is an essential element in many of the decisions rendered throughout our criminal justice system (*Jurek v. Texas*, 1976)

While there are many models that indicate principles of offender assessment and intervention (i.e., RNR, GLM, Correctional Offender Monitoring for Alternative Sanctions [COMPAS], Inventory of Offender Risk, Needs, and Strengths [IORNS], Static Risk Offender Needs Guide—Revised [STRONG-R], Offender Group Reconviction Scale [OGRS], Forensic Operationalized Therapy/Risk Evaluation System [FOTRES], etc.), these tell little about the appropriate selection and utility of assessment methods or tools by practitioners in their everyday roles. Currently, there remains an ethical and legal obligation to assess and manage offenders accurately and effectively through a greater understanding of assessment methods. Additional research is required regarding the historical and more recent developments in assessment methods to ensure that practitioners are fulfilling their role and contributing to offender management effectively. With the limited availability of accurate assessment tools, limited access to offender information, lack of clear guidelines pertaining to the assessment process, and the overall

lack of "knowledge" on how to properly assess the most dangerous of offenders, this study fills a gap in the research. Specifically, I explored the two main contrasting and conflicting approaches (clinical and actuarial) to find if one is statistically more predictive than the other, if they are negligible in their differences, or if they even make a discernible difference in their long-term predictability.

Purpose of the Study

The purpose of this study was to examine the lived experiences of licensed forensic practitioners using risk assessment tools. The issue to be examined was the assessment of offenders as it pertains to future violence, with a specific focus on the clinical utility of different assessment methods used. To achieve this, I examined the current risk assessment methodologies employed by licensed forensic practitioners when evaluating violent offenders. I also explored newer concepts within the literature that have been suggested to improve the assessment of offenders by the lived experiences of the forensic practitioners who have experienced, firsthand, positive and negative results from the tools they were provided

Research Questions

RQ1—Qualitative: What are the lived experiences of licensed forensic practitioners in using risk assessment tools for violent offenders?

RQ2—Qualitative: What are the perceptions of licensed forensic psychologists concerning the accuracy of the used assessment tools?

Theoretical Foundation

In 1939, sociologist Edwin Sutherland (revised in 1947; Brookes, 2021) proposed the widely incorporated differential association theory. Sutherland theorized that criminal behavior is handed down generationally. Sutherland stated that criminal behavior is taught, learned, and developed by the identified criminal's family and peers and through interactions with like-minded individuals. Although Sutherland's theory was established over 80 years ago, it has stood the test of time as it continues to be incredibly important to the field of predictive criminality today (Ward & Brown, 2015).

Most repeat offenders engage in criminal behavior because they are surrounded by like-minded people. Differential association theory is a very general theory that states that people learn criminal behavior and attitudes from others with whom they associate. Thus, prediction by a licensed professional may well be an exercise in futility. Choosing one tool over another may have a negligible impact on prediction. People are independent, individually motivated beings. As a result, they may not learn to become criminals in the ways differential association or the provided assessment tools used by the forensic practitioners can predict.

Nature of the Study

In this study, I adopted a qualitative thematic analysis approach to data collection and analysis. I accomplished this using in-person interviews of licensed forensic practitioners. The data that were gathered from the interviews were coded and analyzed using NVivo, a commonly used form of computer-assisted qualitative data analysis software (CAQDAS).

Within this study, I examined the current literature on violence risk assessment tools by highlighting the lived experiences of licensed forensic practitioners using clinical judgment and actuarial approaches to risk assessments in a population of offenders classified as violent at a secured state facility. The literature review includes an examination of the development of the concept of risk assessment and efforts over the years to improve the assessment of offender danger. The focus of the interviews and surveys helped gain insight into the process and tools each forensic practitioner used to assess future offender behavior.

Definitions

The terms in the following list are used throughout this study:

Expert testimony: Refers to the testimony given by a qualified individual regarding a scientific, technical, or professional issue (Melton et al., 2018).

Forensic psychologist: A licensed psychologist who conducts forensic psychological predictive violence evaluations on offenders (American Psychological Association [APA], 2016).

Multiple data points: The use of multiple sources of information. This typically includes some combination of interviews and review of important documents and records (e.g., medical history, academic records, court records, etc.; Bartol & Bartol, 2015).

Psychological assessment: The instrumentation and tools used to measure the psychological constructs of an individual in psychological evaluations (Jackson & Roesch, 2016).

Psychological evaluation: The examination into the nature and extent of an individual's current psychopathology, mental status, current functioning, and prognosis for future violence (Melton et al., 2018).

Standards of admissibility: The current standards used by the U.S. criminal courts to assist in determining the admissibility of scientific evidence and expert testimony (Shapiro et al., 2015).

Standards of care: The current standards followed by an industry, which are based on judicial constructs that establish minimally accepted professional standards of conduct (Heilbrun et al., 2016).

Standards of practice: Considered to be the "typical way of doing things" in a particular field, developing out of the industry's formal guidelines or best practice standards (Heilbrun et al., 2016).

Assumptions

Conducting a study involving licensed forensic psychologists as participants necessitates some basic assumptions. The first assumption made was that how licensed forensic psychologists are currently conducting their future predictive offender violence evaluations is important to overall judicial proceedings and the public. This assumption was rooted in the literature discussing a lack of a consistent protocol for psychological evaluations as some of the reasoning behind the inadmissibility of the findings and vast differences between success of the currently used tools. The second assumption was that background, education, training, and licensing requirements would vary amongst the licensed forensic psychologists in the study. To help minimize some of this variance,

only psychologists licensed to practice in the United States were included. This purposeful limitation provided the potential for similarities to exist in the way future predictive offender violence evaluations are conducted and the type of assessments used by participants operating under the same standards of judicial admissibility. Further, it was an expectation that while some participants might have a voluntary certification through the American Board of Professional Psychology or another source, many forensic psychologists would not have specific licensure in forensic psychology. Possessing specialty certification was noted but was not a requirement.

Finally, an assumption was made that the participants in this study were truthful in their answers and that they strove to behave and conduct their practices ethically, professionally, and within the guidelines of their discipline and legal jurisdiction. This study provides a detailed description of the current practices by forensic psychologists when conducting future predictive offender violence evaluations.

Scope and Delimitations

While the argument can be made that there is a need to examine how all types of forensic psychological evaluations (competence, product liability, personal injury, etc.) are conducted, in order to generate a baseline of protocol, the scope of this study focused on future offender predictive violence evaluations. This study provides more detailed information on the research that surrounds this topic at various stages. The gap in research pertaining to the individual types of forensic psychological evaluations is an area that needs further research. Toward that end, this study was designed to seek rich and detailed information pertaining to future predictive offender violence evaluations through

qualitative, semistructured interviews with a diverse group of forensic psychologists. For the purpose of this study, a forensic psychologist is defined as a licensed psychologist who conducts or has conducted future predictive offender violence evaluations as a regular part of their practice and part of their current employment duties.

The geographic constraints of the interviews were among the delimitations in the study. This was addressed by conducting interviews through Skype or Facetime when in-person interviewing was not possible. This flexibility was necessary because of the Covid-19 pandemic. It is important to point out that although geographical differences may have influenced how the participants conducted their practices, it was expected that their processes would be more or less related due to the standards of admissibility they operated under and their organizational similarities (Shapiro et al., 2015). As such, the homogeneity of the population from which the participants were selected was based on their profession and specialization, rather than their representation of the greater society.

Another delimiting consideration was the choice to focus specifically on future predictive offender violence evaluation. The study illustrates that these forensic psychological evaluations, in comparison to other types, should be further studied to determine if a standard of care would be beneficial to the whole profession, thus bolstering the reliability, validity, and credibility of the various forensic psychological evaluations. The decision to focus on current practices and insights of forensic psychologists regarding future predictive offender violence evaluations and the reliability of the current tools used helps fill the gap in current research regarding future predictive

offender violence evaluations, but the findings can also further support studies based on other types of psychological evaluations.

A qualitative interview design was the choice for this thematic analysis study. While a quantitative study design would provide predictive, statistical data regarding the similarities and differences in how a forensic psychological evaluation is conducted, employing a thematic analysis approach, using semi-structured interviews, created the ability to take full advantage of the flexible nature of this approach, while also serving as a useful tool to assist in delivering rich, detailed, and descriptive data (Braun & Clark, 2006). Qualitative semi-structured interviews were used to explore how forensic psychologists were conducting forensic psychological evaluations in future predictive offender violence cases, how the current tools used to determine their outcome related to their effectiveness in the cases they gave expert testimony in in their judicial jurisdictions, and their perspectives regarding implementing a consistent protocol when conducting the assessment.

Limitations

The current research was not without its limitations. These challenges included proper sample size, strict inclusion criteria, participant transparency, bias, privacy, and "self-fulfilling prophecies." In addition, research into this area (predictive future violence) is extremely limited. Ever since the isolated focus of research concerning predictive future offender violence from 2010 to 2015 and notwithstanding the predictive future domestic violence study from Van der Put et al. (2019), no detailed study concerning this matter has been published and widely used; therefore, the entire topic

needs an extensive overview. In my study, I explored the topic in detail through the lived experiences of forensic practitioners. This provides greater understanding of the efficacy of existing assessment approaches.

Significance

Offenders' postrelease future violence assessment is just one part of a practitioner's role, yet this role holds a massive responsibility that can have a greater impact on society (Singh et al., 2018). Research has driven the development of approaches to assessment, and within this, psychology has developed a variety of tools and models to assist clinicians in understanding and assessing offenders' complex difficulties. Understanding what led to an individual's offense requires practitioners to understand the person, their life, their attitudes, their coping strategies, and their core beliefs. The overall responsibility of clinicians working within the field is dependent on the information that is available to conduct such assessments. As Hatcher (2012) warned, the consequence of incorrect prediction can be grave. This danger highlights the need to examine the experiences of the forensic practitioners using these risk assessments.

As it pertains to violent offenders, psychiatrists/psychologists spend considerable time assessing the risk of future violent acts by those who have previously committed such acts as society has found value in wanting to save people from harming others. As risk assessment is not an exact science, this study offers insights that could improve outcomes in predicting offender behavior. Indeed, the findings from this study can positively impact forensic practitioners, offenders, and the communities in which they

reside by reducing societal harm, providing greater fairness to offenders, and saving lives.

Summary

The overall aim of this dissertation was to examine the predictive assessment of convicted and incarcerated offenders with a specific focus on the clinical utility of various assessment methods that are used by forensic practitioners. This aim was to find if this current use of the prescribed tools had been highly effective in their overall predictive results and what (if anything) it means for forensic practitioners now and in the future as society is clamoring for added focus on personal safety due to the ever-emerging violent crime rate.

Chapter 2: Literature Review

Introduction

The need for quality forensic predictive offender violence assessments has grown as the numbers of violent crimes have increased dramatically in the last 2 years (Federal Bureau of Investigation [FBI], 2020). Part of developing sound and quality forensic psychological evaluations is evolving the practice toward the development of one specific uniform model/tool that can accurately predict future offender violence. In some cases, not having this specific model/tool for conducting these types of evaluations has led to the evaluation being deemed too vague or unreliable and either inadmissible in some court jurisdictions or leading to a reverse or appeal of an original decision (Naughton et al., 2020). There is a need for more research, which not only substantiates the necessity for, but also moves forward with, additional data collection. More data are essential for the development of a basic framework regarding this specific model/tool for conducting forensic predictive assessments of future offender violence (APA, 2016).

In this chapter, I provide a literature review on the empirically based research on the topic. I also cover, in detail, my conceptual framework, including the theory and model that assisted in the structure and design of this study.

Literature Search Strategy

Five databases were searched: PsycINFO, Medline, EMBASE, Web of Science, and ProQuest. Additionally, the Google Scholar search engine was utilized. Date parameters from 1987 to the present (May 2021) were set where possible, though some databases were searched for earlier publications: PsycINFO (1967 to May 2021), Medline

(1946 to 2021), EMBASE (1974 to May 2021), Web of Science (After 1987), and ProQuest (After 1987). On Google Scholar, all dates were retrieved. Searches were also restricted by language to include English papers only and document type (grey literature was excluded due to the large volume of studies in this area).

Additionally, bibliographies of retrieved papers and reviews were hand searched for relevant studies based on the PICO method (see below). Several key authors in this area were also contacted to obtain papers as well as ask about unpublished studies (papers in preparation) or information about other pertinent studies in the area that they would consider important for review. Three authors responded with papers to be included in the review.

In the search, keywords and other search terms associated with risk assessment, clinical judgement, offenders, and mentally disordered offenders were used. Where possible, mapping to subject headings was utilized in the searches to maximize the inclusivity of available literature. In addition, a keyword search was used to account for variation in coding across the different databases. Wildcards were applied to searches, where appropriate, to additionally maximize the number of articles that were sourced.

Theoretical Foundation

This research was rooted in how forensic psychologists conduct their evaluations in attempting to predict future violence among offenders (Singh et al., 2018). In all cases, regardless of their level (lower or higher court), for expert opinions and scientific findings of any kind to be admissible, they must meet the standards of admissibility for the judicial jurisdiction in which they are presented. As mentioned earlier, there is not a

universally accepted protocol explaining the minimally acceptable standards of professional conduct when conducting future predictive offender violence evaluations. In the context of this challenge, it is important to employ a relevant conceptual framework that possesses the ability to not only account for objectivity in the information gathered, but also carry a component that relays the findings in a manner that can be used to teach and/or promote organizational change. This basically disqualifies many theoretical frameworks; therefore, this study employed a theoretical framework that examined the topic through a risk-need-responsivity (RNR) model (Andrews et al., 2006). McGuire (2012, p. 316) as it is the best fit for this study.

Risk-Need-Responsibility Model

McGuire (2012) defines the RNR model as a "risk management rehabilitation model that seeks to reduce offenders' predisposition to reoffend by eradicating, reducing, or controlling personality and/or situational variables" (p. 316). The overall aim of the model is to target dynamic risk factors through treatment to reduce recidivism rates, and it does this through three key principles (see Table 1). The framework has been instrumental in directing the development and implementation of several assessment tools utilized within the criminal justice system (Bonta & Andrews, 2010). Examples of these include the Offender Group Reconviction Scale (OGRS; Howard et al., 2009); Level of Service Inventory—Revised (LSI-R; Andrews & Bonta, 1995); Offender Assessment System (OASys); Historical, Clinical, and Risk Management—20 (HCR20; Douglas et al., 2013; Webster et al., 1997); Structured Assessment of Risk and Need (SARN;

Thornton, 2002); Risk Matrix 2000 (RM2000; Thornton et al., 2003); and for mentally disordered offenders, Psychopathy Checklist—Revised (PCL-R; Hare, 1991).

The risk principle highlights the importance of the accurate assessment of offenders' risks, to appropriately design interventions to address these. While the efficacy of risk assessment relies on the ability of assessments to accurately predict future behavior (Hatcher, 2012), conducting accurate and robust assessments is also the responsibility of clinicians working within the field and is dependent on the information that is available to conduct such assessments. As Hatcher (2012) asserts, the consequence of incorrect prediction can be problematic. For example, someone who is assessed as unlikely to recidivate may be released from custody. If this prediction is incorrect and the offender goes on to reoffend, this has a real and detrimental impact upon society and the offender.

The framework suggests that interventions that focus on targeting noncriminogenic needs, for example self-esteem or communication skills, are nonessential and as such should be secondary to criminogenic needs. Given the often-complex nature of offenders, particularly those in forensic mental health settings who present with an array of difficulties, focusing only on criminogenic needs both during assessment and intervention would seem inappropriate. The focus on risk and criminogenic needs as opposed to broader needs is likely to demotivate the offender. While the RNR model does provide guidance on dynamic risk factors and thereby indicates what clinicians should be targeting via assessment and intervention, it does not provide practitioners with information regarding how to incorporate such factors into

clinical formulations, treatment plans and intervention designs (Polascheck, 2012). Such factors indicate that there are preferable models of offender assessment and treatment, and more needs to be known about the tools and processes utilized to ensure that offenders are assessed and treated according to their needs, reducing risk.

Good Lives Model

The GLM (Ward & Stewart, 2003), while not strictly a model of offender assessment, informs the assessment and treatment of offenders effectively and overcomes some of the shortcomings of the RNR framework. The approach is defined as a strengths-based approach, and while highlighting the importance of practitioners deriving and addressing criminogenic needs in assessment and treatment, it also places an emphasis on paying attention to offenders' noncriminogenic needs to address and manage their risk effectively (Ward et al., 2007). Despite this, in the context of offender rehabilitation, many offenders' needs may be viewed as being criminogenic. This, again, highlights the importance of accurate assessment to delineate which needs directly impact risk and which are more general noncriminogenic needs.

The model proposes that all human beings inherently strive to achieve several "primary goods," including life, knowledge, excellence in work, play and agency, inner peace, relatedness, spirituality, happiness, and creativity (Ward & Brown, 2004). As such, offending occurs when individuals directly, or indirectly, implement problematic strategies to achieve such goals. In contrast to the RNR model, Ward et al. (2012) suggested that it provides practitioners with guidance in how to engage and motivate offenders. Furthermore, utilizing a strength-based approach, it allows practitioners to

identify treatment strategies while in secure settings and upon release. This enables offenders to access interventions and services that more readily address the breadth of their complex needs. The model promotes collaborative assessment, with offenders taking an active role in identifying their primary goods, alongside identifying how they met these through offending previously. Subsequently, the model then lends itself to interventions that allow offenders to develop skills that will enable them to meet such goods in more pro-social ways, promoting and encouraging desistance from offending (Ward et al., 2012). Ward et al. (2012) argued that this rehabilitation framework guides practitioners in their work with offenders. Overall, it again highlights the importance of practitioners taking an all-encompassing approach to assessment, to appropriately meet offenders' needs and target risks effectively.

Literature Review Related to Key Variables and Concepts

Risk Assessment

Currently, there is an increasing amount of pressure put on clinicians to make decisions regarding offenders' level of risk within forensic settings. This ever-increasing pressure was referenced by Singh et al. (2018) as they mentioned the daily routine of reoffenders that forensic practitioners must continually reassess. Decision making within psychology is an uncertain process, and within forensic psychology it includes identifying, assessing, and quantifying the risk of an individual. Risk assessment in this setting occurs daily, and the quality of patient care is often determined by the accuracy of clinical decision making during this process (Siontis et al., 2015). It is, therefore,

important that the most appropriate and most accurate risk assessment processes are utilized for working with a specific population of offenders.

Risk has been suggested to be a multidimensional concept that looks at an undesirable outcome and the probability of that outcome occurring (Hurst, 2011). Risk is a complex entity and can be even more complex for clinicians to make predictions about. Risk assessment is an inexact science, and, therefore, decisions about levels of risk are ultimately made based on an individual's clinical judgment. It has been acknowledged within the literature that the accuracy and adequacy of risk predictions, specifically with populations of violent offenders, have been questionable (Fazel, 2016). Fazel (2016) argued that mental health professionals' predictions of dangerous behavior were incorrect 95% of the time. Even when correct, Siontis (2015) found that only 16% of new prediction models were validated by different authors within 5 years of their first use, and when external validation of tools did occur, predictive accuracy was reduced. Therefore, the accuracy of judgments relating to risk varies and may be dependent on the professional's discipline and experience.

There are two major approaches to risk assessment that have been widely discussed within psychological literature: clinical judgment and actuarial assessment. The most common approach historically used by clinicians is unstructured, clinical, or professional judgment. As defined by Aeigisdottir et al. (2006), clinical judgment or prediction refers to "any judgement using informal or intuitive processes to combine or integrate client data" (p. 342). This process relies on expertise in gathering, interpreting, and assimilating large amounts of information regarding a patient or client. Alternatively,

actuarial assessment has been suggested to be a method that strives to achieve accurate predictions with validated instruments and algorithms (Falzer, 2013).

Clinical Judgment

The use of the clinical judgment approach allows the professional to have complete control over which information is considered to inform their judgment of an individual's risk. Singh et al. (2018) proposed that one advantage of using this method for risk assessment is that it is flexible and allows a case-specific approach. In contrast to this, however, Singh et al. noted that the approach has low interrater reliability and those decisions made by clinicians who fail to justify these are difficult to question. Further criticism of the approach has been made by Angwin (2016), who criticized the approach for being unstructured, subjective, and suggestive. Angwin (2016) added to this by suggesting that the method is plagued by inherent bias as information is based upon interviewing, observation, and self-reporting. Monahan et al. (2014), in the context of the prediction of violence risk, alternatively argued that using clinical judgment to predict risk is an advantage, as it focuses on the mechanisms by which violence occurs and thus enhances the validity of risk assessment. However, it could be argued that assessment and prediction may be different things and as such require different methods.

Some research into clinical judgment in the past 20 years has been much more optimistic in its ability to accurately predict recidivism (Monahan et al., 2014). Monahan et al. (2014) found that those who were judged by clinicians as minimal risk showed fewer violent incidents in the community; the opposite was found for those judged as elevated risk. In a review of several cases, Berry et al. (2016) found that while actuarial

assessment performed better than clinical judgment in long-term follow-up, the average accuracy during short-term follow-ups was comparable to the average for clinical judgments. It is likely that this is because clinicians were able to judge information accurately and immediately when working closely with offenders. Predicting an individual's behavior in the future, however, becomes more problematic, as clinicians may be unable to predict the change of factors/circumstances, which may impact upon that individual and their risk, reducing the accuracy of clinical judgment predictions in the longer term. Mills (2015) suggested that in the past 20 years of research, one of the key lessons learned is that clinical judgment is a poor and inconsistent method by which to make estimates regarding violent recidivism. One reason for this may be the cognitive biases that occur when humans make such judgments. Singh et al. (2018) highlighted that the true probabilities or likelihood of events, in this case recidivism, are elusive because these "cannot be assessed objectively" (p. 231). They argued that the only way to understand the role of such cognitive biases and more about why human judgments are too high or low would be to analyze the heuristics a person uses to judge the probability of an event. In their research, they looked at availability as one of these heuristics, and this may indicate that judgments made are dependent on the information that is available to the assessor, inherently introducing bias into this process.

Actuarial Assessment

Actuarial assessment methods allow clinicians to make decisions based on data, which can be coded in a predetermined manner. They predict risk based on the relationship between specific cues or risk factors and the occurrence of the behavior—for

example, violence (Naughton et al., 2020). Fazel (2019) suggested that decisions regarding risk are determined according to rules and that this approach undoubtedly improves the consistency of risk assessments. One criticism, as proposed by Skeem and Lowenkamp (2016), is that actuarial approaches ignore individual variations or differences in risk, instead focusing on static variables. They, therefore, failed to prioritize clinically relevant variables and cause passive predictions of risk. Additionally, they have been suggested to limit and undermine the role of the clinician and their experience, as well as the fact that data collection is not standardized, and different clinicians will go about the assessment in diverse ways (Pinals, 2021).

In terms of predictive accuracy for recidivism, Fazel and colleagues (2016) have promoted the validity of actuarial assessments extensively, developing the Violence Risk Appraisal Guide (VRAG; Fazel et al., 2016) and the Sex Offender Risk Appraisal Guide (SORAG; Singh et al., 2018). Early in the assessment oversight process, Harris et al., (2003) compared a variety of actuarial assessment tools in the prediction of recidivism in sexual offenders. They found that all four instruments significantly predicted recidivism at a greater accuracy than chance. Singh et al. (2018) also found that the VRAG, SORAG, Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR), and Static-99 successfully predicted general recidivism.

Clinical Judgment Versus Actuarial Assessment

Clearly, there is conflicting evidence within the literature as to the relative strengths and limitations of clinical judgment or actuarial assessment approaches to risk assessment. The research, however, has gone further than just identifying limitations and

looking at predictive accuracy for the individual methods. It has also compared the predictive accuracy and the relative utility of both clinical judgment and actuarial assessment.

Even before society questioned the predictive assessment process, Monahan (1984) reviewed “first generation” research in the clinical vs. actuarial debate and concluded that clinicians were accurate, in no more than one out of three predictions, in relation to their predictions of violent recidivism. In support of this, a recent review by The American College of Physicians (ACEP, 2015) reported that actuarial assessments had an effect size 88% larger than clinical judgment in predicting sexually violent recidivism. They suggested that this is since clinical judgment is less tied to empiricism and that clinical experience adds little to the accuracy of clinical judgment. Although Gardener et al., (1996) initially stated that while actuarial measures performed better than clinical ratings in predicting violent recidivism in mentally ill patients, clinical ratings were still better than chance. In contrast, as society became more advanced, Fazel (2019) suggested, that the predictive validity of actuarial assessments is not high enough to justify their sole use in the risk assessment process.

There is, however, sufficient empirical evidence to show that clinical judgment is inferior to such formal assessments (Singh et al., 2018). Yet, even if these methods are consistently superior in terms of predictive accuracy, actuarial methods can only be applied when appropriate measures exist and have been validated on the population in question. Many actuarial tools are developed on specific populations, and, therefore, if they are not relevant to the individual undergoing the risk assessment, they are unable to

be used effectively. In practice this becomes more complex. Clinicians make decisions daily which impact whether an individual will be given the opportunity to offend, whereas risk assessment only focuses on the actual recidivism rates of released offenders (Falzer, 2013). As such, the accuracy of such tools is influenced by the accuracy of the clinical judgments which led to an offender's release, highlighting the importance of both approaches.

The requirement for clinicians working with offenders to provide accountable, accurate, and transparent assessments of risk requires greater research into specific populations of offenders (Fazel et al., 2016). At present there is conflicting evidence within the literature and while it tends to highlight the superior accuracy of actuarial assessments, this may not be applicable with certain populations such as mentally disordered offenders (i.e., those with a diagnosis of mental illness and/or personality disorder). This suggests that further investigation into this area is appropriate and required.

Related/Indirect Literature

Regarding the four meta-analyses found, none looked specifically at the predictive accuracy of clinical judgment or actuarial assessment in recidivism, regarding a mentally disordered offending population. Aeigisdottir et al., (2006) in their meta-analysis, looked at clinical vs. "statistical" methods of prediction in general within psychological literature. While touching on the development of "statistical" or actuarial measures in forensic settings, authors did not look at recidivism as an outcome. Additionally, much of the literature is dated before1987,

when “mentally disordered” was not part of the research base. Instead, early research focused on when decisions were made about “dangerousness” as opposed to risk. Although effect sizes within the literature were reviewed, indicating a 13% increase in accuracy when using statistical compared to clinical methods, some of the instruments reviewed were not specific to forensic risk assessment. Therefore, this review was not similar in terms of research questions or outcomes to the current review. Meta-analyses by Spengler et al. (2009) looked at clinical judgment and actuarial assessment; however, this was not in relation to a forensic population. Instead, they examined human health behaviors and mental health and psychosocial issues, respectively. Finally, in another meta-analysis by Hanson and Morton-Bourgon (2009), the predictive accuracy of various approaches to the prediction of recidivism was analyzed. They concluded that empirically derived actuarial measures were more accurate than unstructured professional judgment, however they looked specifically at recidivism amongst sexual offenders. Singh et al. (2018), later with Henwood et al. (2015) in their systematic review and meta-regress, investigated the predictive validity of tools in general and, specifically, their ability to predict violent or sexual recidivism. Neither of these reviews, however, compare the accuracy of such tools with clinical judgment approaches, and both only look at a general offending population. In addition, the meta-review by Singh et al. (2018), was the most relevant, synthesizing nine systematic reviews and 31 meta-analyses between 1995 and 2009 within the forensic risk assessment literature. They were concerned with calculating the probability that anti-social behavior or criminal, violent, or

sexual offending would occur. They examined a variety of themes including, validity of actuarial tools compared with unstructured and structured clinical judgment, a comparison of risk assessment tools, and the predictive validity of these tools for ages and gender. Authors found mixed evidence regarding the predictive accuracy of clinical judgment and actuarial assessment on recidivism in the reviews and meta-analyses. While authors examined the predictive validity of tools for different genders and ethnicities, they did not specifically examine the effectiveness of actuarial assessment or clinical judgment in mentally disordered offenders. Furthermore, the mixed research questions which were addressed resulted in mixed findings and as such indicated a need for further investigation of specific topic areas. Based on the reviews found during the scoping exercise, there is a need for a more specific systematic review which analyses specifically the predictive accuracy of clinical judgment and actuarial assessment on recidivism in a mentally disordered population. In addition, there is a need for more recent literature to be reviewed as reviews have focused on dated research.

Considerable variability and contradictions are evident across the studies, largely because they did not all consistently attempt to measure the same outcomes of the predictive accuracy of clinical judgment vs. actuarial assessment. Two studies that considered the predictive accuracy of actuarial assessment compared to clinical judgment, Bengtson and Langstrom (2007) and Harris et al. (2002), and actuarial assessment alone, as well as looking at socio-demographic variables, found mixed evidence of the effect of these. The first study found that such variables were not found to be significantly

associated with the predictive accuracy of assessment methods (Bengtson & Langstrom 2007). Alternatively, Harris et al. (2002) found that the accuracy of VRAG scores in predicting recidivism were associated with gender, and the VRAG performed better for males than females. They reported a Cohen's d of 1.6 and an effect size of 0.75 $p < 0.001$.

Predictive Accuracy in Assessments

Reviewing the relationship between predictive accuracy of assessment type and clinical variables, a greater number of significant relationships were found. First, for the variable time of follow-up, Bengtson and Langstrom (2007) reported that both clinical judgment and actuarial assessment performed poorly, in terms of predictive accuracy during a short-term follow-up period, with no significant differences between the two approaches ($X^2 = 0.05$-0.99, $df = 1$, $p = 0.32$-0.83). However, the predictive accuracy of actuarial assessments grew as the time that the patient was at risk increased. Snowden et al. (2007) found that the VRAG performed better in short-term follow-up (one year), AUC = 0.86, than long-term follow-up AUC = 0.75. Whereas, in a five-year follow-up (longer-term), Harris et al. (2002) found the VRAG to have high predictive accuracy r (329) = 0.42, $p < 0.001$. Grann et al., (2000) found that within a two-year follow-up, both the VRAG (AUC = 0.68, 95% CI = .63-.76), and H-10 (AUC = 0.71, 95% CI = .66-.76), predicted violent recidivism at levels significantly better than chance.

Singh et al. (2018) found that where clinicians had high confidence in their clinical judgments regarding future violence, there was a strong relationship with actual violence (Wald = 18.947, $p = 0.00$). Further, regarding variables relating to the clinician, Odeh et al., (2006) found that clinical occupation was not a significant factor in any of

the prediction models; however, differences in types of risk cues used were found. A significant logistic regression $X^2(13) = 33.15$, $p = 0.002$, showed that nurses and social workers were more likely than psychologists and psychiatrists to base clinical judgments on hostility (Wald = 6.715, $p = 0.010$), delusions (Wald = 4.248, $p = 0.039$), medication compliance (Wald = 7.683, $p = 0.006$), and family problems (Wald = 4.380, $p = 0.036$). Finally, Huss and Zeiss (2004) found that there was no significant difference in clinician profession on predictive accuracy. They also found that aggregate decisions were accurate above chance levels X^2 (1, $N = 354$) = 14.05, $p = 0.001$. They also found that clinicians were more accurate, although not impressively so, at predicting the severity of future violence, their predictions correlated modestly with actual severity of violence in the sample, $r = 0.12$, $p = 0.03$. It is likely that this is because of the level of detailed information that was available to clinicians.

For other clinical variables that were considered such as sample type, Brouillette-Alarie and Proux (2013), found that the mentally disordered part of the sample had higher scores on the Static-99 (mean = 3.89) than the prison-based sample (mean = 2.11). This could be because of the greater deviance of mentally disordered sex offenders. Also, Ferguson et al., (2009), found that the LSI-R:SV significantly predicted any new offenses in nonsubstance abusers (AUC = 0.78, $p < 0.01$), but not in substance abusers (AUC = 0.51, p>0.05).

Where forensic variables were considered, Bengtson and Langstrom (2007) found that previous sexual offenses were not associated with the predictive accuracy of clinical judgment or actuarial methods, X^2(3, $N = 69$), $p = 0.06$. Bengtson (2008), reported that in

all three assessment tools reviewed, there was lower accuracy in predicting all types of recidivism for rapists than child molesters ($X^2 = 6.16$, *df.* = 1, $p < 0.05$). It is possible that this could be because child molesters have a deviant sexual interest in children and as such are more difficult to treat. Alternatively, it could be because of the wide variety of motives behind, and explanations there are, for rape. Brouillette-Alarie and Proux (2013), found differences for the predictive accuracy of the Static-99R and the Static-99 for sexual aggressors of women and sexual aggressors of children. They found the Static-99R to have better predictive accuracy for both (women: AUC = 0.73, $p < 0.01$; children: AUC = 0.77, $p < 0.001$). Other studies also found forensic variables such as offense type (Kroner et al., 2007) or psychopathy (Tengstrom, 2001) to impact the predictive accuracy of actuarial tools. Kroner et al. (2007) found, for patients who had a violent index offense, their VRAG score predicted general recidivism but not violent recidivism significantly (AUC = 0.702, $p = 0.001$). Tengstrom (2001) found that when psychopathy was removed, the predictive accuracy of the VRAG and H-10 decreased, although this was not significantly (AUC = 07.4, $p = 0.65$).

In examining the findings, there is conflicting evidence regarding the overall predictive accuracy of clinical judgment and actuarial assessment in predicting recidivism in mentally disordered offenders. This variation in findings may be explained by the fact that not all studies looked at both actuarial and clinical judgment methods, choosing instead to focus on one or the other. In studies that considered both actuarial assessment and clinical judgment, Bengtson and Langstrom (2007) found that for predictions of any sexual reconviction the Static-2002 had significantly higher predictive accuracy than

clinical judgment ($X^2 = 4.98$, $df = 1$, $p < .05$). There was no significant difference in the accuracy of predictions made by the Static-99 and those made using clinical judgment. For predictions of a severe sexual reconviction, the Static99 had a significantly higher predictive accuracy than clinical judgment ($X^2 = 5.11$, $df = 1$, $p < .05$), whereas the predictive accuracy of the Static-2002 over clinical judgment fell short of statistical significance. Regarding the predictive accuracy of clinical judgment in predicting violent recidivism, there were no differences found between the two measures. Overall findings suggest superiority of the actuarial assessment method.

Similarly, Harris et al. (2002) compared clinical judgments with actuarial assessments which assess violent recidivism. They found that composite clinical judgment predictions did relate to violent recidivism overall, r (383) = 0.17, $p < 0.001$, especially among male patients, r (329) = 0.23, $p < 0.01$. Suggesting that such clinical judgments do have value in assessing risk of violence in a mentally disordered population. However, they also found that these correlations were significantly lower (p < 0.05) than achieved by the VRAG on the same patients, r (329) = 0.42, $p < 0.001$. These findings highlighted when comparing measures directly, the superiority of the actuarial assessment method.

For those studies that solely looked at clinical judgment, there was again disagreement regarding its predictive accuracy. Singh et al. (2018) review suggested that clinical judgment does accurately predict actual violence outcomes, when clinicians have high confidence (Wald = 18.947, $p = 0.000$), however, this accuracy does decrease when clinicians only have moderate (Wald = 4.336, $p = .0373$) and low confidence (Wald =

0.208, $p = .6480$) in their clinical judgments. In contrast, Odeh et al., (2006) found that clinical judgments of violence were not found to be associated with actual violent outcomes ($X^2(14) = 16.803$, $p = 0.267$) and that clinical occupation did not significantly impact predictive abilities.

Similarly, Huss and Zeiss (2004) found that experienced clinicians were not able to predict violence at levels above chance (X^2 1(354) = 1.68, $p = 0.24$). In contrast however, they found that group dichotomous predictions were accurate above chance levels (X^2 1(354) = 14.05, $p = 0.001$), although when probability ratings of violence were averaged, aggregated clinicians were unable to predict future violence accurately, t (1,354) = 16.4, $p = 0.10$. They suggested that in general clinical judgment lacks predictive accuracy; however, it is possible that when clinician's predictions are grouped, this accuracy is improved. It remains unclear however, whether this would be more accurate than actuarial predictions of risk, although such approaches are used in practice to enhance the validity of assessments.

Included studies which specifically looked at actuarial assessment methods were split into sexual offending measures, violent offending measures, and general offending measures. Four studies looked at sexual offending measures (Bengtson, 2008; Brouillette-Alarie and Proux, 2013; Hanson et al., 2010; Hanson & Thornton, 2000). Hanson and Thornton (2000) found out of the measures they looked at; the Static-99 was more accurate (AUC = 0.71) than the RRASOR (AUC = 0.68, $p < 0.05$) or the SACJ-Min (AUC = 0.67, $p < 0.01$) in predicting sexual recidivism. The Static -99 was also found to

be more accurate in predicting violent recidivism (AUC = 0.69) than the RRASOR (AUC = 0.64, $p < 0.001$) or the SACJ-Min (AUC = 0.64, $p < 0.001$).

Highlighting the Static-99's superiority in actuarially assessing risk of recidivism. Bengtson (2008), also looked at the Static-99 in comparison to two newer measures, the Static-2002 and the RM2000. It was reported that all measures predicted any sexual, nonsexual violent, and violent recidivism significantly higher than chance levels (p < 0.05) in a mentally disordered offending population. Similarly, Hanson et al. (2010) found that Static-2002 predicted all types of recidivism with greater accuracy than Static-99, but differences were not large (sexual AUC = 0.68 vs.0.66; violent AUC = 0.70 vs. 0.66; any AUC = 0.71 vs. 0.66). Finally, Brouillette-Alarie and Proux (2013) found that in the mentally disordered offenders within their sample, the Static-99R (AUC = 0.65, $p < 0.05$) significantly predicted nonsexual violent recidivism at higher levels than the Static-99 (AUC = 0.68, $p < 0.01$). However, for nonviolent recidivism, predictive accuracy was not significant unless looking at the whole sample (which included nonmentally disordered offenders as well). Results suggest that recent actuarial tools developed primarily for predicting sexual recidivism are successful in doing so.

Four included studies also looked at actuarial measures for assessing risk of violence (Grann et al., 2000; Kroner et al., 2007; Snowden et al., 2007; Tengstrom 2001). Grann et al., (2000) looked at the H-10 and VRAG and found that for the whole sample the VRAG's ability to predict violent recidivism, AUC = 0.68. The H-10's AUC = 0.71, was larger; however, this was not significantly so ($X^2(1) = 2.07$, $p = 0.1505$). The AUC's found by Kroner et al. (2007) for the VRAG were slightly higher (AUC = 0.703, $p =$

0.000) and increased further to 0.763 ($p = 0.004$) when the outcome was limited to violent recidivism as opposed to general. Similarly, Snowden et al. (2007) found that the predictive accuracy for the VRAG increased from AUC = 0.743 to 0.776 for general and violent recidivism, respectively. In addition, they found that the OGRS also had prominent levels for general (AUC = 0.785) and violent (AUC = 0.762) recidivism. All the AUCs were found to be significant above chance levels for both measures ($p < 0.0001$). Finally, Tengstrom (2001) also found the VRAG to have a slightly lower predictive accuracy (AUC = 0.68) in comparison to the H-10 (AUC = 0.76) in this sample. According to the research, all actuarial measures significantly predicted violent and/or general recidivism at levels above chance and, therefore, emphasize their utility in clinical settings when working with mentally disordered offenders.

Two studies were also included that looked at other actuarial measures. Ferguson et al., (2009) assessed the predictive validity of the LSI-R:SV in predicting recidivism. They found that it did so at a significant level above chance for any new offense (AUC = 0.67, $p < 0.001$), for a nonviolent new offense (AUC = 0.67, $p < 0.001$), and for a violent new offense (AUC = 0.60, $p < 0.05$). Monahan et al., (2014) looked at developing a new actuarial method for use in predicting risk in a mentally disordered population in clinical settings, the ICT. They also found that this did so at a level significantly above chance (AUC = 0.80, $p < 0.001$). These findings further support the use of actuarial assessment methods when assessing risk.

As mentioned above, the 15 studies included for review had a range of QAS. They showed similarities regarding their methodological approaches and outcomes that

were being considered (Grann et al., 2000; Huss and Zeiss, 2004; Odeh et al., 2006); all studies, however, did not clearly outline outcomes limitation of these studies. The outcomes considered and methodologies used are comparable with other studies, which have also considered the predictive accuracy of clinical judgment and actuarial assessment methods in other populations. Much of the literature in this area, however, is comprised of descriptive papers, as opposed to research studies, and where observational studies have been conducted this has been on general offending populations. One of the studies' strengths is that they represent a mentally disordered offending population. Sample sizes ranged from exceedingly small (Odeh et al., 2006) to exceptionally large (Monahan et al., 2014; Snowden et al., 2007). Those with small samples were likely to have less power and predictive weight, resulting in them being less representative of the population than the studies with larger sample sizes. While Hanson et al. (2010) had a total sample of 3,304, only 311 of these participants were mentally disordered; this was similar in the work by Hanson and Thornton (2000), whose mentally disordered sample was also smaller than the total sample. This again challenges the representativeness of the cohorts in these studies and may have accounted for observed differences in reports of predictive validity of the different methods across studies.

Differences in the quality of studies were evident across the papers that were reviewed. One limitation that is evident across papers is that not all papers use appropriate statistical analysis for outcomes being measured. Fawcett (2006) stated that carrying out receiver operating characteristic (ROC) analysis allows an area under the curve (AUC) to be determined by plotting the relationship between specificity and

sensitivity. This AUC represents the probability that a test or process will classify a randomly chosen positive finding, higher than a randomly chosen negative finding, regardless of base rates. Therefore, to determine the predictive accuracy of a measure (clinical judgment or actuarial assessment) it would suggest this type of analysis would be required, although not all studies used this (Huss & Zeiss, 2004; Odeh et al., 2006). Some researchers also suggested that reporting sensitivity and specificity as well as AUC's is important in providing a full understanding of a test's accuracy (Swets et al., 2000). Despite this, four of the included studies reported AUC's but not sensitivity and specificity, suggesting that findings regarding the predictive accuracy of the measures in these studies may be limited (Bengtson & Langstrom, 2007; Hanson et al., 2010; Hanson & Thornton, 2000; Snowden et al., 2007).

Additionally, a further limitation across all studies except for Monahan et al., (2014), is that they relied on case notes of the patients being studied to score measures or make clinical judgments. While other factors were relied upon as well, this still poses a variety of problems. For example, authors were unable to control how data was originally collected, and there may have been missing data which would have impacted the final data set. Further, this meant that in the case of looking at the accuracy of clinical judgment, clinicians would not have interacted or observed patients, resulting in a lack of information on which to make predictions. Finally, often case records and actuarial assessments are completed using patient self-report, leaving the studies open to an inherent bias.

While all studies made some attempts to identify and control for confounding variable; success of these attempts were limited. Particularly striking, considering the population being considered (mentally disordered offenders), was the number of studies that failed to consider forensic history and the impact that this may have had on the predictive accuracy of assessment methods. Those that looked at clinical judgment (Bengtson & Langstrom, 2007; Harris et al., 2002; Huss & Zeiss, 2004; Odeh et al., 2006) failed to acknowledge the impact clinician's previous knowledge of a patients' offenses (i.e., nature and severity) may have had on their judgments. Additionally, most studies failed to consider more clinical variables such as length of stay. Snowden et al., (2007), did include this variable, but others did not consider it at all, and this could have been a potentially important confounding variable. If a patient had had a longer stay, and clinicians were aware and knowledgeable about the patient, then this is likely to have influenced their clinical judgments. In addition, if a patient has had a longer stay, it is likely that they may have completed numerous psychometric tests and were, therefore, are able to "fake good" and provide an inaccurate profile, as many of the measures were scored using file data, and retrospectively, the actuarial assessments may have inaccurately identified their risk level. Alternatively, the increased length of stay could also have impacted those individuals to become more honest and open, making assessments more accurate. There was also a poor description of sample characteristics in some cases (Bengtson, 2008; Bengtson & Langstrom, 2007; Brouillette-Alarie & Proux, 2013; Grann et al., 2000; Hanson et al., 2010; Hanson & Thornton, 2000; Harris et al., 2002; Kroner et al., 2007), which made it difficult to understand the choice of variables

selected. Studies were penalized accordingly in QA for this, along with the studies' lack of consistency in statistical analyses, bringing the generalizability of studies reviewed into question. While they may be comparable with other studies, which have looked at the predictive accuracy of clinical judgment and actuarial assessment, it is difficult to comment with any great certainty as to whether these findings can be extrapolated to the wider mentally disordered population. Greater specificity in the selection of statistical analysis used, as well as transparency in establishing outcomes and variables to be assessed, may have strengthened the quality of some of the studies.

The Assessment of Offenders

In more modern overviews of the analysis of the assessment tools in conjunction with, the importance of assessing offenders and their risk accurately, it is important to be more detailed. Copeland and Marsden (2020) suggested that any assessment which does not take account of offense data is deficient and it is possible that detailed information regarding an individual's index offense can provide more in-depth information regarding personality difficulties. In addition, other researchers (Silver et al., 2017), have suggested that index offense analysis (IOA) should be a core task of any forensic clinician who is engaged in the assessment of offenders. It is proposed that this should provide as full an account as possible of an offender's relevant criminal events and should also use available crime scene photographs and associated reports. It is argued that this information can then be used to aid formulation related to the individual's risk and treatment planning.

Completing a full assessment including detailed information in relation to an offender's index offense is inevitably difficult; offenders' accounts of their offense may not always be genuine. For example, Logan and Lloyd (2019) found that offenders who had committed more violent index offenses were more inclined to deny, minimize the severity of, or blame their crimes on accidents, alcohol, drugs, uncontrolled emotional arousal, or situational factors than offenders who have committed less violent offenses. Pinals (2021) highlighted that relying on an offender's narrative can result in distortions of the truth. Lastly, Barabas (2019) stated that risk assessment tools (all kinds) are "fundamentally flawed" and prescribed to "magical thinking" in their approach to predicting future offender violence and belief that it can be reliable and effective for all involved.

The assessments which clinicians complete feed into important decisions regarding admission, treatment, risk of reoffending, and discharge from secure services. It is difficult to establish how such decisions can be made if practitioners fail to have a full awareness and understanding of all the evidence and context concerning an individual's specific index offense. This would then result in the practitioner's knowledge of the individual being limited, potentially making their assessment redundant. Information gained from an in-depth review of the offense, may enable practitioners to devise hypotheses regarding the etiology of an individual's offending, by clearly identifying intrapersonal, interpersonal, and situational variables, that had an impact upon the individual. However, if clinicians working with and assessing offenders in their everyday practice do not have knowledge of the benefits of index offense work (IOW) or

what such work entails, it is possible that they will be ineffective in using it. The implementation, therefore, of a structured framework to assist practitioners in the completion of IOW/IOA may be useful. Such frameworks have been developed over the last 20 years in relation to the assessment and prediction of risk, for example SPJ tools. As indicated by Douglas and Belfrage (2014), the SPJ approach allows for a structured professional decision-making system to help facilitate professional risk assessment and management. This approach is now widely used with positive results within the risk assessment field. This may indicate that a similar structured framework or tool in IOA/IOW may also be useful for practitioners working within forensic settings.

Research Relating to Index Offense Analysis/Work

Psychologists working within secure forensic settings often have several methods which they utilize to assess their clients. These models analyzed within this paper has been the primary sources of predictive assessments for sex offenders (Tulley et al., 2013), stalkers (Senkans et al., 2020), fire setters (Perks et al., 2019), violent offenders (Silver et al., 2017) and for this research the primary tools used by the forensic practitioners at the State Hospital.

A functional analysis approach looks at the outward presentation of the individual's behavior but focuses more on the function of such behaviors. It typically involves the practitioner obtaining detailed information about the antecedents, the behaviors, and the consequences of offending (the ABC model). Beech et al. (2003) stated that it should include the actual behaviors carried out, along with the accompanying thoughts and emotions. Other methods include a SORC analysis, as

proposed by Vossekuil et al., (2015). The SORC (S: setting conditions; O: organism variables; R: response variables; C: consequences) incorporates the developmental history and learning experiences of the individual. While these methods of analysis could be and are applied to understanding an individual's index offense, as highlighted by West and Greenhall (2011), currently there appears to be no such structured tool which incorporates these ideas and assists practitioners in specifically carrying out the analysis of an individual's index offense. It is suggested that little is known within the research literature regarding what IOA/IOW comprises, and there appears to be no formal definition. West and Greenhall (2011), however, suggested that IOA can be defined as. "The formal and structured examination of the events, circumstances, and behaviors that occurred before, during and after the last set of criminal actions that brought an offender into contact with the criminal justice system" (p.144-145).

Knauer et al., (2017) suggested that as clinicians, their experience of IOW was a process which assisted the multidisciplinary team to understand the factors which brought the individual into secure services. In their chapter they refered to it as a piece of work which is like a functional analysis which focuses on the individual's offense. A piece of work such as this is likely to assist practitioners in identifying the factors involved in the offense and enable them to link this to potential future risk. In addition, it could aid practitioners in identifying treatment targets for the individual, creating an active account of the offense and provide an understanding of potential cognitive distortions (i.e., thoughts associated with justification and neutralization of the individual's offending behavior).

Within the research literature there appear to have been some attempts to look at the ways in which clinicians may be able to incorporate IOA into the assessment process. Singh et al. (2018) proposed a multiple sequential functional analysis methodology to be applied by clinicians retrospectively to an offender's criminal behaviors. They recommended that this would provide a clear and coherent summary of the individual and enable practitioners to identify situational variables that may promote further offending.

In addition, Singh et al. (2018), proposed the use of functional analysis on an individual's offending behavior, with practitioners asking specific questions in relation to the location of the offense, the victim, and what the offense entailed. The concept of practitioners using formulation or functional analysis to incorporate IOA into their assessments of offenders is not a radical idea. It is already used widely in the general assessment of offenders and the idea itself has been around since Lazarus (1971). It is customary practice that clinical and forensic psychologists utilize this model when working with complex individuals (Wong, 2015). Best practice guidelines for formulation as indicated by the British Psychological Society (BPS. 2016), state that formulations of presenting problems or situations, should integrate information from assessments within a coherent framework. This framework should draw upon psychological theory and evidence which incorporates interpersonal, societal, cultural, and biological factors (BPS, 2016).

Singh et al., (2018), suggested that case formulation is one of the most difficult tasks faced by practitioners, having found that asking clinicians to accurately identify why individuals behave in a specific way is surprisingly difficult. Singh et al. (2018) has

identified the need for further development of an approach to the assessment of offenders, which focuses on understanding more about the complexity of violent behavior, to aid decisions in relation to risk. McDougal et al., (2013) in their research, looked at the contribution of examining offense-related behavior of offenders in prison, prior to their release, and the contribution of this to risk prediction. They found a strong correlation between observed negative behaviors in prison and their frequency in the community. This correlation only indicates a relationship between the two variables, but findings also showed that the frequency of these behaviors significantly predicted the offenders who would reoffend or be recalled to prison. This, therefore, suggests that exploring offense related behaviors in greater detail can have an impact upon the prediction of risk and is something that practitioners could potentially utilize in their assessment of offenders.

McDougal et al., (2013) mentioned that criminological research indicates that one of the major predictors of recidivism is the type and frequency of previous convictions highlighting that past behavior is the best predictor of future behavior. These findings suggest that it is possible to accurately predict offense-related behavior in the prison environment, based on an objective behavioral analysis of the offense. In practice, however, this may not be as easy, for example, in cases where the individual has committed murder, the offender may not have a history of previous offenses. Dobash et al., (2017) found that 13% of murderers had no previous convictions; they, therefore, suggested that further investigation in relation to the assessment of these types of offenders is needed, including a focus on the type of murder and specific situation and contextual factors that may further explain their offending. They indicated that this

supports the need for a robust case formulation approach to the assessment of individual cases and offenses by practitioners. Herman (1990) suggests that, often in psychological formulations regarding the motives of sex offenders, “the sexual offense virtually disappears” (p.182).

Singh et al. (2018), in contrast to others within the literature, suggest that a case formulation approach to assessment such as functional analysis, only focuses on historical discrete episodes of an individual’s offending behavior. It could be argued that this is because this is the only information available to practitioners working within certain forensic settings. This does make sense as generally within forensic settings, interventions with offenders involve a systematic exploration of an individual’s offense—for example, the “decision chain” used in sex offender treatment programs within the prison environment. This looks at a sequence of choices leading to an individual’s offense. Wheeler et al. (2019) highlighted that it is characterized by the situation in which it took place, the thoughts that made sense of and responded to the situation, and the emotions and actions that arose from those thoughts. While this may be useful in providing a practitioner with information regarding an individual’s index offense, it relies heavily on an individual’s ability and willingness to self-report these events, which can be problematic. In addition, the utility of such a process is dependent upon what is then done with it, whether it is further analyzed to provide information regarding an individual’s problematic personality characteristics relevant to their offense, or whether it is just completed as a tick box within a wider intervention. The latter could potentially result in a failure to address some aspects of individual’s offense related thinking,

feelings, or behavior. Further, the offenders that clinicians are working with often must go over their offense several times, in court, parole hearings, assessments, and therapeutic settings, and this may result in the account having a lack of emotional impact upon the offender. In addition, this type of work can be difficult, with offenders reporting that they have poor recollections of the offense due to psychosis or substance use (Pinals, 2021), or a self-defensive strategy that could be conscious or unconscious. There is, therefore, a suggestion that a case formulation exploring Offense Paralleling Behaviors (OPB's) by clinicians would be more beneficial in this type of work (West & Greenhall, 2011); however, this formulation approach would still assume that there was a knowledge of the index offense.

There is evidence within the OPB research which suggests that situational and contextual factors play a significant role in the understanding and prediction of future behavior (Knauer et al., 2017). Therefore, it seems logical that practitioners working with complex individuals should pay more attention to specific aspects of the index offense and use these when developing formulations that will inform treatment and risk-related decisions. The tool proposed by West and Greenhall (2011) to be used for IOA, places an emphasis on including empirical evidence such as that relating to typologies of offenders, (sexual murderers, rapists, child molesters and serious violence), by clinicians in their IOA, rather than just the self-report of behaviors from the offender themselves. They also emphasize the need to corroborate and collate this information in relation to other collateral sources such as witness depositions and crime scene evidence. This is likely to provide a more robust assessment of an individual's index offense, as for example

looking at typologies alone may be limited due to their lack of empirical support and are in fact descriptive, resulting in the assessment being impoverished. What is clear from the research literature is that there is evidence to suggest some form of IOW should be conducted when working with offenders; however, there is disagreement regarding what approach would be most beneficial and a lack of information regarding what such work would involve.

The Use of Index Offense Analysis/Work by Clinicians

There is official guidance which notes that IOW/IOA should be undertaken in forensic and clinical practice, and clinicians are often required to have knowledge of the offenders' index offense and report included at various stages of their work (APA, 2016). For example, those working with offenders who provide the Department of Justice with reports in relation to restricted offenders in secure hospitals must respond to questions relating to the factors underpinning the index offense. This inevitably is not always an easy task when working with individuals who present complex needs. In addition, the U.S Department of Health (2018) outlined those doctors assessing offenders for admission to secure hospital should request "relevant" documentation and information in relation to the offense. However, such guidance poses questions regarding what different professionals may interpret as relevant. The Risk Management Authority (RMA; 2016) stipulates a requirement for clinicians to undertake an analysis of offender's past and current offending, which sets out the specific criminogenic factors relating to the offender. The RMA states that this should include a detailed analysis of patterns of behavior, motivation, antecedents, and diversity of offending. Without this robust

understanding of offenders' forensic histories, it is possible that failures within the criminal justice system may occur, such as that indicated by the U.S Department of Corrections (2016). The findings of these investigations highlight those practitioners who may have failed to have a robust understanding of their clients' forensic histories and their potential to commit further offenses, resulting in significant offender management failures. Inquiring more thoroughly into the criminal history of the offender they are working with should result in a more accurate appraisal of an individual's risk.

Despite extensive guidance outlining the requirement for such work to be carried out, some graduate research found that this still does not happen in practice and that in fact there is little understanding in relation to what IOW/IOA is or what it involves. Ramesh (2018) investigated the level of knowledge of the clinical team in relation to patients' index offenses in a medium secure unit. Findings indicated that staff who were qualified and more senior had a greater awareness of index offense information; however, most staff had not seen witness depositions or crime scene photographs, and many staff working with offenders daily had a limited awareness of their index offense. It is evident that this could inevitably be problematic as a full picture of an individual's offending behaviors and potential OPB's cannot be identified and, therefore, inform risk management decisions and treatment plans appropriately.

It is likely that there are practitioners who include IOW/IOA within their assessment of offenders. However, as identified by West and Greenhall (2011), due to the absence of a formal protocol or guide, the process that they used is likely to be unstructured which then risks compromising the validity of the assessment. In addition, it

means that the use of IOW as part of the assessment process is likely to be not as widespread or as thorough as it should be. They also provide a proposed guide using the principles of functional analysis which ensures that index offense information is collected, analyzed, and incorporated into the assessment process by practitioners. It uses an offender's account of their index offense as a baseline to compare collateral evidence against and relates this to relevant empirical research evidence for that individual's offense (West & Greenhall, 2011). There is, however, no research evidence which indicates that practitioners throughout the United States are currently using such a framework or whether they have developed their own for use within their service. There is also no further research like that of Wanamaker et al. (2018), which indicates the extent to which practitioners have knowledge of or understand the importance of including index offense information in assessments and how they may do this.

Without clear research evidence, it is difficult to know how many psychologists review collateral sources of information in their assessment of offenders and if this involves an analysis of the individual's index offense. It is unclear whether clinicians rely on the most recent data in relation to the offender to avoid a time-consuming crawl through original documents, which may provide valuable information in informing an assessment. Fazel et al. (2019) suggested that an improved assessment procedure will result in an improved formulation, which will provide a comprehensive explanation of offending behavior in each individual case. It is likely that this will further assist in leading practitioners to be more specific in the identification of treatment targets. Fazel (2019) emphasized that a complete assessment is essential for formulation and

appropriate treatment, and it is apparent that IOW/IOA is something which is necessary to ensure a complete assessment.

As outlined here, to date, there is limited research in relation to the concept of IOA/IOW, including practitioners' understanding of what it involves, how they carry it out, the existence of standardized protocols, and how these are all incorporated into their assessment of offenders. Some clinicians may undertake other work prior to or following offense work that allows offenders to engage with the work, process the experience, find a way to live with the emotions resulting from an offense, and commit to a life without offending. This highlights the fact that different practitioners may employ different methods and procedures which comprise IOW. At present there is no research which analyses this, and more specifically, there has been no qualitative research carried out, which explores clinicians' understanding and use of IOW/IOA. An approach such as this has the potential to identify indicators and shared areas of good practice in relation to the assessment of offenders and their index offense.

Summary and Conclusions

This systematic review found that there is a conflict between whether clinical judgment or actuarial assessment is more accurate in predicting recidivism, in a mentally disordered offending population. Overall, notwithstanding the limitations, the findings of the studies reviewed would suggest that actuarial assessment is superior in terms of predictive accuracy as opposed to clinical judgment. All fifteen studies within this review considered different socio-demographic, clinical, and forensic variables in relation to their influence on predictive accuracy. The inconsistency between the variables

considered and the overall findings suggest convincing evidence that there is a necessity for further research in this area, which further considers mentally disordered offending variables.

Most studies considered in this review look at violent recidivism although there are those that consider both violent and sexual recidivism (Wheeler et al., 2019), this discrepancy may account for some of the inconsistency in findings. It may be that clinical judgment and actuarial assessments are affected by offense type and have differing predictive accuracy for several types of offending behavior as Concannon's study would suggest. Further research would benefit from considering such forensic variables as this.

Alternatively, further research could draw more heavily on socio-demographic variables such as gender as such factors are important when considering the tools use in both male and female population groups. Berk et al. (2018), investigated the relationships between gender and clinicians' judgments of dangerousness in a civil psychiatric facility. They found that there were higher judgments of dangerousness for males than females and that there was also a significant interaction between clinicians' own gender and patient gender. While not in a forensic population, this suggests that gender could play a key role in the judgment of recidivism, and rather than aiding risk assessment in psychiatric populations, gender may contribute to the inaccuracy of risk assessment. It is important to note however, that like risk, dangerousness is ascribed to a person and does not help clarify the immediacy, severity, or nature of harm of the individual (Siontis et al., 2015). All of these are also missing from risk assessments and evidence of their

limitation in assisting clinicians in making appropriate judgments regarding someone's risk or release.

The studies reviewed here had a mixed population of males and females, and despite this, gender was not widely considered as a variable. It is possible that future research that took such variables into account, could add significantly valuable information to what is already known about the predictive validity of assessment methods used by clinicians working with mentally disordered offenders. Further, it would be beneficial for researchers to consider male and female populations as separate entities and reporting the differences observed in predictive accuracy. This would have the potential to make findings more externally valid to the wider population of mentally disordered offenders, particularly due to the comparatively smaller percentage of females to males (DOJ, 2019).

Given the small number of studies analyzed in this review, which directly compare the two methods, this clearly emphasizes the need for further research in this area. In addition, it is an indicator that not many firm conclusions can be drawn regarding the predictive accuracy of different assessment types. Research by Monahan et al., (2014) has suggested that a two-stage procedure of risk assessment is employed that begins with actuarial assessment and then moves to a second stage of clinical judgment. A process that keeps the two approaches conceptually distinct but utilizes the clinical advantages of both. However, Singh et al. (2018) suggests that combining assessments does not increase the accuracy in prediction and can, in fact, reduce it. In recent years there has been a move to the development of the structured professional judgment approach (SPJ),

with several risk assessment tools which utilize this approach being developed. One of these, the HCR-20 Version 3, is discussed in greater detail in the following chapter. Overall, what is clear from this review, is that there is a need for additional research on clinical and actuarial prediction, not just of violence but for all types of offenses. A greater understanding would assist clinicians in having a sufficient understanding of the individuals they work with to assess their risk. Furthermore, further research would allow for the development of better tools to aid clinicians, in turn allowing tribunals or other professional bodies to make accurate decisions about patients discharge and risk management. As such, the accuracy of such tools is influenced by the accuracy of the clinical judgments which led to an offender's release, highlighting the importance of both approaches

The requirement for clinicians working with offenders to provide accountable, accurate and transparent assessments of risk requires greater research into specific populations of offenders. At present there is conflicting evidence within the literature, and while it tends to highlight the superior accuracy of actuarial assessments, this may not be applicable with certain populations such as mentally disordered offenders (i.e., those with a diagnosis of mental illness and/or personality disorder). This suggests that further investigation into this area is appropriate and required.

Chapter 3: Methodology

Introduction

Through this study, I aimed to explore clinical and forensic psychologists' understanding and use of IOA/IOW, in the context of their work with offenders in secure hospitals. This was achieved through applying a bottom-up thematic analysis (TA) of practitioners' accounts of the content of their IOW, distinctions between IOW and IOA, and personal challenges that they had faced when conducting such work. The main research questions were as follows:

- What are the lived experiences of licensed forensic practitioners in using risk assessment tools for violent offenders?
- What are the perceptions of licensed forensic psychologists concerning the accuracy of the used assessment tools?

Research Design and Rationale

This study adopted a qualitative method approach to data collection and analysis of the current tools used in the Arizona State Mental Hospital. The data were analyzed using NVivo (computer-assisted software), which is effective for real-time and future analysis. This was done to ensure that the most reliable, ethical, and truthful information was received and used within the study.

A TA approach was selected to analyze data qualitatively and highlight the broader themes surrounding the nature of IOW. TA is a method for identifying, analyzing, and reporting patterns or themes within a set of data. In the case of this research study, TA was applied to transcripts I produced following questionnaires/

interviews. TA was used to organize the data and describe it in rich detail (Braun & Clarke, 2013). TA is not wedded to any preexisting theoretical framework and, therefore, can be used within different theoretical frameworks. I considered TA to be a desirable choice for this type of research, where there is little existing information, and no theories/models are already developed or defined.

There is limited research regarding this topic; as such, studies could be designed using quantitative or qualitative research methodologies, depending on the focus of the study. Patton (2015) pointed out that quantitative research methodologies are employed to test objective theories by identifying and analyzing the relationship between specific variables in an effort to determine whether the specified variables are related to one another. Because I sought in this study to examine how a diverse group of forensic psychologists were conducting their predictive future offender violence evaluations and what their perspectives on implementing a standard of care for future evaluations were, the use of a qualitative approach was employed.

The goal of this qualitative study was to assist in providing the necessary data to develop a basic framework for a standard of care in conducting predictive future offender violence evaluations. As such, the methodology of this qualitative study was thematic analysis. Thematic analysis was the most appropriate methodology, like the more traditional phenomenological approach, as it allows for the rewording and reframing of interview questions in response to discoveries made throughout the data collection process. However, it is more flexible in the number of participants. This afforded the opportunity to have more interviews, as necessary, to reach data saturation. While

thematic analysis is not one of the traditionally employed approaches, its natural flexibility is a useful research tool that can deliver rich, detailed, and descriptive data (Braun & Clark, 2006).

Role of the Researcher

To maintain transparency and aid the reader in understanding potential biases and perspectives in relation to the research area, it is important to include a section on reflexivity. This assists in providing recognition by myself that I am involved in the study and as a result, I could potentially impact its outcomes. In this study, I (as a forensic psychology doctoral student) had undergone similar doctoral training as some of the participants. As such, I had similar experiences working with offenders and conducting IOW within secure forensic settings. I also had some prior knowledge and understanding of processes and concepts within this area. Furthermore, at the time of the analysis, I was working within a prison environment as opposed to a secure hospital, and the potential differences in the ways IOW is conducted in different settings can impact data interpretation.

Methodology

Participants

Participants in this study were recruited from a secure forensic hospital that provided approval for the research to be carried out using its staff. The secure hospital is in Arizona, is of medium/high security, and has male and female wards. The head of psychology was approached through a formal email, which invited qualified clinical and forensic psychologists to participate in the research.

As recommendations for qualitative studies have suggested (Guest et al., 2012), a purposive sampling method was used, which means that the individuals in the sample were chosen because they fulfilled a common criterion, the inclusion criteria (Guest et al., 2012). The inclusion criteria for participants in this study were that all participants were qualified forensic or clinical psychologists who worked with service users and undertook assessments and treatments with them. This approach was taken as only qualified clinical and forensic psychologists could provide rich descriptions of the specific phenomenon that was being explored. Selecting participants who met the criteria afforded me the ability to achieve maximum variation in the diverse group I sought, while also expanding the sample size as suggested by the Singh et al. (2018) study.

The recruitment process resulted in a total sample size of 21 participants. The interviews were run via teleconference via Zoom, with each lasting approximately 60 minutes. Of the 21 participants recruited, 15 were female and six were male.

Data Collection

I obtained permission from the Arizona State Hospital to display an informational flyer at an authorized location throughout the facility with the criteria needed if anyone desired to participate in the study. The selection criteria for the research were specific, requiring that the participants were licensed psychologists or had current experience conducting or had conducted predictive offender violence evaluations within the last 5 years in the United States. A contact number/email was provided for the individual to make contact. Participation was voluntary. Information for the study was collected via engaging participants in one-on-one sessions regarding IOW. I liaised with participants to

establish a suitable time and location to conduct the interview. The rooms were of reasonable size. To avoid any major disruptions, interviews were solo and via teleconference (Zoom) and were carried out on a variety of dates and at various times to suit the services involved.

I developed a questionnaire to explore clinicians' understanding of IOW. The questionnaire was designed to provide some descriptive information in relation to practitioners' understanding and use of IOW, including the frequency of this work, the presence of existing policies/protocols within the service, and the number of hours spent completing this work on a weekly basis. A semistructured interview schedule was also developed by me, with questions considered pertinent to the research question being explored. This was for promoting discussion of participants' understanding of IOW, how they conducted this work, as well as the challenges that this type of work posed. In addition, the schedule contained prompts for me to explore each question, to promote discussion, and ensure that participants fully understood what they were being asked to discuss. The prompts also enabled flexibility and enabled me to explore issues that emerged during the discussion. Each interview was video recorded, as opposed to just audio recorded, due to the fact that it may have made it difficult to distinguish between participants when it came to transcription (due to Covid restrictions, this was done strictly online). I obtained informed consent for each participant. Once informed consent had been gained, participants were tasked with completing a questionnaire.

All interviews were transcribed by me from the audio recordings, verbatim, with all identifying information being redacted during the transcription process, and only

numbers used to identify participants. Any significant nonverbal information was also inserted into the transcripts. Following transcription, all audio/video recordings were stored in a secured area only known and accessed by me, and only the transcriptions were kept for analytic purposes, with all material from the interviews deleted upon completion of the study.

Data Treatment and Analysis Process

In this study, I followed the comprehensive seven-step guidelines for conducting TA as outlined by Braun and Clarke (2013). To be consistent with the main principles of this approach, the stages were completed in an iterative manner.

1. Transcription—Transcribing data from participants using orthographic transcription.
2. Reading and familiarization—Reading and rereading the data and noting down initial ideas in relation to the research question.
3. Coding (complete), across the entire dataset—Coding interesting features of the data in a systematic fashion and collating data relevant to each code.
4. Searching for themes—Amalgamating codes into potential themes and gathering all data into each potential theme.
5. Reviewing themes—Checking if the themes are in relation to the sections of coded data. Generating a thematic map of the analysis.
6. Defining and naming themes—This is ongoing and involves refining the specifics of each theme and the overall story that the analysis describes about the data. Generates clear definitions and names for each theme.

7. Writing and finalizing analysis—The final opportunity to perform analysis on the data, final analysis of selected data extracts, relating back the analysis to the research question and literature, producing a scholarly report of the analysis.

Issues of Trustworthiness

Validity and Quality

Singh et al. (2018) suggested that assessing the quality of qualitative research requires the use of different criteria than those that are used for assessing the validity of research that utilizes a quantitative methodology. In TA, they suggested that face validity is an important concept, and that transparency of the process is critical for making a convincing case for research findings and interpretations.

Ethical Procedures

In order to meet reasonable expectations of ethical research with human subjects, researchers must provide evidence that the potential harm caused by the research is outweighed by the potential gain. These final decisions are often decided by an institutional review board. In the case of this research, that was conducted by Walden University. One of the tools used to ensure this is a consent agreement that is given to each participant that explains the purpose, assures confidentiality, names potential risks/benefits of their individual participation, and confirms the right to withdraw from the research for any reason and at any time.

Confidentiality

When conducting qualitative research, confidentiality assures participants that their name will not be connected to the research. This level of confidentiality helps participants be more honest and minimizes fear of professional or personal retribution should their responses be linked to them. Traditional methods of ensuring confidentiality are to use pseudonyms and to eliminate data from responses used as direct quotations that would make the participants easily recognizable.

Summary

As violent crime trends to record heights (FBI Data, 2020), so does the need for development and implementation of reliable assessments for forensic psychologists who conduct mental health evaluations and assessments concerning future potential violence for the courts. Through this study, I aimed to provide the in-depth data necessary to further understand how forensic psychologists operating in a state mental hospital (in Arizona) were conducting their predictive violence evaluations and to understand their perspectives on implementing proper techniques and tools needed for this specific evaluation. It is my hope that future studies will be able to combine this study's findings with other empirically based studies, to generate a tangible working prototype that is universally accepted as the top choice for conducting forensic psychological evaluations and assessments that predict potential future violence.

In this chapter, I have identified the central concepts of my study while also explaining the rationale for my selection of thematic analysis for exploring the phenomenon. I examined my role as the sole researcher in conjunction with my overall

worldview and addressed potential bias. I provided a thorough account of the participant population, sample size, and the recruitment process. I further identified the various strategies I implemented, throughout the study, to address the credibility, transferability, and confirmability of the research. Finally, I delineated the ethical procedures I implemented to conduct the research study in an ethical manner, while also protecting the research participants and the overall integrity of the study.

Chapter 4: Results

Introduction

This study aimed to explore clinical and forensic psychologists' understanding and use of IOA/IOW, in the context of their work with offenders in secure hospitals. This was achieved through applying a bottom-up TA of practitioners' accounts of the content of their IOW, distinctions between IOW and IOA, and personal challenges that they face when conducting such work. The main research question was the following: How do clinicians working within secure forensic hospitals understand and use index offence work and analysis? Due to the lack of literature regarding index offense work/analysis, I aimed to explore clinical and forensic psychologists' understanding and use of these, in the context of their work with offenders.

A thematic analysis was performed on discussions held between practitioners during the interview process, which were conducted by me. Discussions surrounded practitioners' use and understanding of such work.

The qualitative methodology used resulted in the extraction of a number of themes relating to the processes utilized by practitioners in IOW, these were consistent with models of offender assessment and rehabilitation. A number of themes were also obtained, which highlighted the lack of consistency and understanding amongst professionals and services.

Setting

No abnormal personal nor organizational conditions were referenced by participants that would have significantly affected or influenced the study results. Some

participants reflected on ways that they were frustrated by the challenges of their positions, but this was part of the stories I collected.

Demographics

Participants in this study were recruited from a forensic hospital that provided ethical approval for the research to be carried out using its staff. The secure hospital was located in the state of Arizona and included low- and medium-security sections and had a mixture of male and female wards. Following ethical approval being gained, the head of psychology at the site was approached through an email that invited qualified clinical and forensic psychologists to participate in the research. A summary of the research was included and then cascaded to potential participants; this was so that they were able to opt in to focus groups, prior to seeing the formal participant information sheet and signing a consent form at the focus group stage. I then liaised with participants to establish an appropriate time to visit each site and conduct the focus groups.

As recommendations for qualitative studies have suggested (Guest et al., 2012), a purposive sampling method was used, which means that the samples were chosen because they fulfilled a common criterion, the inclusion criteria. The inclusion criteria for participants in this study were that all participants were qualified forensic or clinical psychologists who worked with service users and undertook assessments and treatment with the data from the assessments. This approach was taken as it was deemed that the qualified clinical and forensic psychologists who would participate in this study would be able to provide rich descriptions of the specific phenomenon that was being explored.

Following the recruitment process, a total sample size of 21 participants was recruited. Personal interviews lasted approximately 60 minutes. Three of the focus groups had five participants, and one had six. The sample recruited was in line with the recommendations for qualitative research (detailed above). Of the 21 participants recruited, 15 were female and six were male. A summary of participant details can be found in Table 2.

Table 2

Summary of Participant Details

Description	Total number
Gender	
Men	6
Women	15
Job description	
Clinical/forensic psychologist	21
Hospital type	
State hospital	15
Correctional facility	6

Data Collection

This study adopted a qualitative approach to data collection and analysis; some quantitative analysis was also conducted on the questionnaire data that were collected, in order to provide descriptive statistics regarding IOW.

Data Analysis

The data gathered from the questionnaires were put into a spreadsheet and analyzed using the SPSS statistics package (version 22) and then was interpreted. The quantitative analysis was minimal as the primary analytic approach in this study was qualitative. This was chosen in order to ensure that sufficiently rich data were collected to

generate unique and distinctive information relating to practitioners' understanding and use of IOW. Within qualitative approaches, it is regarded as important to explain the rationale behind method selection (Singh et al., 2018).

Evidence of Trustworthiness

Validity and Quality

All stages of the data collection and analysis process of this research were reported. This careful detail enables those utilizing the research to make informed assessments on the credibility and validity of the research findings. Furthermore, the use of transcriptions protocols as discussed in the data treatment section enhances validity of the data by ensuring consistency.

Another way in which the validity of this research study was enhanced was through the production of a codebook (Singh et al., 2018). During the development of this codebook, themes, subthemes, and codes were reviewed by an academic peer. This enabled a discussion regarding the names and meaning of themes and enabled me to review and rename these. This increased the face validity of the themes and subthemes developed by me. Furthermore, I supported all themes with quotes in the results section to further increase the validity of findings, as it directly connects interpretations with what participants reported within the focus groups.

Ethical Procedures

Ethical approval for this proposal was provided by the Walden University Institutional Review Board (IRB). It was also asked for by the respective departments at each of the proposed sites. Consent agreements were given out to each potential

participant to explain the purpose, assure confidentiality, outline potential risks/benefits of their individual participation, and indicate the right to withdraw from the research for any reason and at any time.

Informed Consent

Participants were provided with the research summary initially so that they were able to understand the nature of the study. Upon confirmation of a participant's interest in taking part in the research, they were provided with participant information. This outlined to all potential participants the purpose of the study, as well as information regarding the storage of personal information. The information sheets also provided information regarding withdrawal and the secure disposal of data.

Prior to the individual interview, each participant was provided with a consent form to confirm that they were willing to take part in the study. All information was stored securely. Participants were reminded at this stage of their right to withdraw. Participants were not deceived in any way during this study, and they were provided with details of the study aims and objectives from the outset.

Confidentiality

All information and data were stored in encrypted files on a password-protected computer that only I had access to. The video recordings of the interviews were also kept on a password-protected computer and were deleted once transcribed. Transcriptions of the interviews were also stored in encrypted files.

Personal information and consent forms were stored, anonymized, and kept apart from questionnaire information. Participants were notified through the participant

information sheet and again when providing informed consent that they would be quoted in transcripts for the purpose of analysis but would not be identifiable. Upon the completion of this research, all personal information will be destroyed. Due to data protection, transcripts must be kept for a period of 10 years; I saved these to an encrypted memory stick, and these will be kept securely for this time.

To ensure the confidentiality of service users who were referred to during the focus groups, all participants were asked to refrain from using names or other identifying information about service users. Where this did occur, it was redacted from transcripts. At the start of each focus group, participants were reminded to keep discussions confidential.

Results

I began by asking each subject some preliminary questions about departmental policies as they pertained to their work and how important these policies were to conducting proper evaluations of the assigned subjects. These questions also included how much “stock” each forensic psychologist felt these policies contributed to their findings and if the department supported their individual and professional needs for making a proper evaluation. From the responses, I concluded that each forensic psychologist used the tools provided to some extent and that they positively assisted in proper evaluations. Additionally, I learned that their facility supported them in their quest to evaluate each subject fairly and properly.

Analysis of the data revealed a total of three overarching themes relating to IOW/IOA. I asked participants a series of questions in order to gather data on their

knowledge, understanding, and use of IOW. Overarching themes and subthemes that were derived from the data map onto the questions that were asked. All themes relating to each question and the overall research question are summarized below and are presented in a hierarchical manner. In this section, I examine all data extracted regarding IOW/IOA. Select illustrative items and codes are presented here in order to provide context and support for the extracted themes.

Issues Regarding Understanding of Index Offense Work/Index Offense Analysis

A total of four broad subthemes were extracted from the data relating to issues regarding understanding of IOW/IOA. Relevant subthemes were delineated into sub-subthemes in order to ensure that distinct ancillary items were incorporated. The opinions of participants in this area related to difficulties understanding IOW/IOA. Salient subthemes included having issues regarding semantics, the influence of the profession, the influence of the setting, and a reconciliation of considering both mental health issues and risk.

Issues Regarding Semantics

In the context of what IOW involved for practitioners, it became evident through participants' discussions that there were a number of issues relating to the definition of IOW and an "index offense" (n = 18). Participants shared that labeling an index offense an IOW made things more confusing because the work of an IOW is broader than this and does not just focus on an individual's index offense. Participants spoke about "hating the term" and shared frustration that it has different meanings to different people. This

links to ideas endorsed by other participants (*n* = 2) that IOW can incorporate a variety of models and, therefore, cannot be simplistically defined as one thing.

Two participants also endorsed the idea that using the abbreviation IOW can be problematic in relation to what the client internalizes and understands in relation to IOW. Participant 20 suggested that

> Calling it the index offense is the bit that that makes it confusing and a bit like it's very specific, when actually the index offense work will never just be the index offense as you would never just focus on that.

Participant 16 suggested that

> It's inappropriate, problematic behavior. I think the focus is just when you talk about index offense, it's just sometimes assumed that you're going to focus on you know one offense that somebody did and actually you're not often looking at that, you're looking at things way back in the past that led to you know people having the feelings they did about the world and the strategies they then learnt for dealing with their difficulties and that you address those.

Influence of Profession and Setting

Across participants, a subtheme of differences in understanding related to different professionals was seen across participant interviews (*n* = 12). However, this was particularly relevant when participants were asked to discuss what IOW involves them. Participants spoke about how the background of the professional can impact upon the understanding of IOW and how the setting in which it is being conducted can influence this. This resulted in two sub-subthemes, profession and setting.

Profession. A number of participants (*n* = 5) across the focus groups shared that commissioners directing that practitioners should conduct IOW have a lack of understanding in relation to IOW and what it really involves. In addition, participants also spoke about how challenges in understanding the full breadth of IOW were prevalent amongst colleagues within their own teams (*n* = 5). During discussions, some participants referenced potential differences between the training received by forensic and clinical psychologists. This theme may indicate advanced training needs. Participant 16 shared, “But I think commissioners don’t understand that … unless you’re actually talking about the offense itself. Actually, talking about the offense is not going do anything as it’s all about the precursors to it.”

Participant 21 further clarified the challenge:

> I actually think that people are here because of their risk, because if it wasn’t about their risk they’d be in adult services predominantly … I think maybe that’s where the department of health and our, perhaps, psychiatric colleagues particularly do get very focused on the index offense or the incident of risk behavior that’s typically led to their admission, and I think that’s their understanding of index offense, whereas we tend to go “Okay, index offense and then all of the rest of this.” I think sometimes there’s a sense within the clinical team, perhaps, and nursing staff to just deal with the index offense, and that means all of their risk goes away, and so there’s a complete misunderstanding of risk reduction work.

Setting. A number of differences were observed in relation to participants' views on the influence of setting. This largely surrounded the differences between forensic mental health settings and other forensic settings, namely prisons. Comments from participants may also indicate a consensus that secure forensic hospitals are better able to cater to individual needs, rather than generic programs that treat all types of offending. One participant who emphasized that he was from a prison service background highlighted that group offending interventions have been shown to be "what works" within the literature. Some participants (*n* = 2) also discussed how the difference in relation to more formal settings such as tribunals compared with CPAs can impact an IOW and the understanding of the patient. Participant 15 shared,

> Informality works well versus a more formal setting of like a tribunal, where you know the index offense can be very central to panels or decisions you're making about where patients are at with their understanding of that and their risk factors, the CPA process is a more friendly patient friendly forum.

Participant 8 also reflected on the focus of prisons, "Yes, I hadn't thought about that, and I think there's more of a focus on that in prisons isn't there? In the offending behavior programs."

Conceptual Confusion

Regarding differences between IOA and IOW, there was considerable confusion (*n* = 15) among participants. In relation to the processes used within IOW and IOA, a number of participants indicated that IOW and IOA are distinct processes, indicating that one stage follows another, and this usually begins with IOA, with IOW being conducted

dependent on factors such as treatment readiness. Other participants (*n* = 5) suggested that there was an overlap between the analysis and work. This confusion connects to opinions voiced within the focus group of difficulties in the definitions that are used. The idea of IOA and IOW were viewed by some participants (*n* = 2) to be a newer and developing concept in forensic mental health services, which again may be the reason for advanced training. Participant 7 explained, “Yes, so it’s more about getting someone to identify themselves, what do you think you’re current, what are your risks, what are we talking about, what’s likely to potentially happen again?” Another participant (Participant 6) suggested the process was more “like formulating the index offense and what factors impacted on it.” Still another participant (Participant 3) explained that

> There’s two parts, the analysis and then the work. From my point of view the analysis which you would do with everybody is to establish risk and where the risks are and what might need working on as those are usually multiple, but I think with some of our service users you don’t then go on to do the second part, because they may be not at a point where they’re ready, they can’t engage, or they’ve done some work in the past and don’t want to do any more, so the very basic thing you would get from it is information that helps with risk.

Participant 15 agreed by suggesting, “I mean, obviously, the analysis is key before and that’s the formulation really before the work starts,” and Participant 7 warned that “Bringing mental health and risk together can be difficult.”

Work Issues

Participants focused on the idea of mental health and risk issues within secure forensic mental health services. This subtheme pertained to the concept that the combination of mental health and risk can be problematic (n = 10). This was highlighted by Participant 3 who explained the idea of two separate models attempting to come together ineffectively. This subtheme is further separated out into two sub-subthemes relating to treatment of mental health and risk issues and influence of forensic mental health setting.

Treatment of Mental Health and Risk Issues. Related to the opinion provided by Participant 3, other participants spoke about the idea of how IOW and recovery from mental disorder promote risk reduction (n = 3). Some participants indicated that a focus on either risk or mental health is not required for the other; however, some participants highlighted that risk should be the focus. Participant 3 shared

> It's interesting this idea of offense work and contributing to people's recovery, because in some ways it's like you've got two kind of models they're trying to meld together really in some kind of language and I think concerning offense work, does it help somebody's recovery from mental illness? It might but that's not the main aim of it.

Participant 4 added,

> I'm thinking that maybe index offense work might help recovery in the sense that it's helping the service user think about that aspect of themselves which often they cut off from as they don't often like to think of themselves as a perpetrator or

> what they've done and so it might help people to look at the good and bad aspects of themselves and behavior so I guess that might help with recovery in some way.

Influence of Forensic Mental Health Setting. Citing an influence of the setting impacting on the view of risk and recovery was prevalent across participants. In particular, issues regarding specific views held within the setting were evident, as well as the idea of risk and mental health issues being problematic within the wider team. Participants spoke about the confusion between risk and mental health issues, with one participant highlighting that within secure forensic mental health, suggesting that mental health "trumps" risk most of the time. Two participants, in contrast to this, highlighted that this goes against what the literature indicates in relation to mental health and risk, with another two participants emphasizing that the general focus on mental health factors results in important social factors being missed. Following from this, a few participants highlighted how such views can be problematic within the wider team, thus indicating the challenges of IOW within forensic mental health settings. Participant 21 shared,

> I've heard something that's even worse than that. When dealing with the mental health aspect of the offender, once the risk goes away which ironically was the original battle when we were trying to get a risk program even established, there was significant debates about whether that was even required, because it's not relevant to somebody's recovery, which is interesting and at times quite laughable really.

While Participant 17 suggested, “Well, it goes against all the literature that says basically people with mental health problems are no more prone to committing offenses than anybody else so how does that work? If that is the sole cause.”

Participant 7 admitted,

> Partly I think the thing I struggle with sometimes sitting on a clinical team is if the team is just purely focused on moving the offender through the system far too quickly and haven’t actually done any index offense work or thought about it as they might have just in quite a superficial way done some early warning signs work with somebody and then just because they’re stable, they’re looking for discharge.

Participant 19 summarized by saying,

> I think what happens is it’s easier to conceptualize it as mental health has had an overbearing factor because then in the back of their minds I imagine the rest of the clinical team will think other people with those social environmental factors might not have had the same kind of offense pathway, therefore the only obvious difference is mental health, however I totally agree that people with mental health problems aren’t more likely to commit offenses, however, there is a reality that people do act on their command hallucinations and whether it’s just based on that or whether it’s because they’ve had experiences of offenses beforehand. I think that’s the tension that we end up holding this idea that the dominant narrative that it was at some point mental health causes offenses. I think trying to hold both in mind is really difficult and I find myself swaying from and then correcting myself

and saying lets really think about the offense and the mental health both as they interplay and individually.

Content, Processes, and Format of Index Offense Work

Three broad subthemes were extracted from the data relating to the overarching theme of Content, Processes and Format of IOW. Due to the breadth of this overarching theme and its subthemes, subthemes were further separated. This theme dominated most discussions held within focus groups. Overall, in relation to this theme, participants debated the content and goals of IOW, what factors impact the format of IOW, and key processes which are utilized when conducting IOW.

Content and Goals of IOW

A pervasive subtheme relating to the content, processes, and format of IOW was content and goals of IOW. Practitioners (*n* = 17) spoke about developing their own content and goals, the service users' content and goals, and the wider team's insight into factors relating to individual's clinical and risk needs. This was further separated into three sub-subthemes: targeting criminogenic needs, targeting clinical needs, and informing treatment pathway.

Targeting Criminogenic Needs. A predominant sub-subtheme within participants' dialogue, was targeting service users' criminogenic needs through IOW (*n* = 17). Participants inferred that addressing the risk of reoffending was the primary goal of such work and it allowed practitioners to clearly identify risks and risk factors for each individual. Therefore, they focused on establishing the causal factors and functions of offending behavior and addressing these appropriately. Two participants also recognized

that IOW has another goal within secure settings itself, in helping to identify Offending Behavior Programs (OPBs). No other participants supported this viewpoint, and this may be due to the fact that these participants' work in a personality disorder ward where such behaviors may be more prevalent. Participants (*n* = 6) did, however, identify another goal relating to criminogenic factors, developing the wider team's insight into an individual's risk, and making the team aware of relevant behaviors. This indicates that IOW plays a role in the development of risk management strategies. Participant 4, for example, explained, "I think the primary aim is to reduce risks of reoffending." Participant 7, however, shared,

> I always think that this is kind of what I view as the idealized outcome of index offense work. I was thinking about offense paralleling behavior and if someone's index offense is relational in nature, if they could get to a point where they can start to notice where they might be enacting something, so I was thinking about some of the men on with sexual offenses. One in particular engages in lots of offense paralleling behavior. Now if you can get to a point where he can actually notice that he might be using someone for example in a sadistic way and gain some pleasure from talking to the psychologist about their index offense for example, that would be like the ideal outcome is someone gains that level of awareness. I don't know if we really get that far.

Targeting Clinical Needs. Several participants identified other indirect goals of IOW (*n* = 14). These included addressing problematic behavior that an individual presents with, having a global understanding of the individual, as well as enhancing the

service user's understanding of their risk and protective factors and the service user's insight into managing these. Five focus group members also noted that a key goal of IOW is to assist offenders in processing the offense and thereby indirectly develop insight. In addition, one participant identified how specifically working on an individual's mental health issues assisted with indirectly reducing risk. Participant 10 indicated, "I've worked with people where actually the mental health awareness has been the key thing in reducing their risk." Participant 4, however, shared,

> I think the primary aim is to reduce risks of reoffending, but you've also got the goal alongside of helping the offender process the offense and that might indirectly reduce risks of reoffending for their own well-being. I think to process what's happened and to adjust to what's happened and what life might be like after the offense, that's my understanding of it.

Informing Treatment Pathway. Thirteen participants discussed the goal of IOW being associated with informing service user's treatment pathways. Participants (*n* = 9) discussed how assessments, which form a significant part of the IOW process, provide important information regarding what interventions should target and thus inform individual's treatment pathways. Participant 16 explained, "The treatments informed by the formulation because it tells you what areas you need to work on, so I'd say that formulation underlies everything."

A smaller number of participants (*n* = 7) shared that one of the goals of IOW is to direct service users' release from forensic services. This is accomplished both in terms of the practitioner and the individual service user thinking about working towards their

release, as well as the wider team and external influences, such as tribunals and the decisions that they make. Highlighting the wider impact of IOW, Participant 7 shared, “So often the work might be indirect. We might do a risk assessment, care plan someone’s needs for the longer term, but not actually meet with the person at all and you might share that with the team and think about what the risks are but not actually do that work if they’re not ready.” Participant 2, similarly noted, “If they haven’t done a good offense formulation in assessment, you can’t make that explicit, so it might be more difficult for people if they’re not able to engage in that part of the work, to argue in court that anything’s changed.”

Format of IOW

This subtheme related to factors which impact or influence the format IOW takes within forensic mental health settings. The topic promoted a lot of discussion which resulted in this theme being discussed by all focus group participants (*n* = 21). A variety of factors relating to IOW’s format were discussed, and, therefore, there was a need to further divide this subtheme. This was done to demonstrate the discrete factors which may impact this aspect of conducting IOW.

Nature of the Intervention. Some participants focused on discussions surrounding the nature of the intervention itself (*n* = 14). This dialogue corresponded to the intervention regularly involving preparatory or psychoeducational work. More specifically, this dialogue corresponded to motivational work to get service users engaged or to provide them with the necessary coping strategies to tolerate risk reduction work. One participant highlighted that the intervention often focused on further exploratory

work following a risk assessment to really understand where the risk for those individual lives. Another highlighted that, as part of psychoeducational work, external resources to the service were often utilized. Generally, the consensus was that such work involved educating service users how to stay well if they are mentally ill, and as a result, this impacted their ability to manage their risks and engage in IOW effectively. Participant 2 explained,

> There might be motivational work in between which could be protracted for some people. Is there something we can do that makes it more likely that this person is going to engage in work that they need to do to reduce their risks, and therefore get out of hospital and be safe in the community? It might be about getting that person engaged in if they can work collaboratively with other people.

Participant 17 added,

> I'm working with somebody at the moment and I'm doing exploratory work because I need to understand and formulate where that individual's risks lie, because I'm not convinced that it's specifically lying purely in his mental illness for example. I guess my view is almost exploring it with the individual, to say well you tell me where your risks sit and what's going to make them worse or better.

As part of this sub-subtheme, participants discussed how their own background influences the work that they do (*n* = 3). In addition, the expectations of other professionals and settings, such as psychiatrists, tribunals, or commissioners as to the works format (*n* = 4) and how this can impact upon the nature of the intervention were

also described. Interestingly participants who spoke about their own background influencing the work were service leads/senior psychologists (*n* = 2), and all had a background working in the prison service (*n* = 3). This may indicate that a wider range of experience enables practitioners to be better able to influence/ understand how IOW should be approached. Participant 16, for example said,

> I was doing an assessment in consultation, and they were talking about this person in the group, and they were just saying he's just not taking anything in. There saying he had a horrendous past and that he's obviously got no feelings for anybody else, least of all himself. I said, has any work been done on his own victimization and they said no. I said I think that's the starting point and so how can you expect him to worry about anyone else if he doesn't worry about himself, or think he's worthwhile? What's going to motivate him to change his life if you know he just has a real downer on himself?

Participant 21 shared,

> For people here perhaps, who might be going back into the prison service as opposed to being discharged out into the community, the prison service and parole boards are very clear that if you've got somebody who came into prison for a violent offense, but they've got a history of sexual offending, before they can be paroled, they will have to address their SOTP work, even if that was not their index offense. My sense is that it's not about the specific offense and when it was committed in terms of a pattern of offending, it's about what will help this person to lead a more law abiding and less risky, safer, and more fulfilling life.

Influence of Clinical Factors. A highly prevalent sub-subtheme, endorsed by participants (*n* = 17), was the role of clinical factors relating to the service user. This theme is related to the treatment readiness or engagement of the client. Resistance and trauma were also discussed regarding how they affected how the work is conducted, or on occasion, how they prevented practitioners from doing the work. Two participants who work on ASD wards also spoke about how working with client groups who present with significant cognitive or social functioning difficulties can force the practitioner to change the way in which they conduct it. Another emphasized this through stating that service users are often unwell and unable to encode information. All these factors highlight the complex nature of the population within forensic mental health settings and how this inevitably affects IOW. Participant 12 shared, "I think particularly with our ward as well, being ASD, we've got to be more careful because of their literal interpretation of things at times and their already deficit in their social awareness and skills so doing group work particularly around sexual offending could prove detrimental rather than helpful"

Eleven participants also spoke about the fact that often groups cannot be run because of individual clinical factors relating to not having enough service users at the same level of treatment readiness to run groups and the inability of service users to engage. Participant 16 explained that

> The problem is that's sometimes in a group that people who are very quiet cannot contribute very much and then they slip through the net. I remember seeing one man who had borderline learning disabilities and he's been in a group, and they'd

> been talking about the four steps to offending and I was asking him about this and what the four steps were, and he couldn't recall any of them.

Influence of Offense Type. A smaller but relevant sub-subtheme which participants spoke about was the influence of service users' offense types on IOW (*n* = 11). Consistently, participants spoke about how often work must be individualized because of this. In addition, participants held views which emphasized that violent and sexual offenses took priority for IOW, and, therefore, often people who didn't have these types of offenses missed out on carrying out any specific work. Participant 9 explained,

> Well, there was a man that I worked with, and he was involved in many burglaries. He would then get caught, go to prison, and then relapse. Now he has become unwell and very violent in prison, but actually when you did the HCR-20 and you looked at his history and his actual index offense wasn't violence related. I think it's difficult because that was overlooked in that sense.

Participant 3 shared,

> I think that's the difficult thing about the population, even though we're quite a big unit it's surprising when you actually try to get together a group of people with a similar offense, at a similar stage, it's quite hard to do. I think VOTP will be different because I think that kind of extends beyond just well lots of people have got violence in their history, haven't they?

Participants also discussed the fact that for some offense types such as sex offending, group work can put them at risk from others, making service users not wanting to engage. Participant 3 acknowledged, "It's balancing those things. We have tended to

do the sex offender work individually, because you know we've been doing sort of a needs analysis over a period of time, and we just don't have that group of people at the same level that would benefit from a group intervention."

One-to-One Versus Group Work. The topic of whether to conduct IOW on a one-to-one or group basis promoted considerable discussion across all four focus groups. While participants spoke more about group work, one-to-one work was also reviewed by practitioners (*n* = 16). This was mostly regarding the need for IOW to be individualized, as views were held that often group work risks not meeting service users' needs effectively. While participants acknowledged the benefits of group programs, they explained that these were often difficult in practice, and as such, much of their offense focused work or work relating to IOW, was carried out on a one-to-one basis. Participant 6 shared, "I think the actual work focusing on the index offense in this service, at the moment as things are, would mainly be one to one."

Participant 17 explained in greater detail that

> It's the factors that lead you to offend in the first place which are the factors that need addressing. I mean just as you compared two different fire setters, you've got somebody who has no interest in fire whatsoever but are desperate for help because something else has gone wrong in their life and fire was, I guess maybe the impulsive act, so putting them on a six-week program for fire setting for that particular individual is not going to be very helpful, or an effective use of time to be honest and that's where I think CTM's struggle. It's trying to convince people

> that manualized programs have their place, but I think they're very difficult to work into practice in these types of environments.

IOW in a group format was also spoken about by the majority of participants (*n* = 18), indicating it was an area that is central to IOW and its execution in secure settings. Focus group members spoke about both advantages and disadvantages of groups. Some participants expressed views which identified advantages of group IOW (*n* = 9). Essentially, dialogue focused on the ability of the group process to enhance service users' understanding and how often challenges are more powerful when coming from peers. In contrast, one participant identified how sometimes "group think" (Janis, 1982) can be problematic for practitioners to manage. Further, a few participants identified that groups can be useful for conducting indirect IOW, such as substance-related groups, and also that groups can provide important information for the assessment of offenders. For example, some groups provided a better understanding of individual risk factors, indicating that groups do have a role in IOW. Participant 14 explained,

> I suppose what it can do group work like that, you do see people suddenly jumping on an idea so readily, it makes you realize that just how close to the surface those desires are and with just minor amount of prompting from somebody, you know perhaps it's about them wanting to hear that, and somebody only has to say it and then boom they're there, but at least that you're aware of it so that you can deal with it.

Participant 11 shared,

> We've had a group that did really well, quite a mixed ability group actually who did work together really well and challenged each other and pushed each other and seemed to get a lot out of that from the different challenges that they had, but we even saw people who weren't very confident saying 'oh that doesn't make sense', 'you're saying that's going to help you avoid this but it's not, you're just going to end up here' and they were quite accepting of that.

Ten participants also discussed responsivity issues relating to groups and one-to-one work and the importance of considering these. They suggested that such considerations resulted in service users obtaining more benefit from groups, and responsivity across IOW was viewed as a key issue. Participant 9 explained that "There's also lots of anxiety about the service users sharing their index offense within a group setting." Participant 21, however, shared,

> But for me also it's about understanding what a manualized approach is. The manuals are written in a way that supports the strategies and processes and techniques to get the best out of the group and they're flexible enough to consider the individual formulation, so you may do the same task with each person but actually the way in which it's delivered in terms of the skill of the practitioner, is that you would hold that formulation and work that process through with that individual, thereby individualizing the technique or the skill or the focus of that discussion to that individual, which would be different to the person next to you."
> Participant 21

Effects of Disclosure. Offense disclosure was a smaller part of the overall subtheme relating to the format of IOW and was spoken about by a few participants as being problematic when thinking about running IOW in group formats (*n* = 7). Inevitably it is difficult to ask service users not to disclose, as this may be problematic in itself, as highlighted by Participant 1. However, through disclosing offenses, this brings into question service users' safety and well-being, and it was suggested that disclosing may have a potential negative psychological impact. Participants emphasized that this was particularly relevant in secure hospitals due to the small environments, but this, again, poses questions about differences between forensic mental health and other forensic services. Participant 1 shared,

> I imagine if you were to have a group that was specifically about index offense, then you would end up with interesting questions about what it would mean to disclose or not to disclose, what is spoken about, what is not spoken about, and who knows what. I could imagine that being a tricky thing to think about, in that for people's safety and well-being, in many ways it's the obvious thing not to ask not to disclose their index offense.

Additionally, Participant 16 shared,

> The thing I wanted to say about the sex offender groups and index offense work is that it used to be the case that people would be expected to go into the actual offense in gory detail, which is completely and utterly inappropriate and also very boring for a lot of people and titillating for others, which is you know both cases are quite detrimentally harmful.

Processes Utilized in IOW

Processes utilized by practitioners were a central aspect across participant discussions. This subtheme embodies the processes involved and used by practitioners when conducting such work as part of their job role and the challenges faced which impact upon this process. Due to the expansive nature of the discussions relating to this area, the subtheme was further separated into sub-subthemes to demonstrate the variety of factors relating to the process utilized within IOW.

Assessment. A key component of IOW that was noted by participants was the assessment process (*n* = 16). Many participants (*n* = 9) highlighted the assessment process as something that enabled them to gain an understanding of service users' risks and needs. In particular, they spoke about taking a history as being the starting point to the assessment in order to establish where a service user is at. It was evident that key components in the context of a broader psychological assessment involved taking a history and completing a file review. A view was also held that such assessments should be completed on an individual basis. Participant 5 shared,

> I always tend to start with talking about the antecedents to the offense because it can be helpful for the person to tell a story about what was going on for them before. I think I nearly always start with that, often doing a timeline thus allowing them to make a choice about what they can tolerate.

Similarly, Participant 21 noted,

> So, from my perspective I will do index offense work with everybody, but it has the potential to be different depending on who I'm working with. The first part for

> me is always the formulation and understanding the risk issues that are much more global than just the index offense and trying to think about how we cover all of the risk behaviors, because we'll get people who have index offenses that are perhaps regarded as less serious than perhaps some of their previous offending, so I suppose coming from a prison background my experience teaches me that just dealing with an index offense is not always enough.

Formulation. A number of participants spoke about formulation happening first in the assessment process and that this underlies everything that follows. Such processes were explained as allowing practitioners to identify the risk, need of the service user, and make recommendations for to target risk factors/ needs. Additionally, through observing participants' discussions, it was established that formulation is now a formal part of the risk assessment process and allows practitioners to formulate and understand an individual's offending behavior. It seemed that this was a key factor in assisting practitioners' execution of IOW. One participant highlighted how the assessment process allows for everyone involved in an individual's care pathway to understand what can realistically be achieved with that service user. This highlights the importance of the process of formulation in IOW and specifically within the wider context of a secure forensic hospital. Participant 16 explained that "the treatments informed by the formulation, because it tells you what areas you need to work on, so I'd say that formulation underlies everything really." Participant 7 suggested,

> You start with assessment really to try and identify what someone's clinical needs are in terms of their what their risks are, so what they are linked to particularly.

> Obviously thinking about risk of violence to others and whether it's more about someone's sexual offending or whether it's something that you can identify to what the risks are that you need to address.

Participants also voiced opinions which tended to focus on the purpose of IOA (*n* = 10). The majority of participants who spoke about IOA endorsed the idea that it is the formulation aspect of work with a service user (*n* = 6). Only one participant suggested that IOA was a specific formulation of an individual's offense, highlighting a lack of understanding amongst practitioners generally. Participant 16 said, "It's just semantic in a way, because analysis is about doing a formulation and what's it all about and the work is actually addressing the deficits and helping people find other coping strategies, or ways of meeting their needs"

Participant 20, however, expanded,

> I think it's all the same, I think there's a difference between index offense work and index offense analysis, because I think that index offense work is the formulation, but I also think the analysis is when you really go into that specific incident and your yes it might fit into the wider formulation, in terms of coping skills, and alcohol, and or substance misuse, but I think your kind of looking into seemingly irrelevant decisions and how did you get there and why. I think that's more analysis whereas having a formulation that looks at their patterns, is different.

Nine participants also postulated that formulation allows for the whole team to have an understanding in assisting with managing and containing service users, again highlighting its importance in the context of secure forensic settings.

Standard Approaches/Processes. A number of participants spoke about standard processes (*n* = 15) that are in place within their services which are linked to IOW. Participants identified care plans, risk assessment, and formulation as standard processes that they use when conducting IOW. This theme was not prevalent in focus group one, where participants instead focused on the lack of standard processes, which may indicate a specific view. All participants (*n* = 21) identified the need for IOW to be individual in process and two participants identified that there are no guidelines regarding the process or format that IOW should take. Overall, standardized processes were viewed as not useful in this setting, due to the influence of service users and organizational factors. Participant 14 shared, “I suppose when it really comes down to it, it is the processes that are standardized in people’s treatment. The assessment tools and everything else is individualistic.” Participant 20 echoed the sentiment by adding, “There is no guideline that you follow as you base it on your formulation, and you do that work.”

Some participants also spoke about the lack of well-established standardized guidelines for IOW within forensic mental health settings and how having to have such guidelines would have implications for practice (*n* = 9). Participants zeroed in on the lack of guidelines and a lack of formal protocols for working with risk in general (*n* = 4). This may indicate that participants feel ill-equipped when conducting such work. In general, however, participants identified how a standardized approach would risk not meeting

service users' needs, and thus it needed to be individualized and not prescriptive. One participant suggested that where standardized approaches are used this may be due to a lack of resources and another indicated that such "manualized" approaches were used within prison service in conducting IOW. This may indicate further differences between secure forensic hospitals and other secure forensic services. Participant 21 shared,

> I think that it's about whether we become so prescriptive that all these things have to be covered and then you get into that awful position of I can't do this, or this person can't do this, what if I haven't done it, and what are the consequences of not doing that? So, we sort of say that most of the risk literature in terms of intervention will say an assessment, a formulation, an intervention which usually covers a focus on a behavior, a focus on a trajectory, a focus on victims, a focus on staying away from further offending. To me that's as tight as I'd want to see it. I would probably rebel against that despite the fact that that's exactly what I used to do while working in the prison service and I just think if most people know that typical risk work will include certain blocks of work then actually how you do them is about being responsive to the client.

Participant 16 explained,

> You'd be doing the patients a disservice, so people use set protocols when they haven't got resources to offer more, I mean obviously we're lucky because we can work with people individually, we don't need a sort of one size fits all type approach which often ends up then not meeting many people's needs at all.

A Narrative of the Offense. A pertinent sub-subtheme that was extracted from the data was the centrality of an offense narrative to the process of conducting IOW. Participants spoke about this in relation to the practical aspect of conducting IOW (*n* = 15) and the necessity of its interpretation (*n* = 14). Overall participants spoke about the relevance of having a narrative regarding an offense and how this helped them in their role as psychologists, as well as helping the service users themselves.

Through participants' accounts, it was evident that its interpretation was important in providing information about the service user and their risk (*n* = 14). Some participants also highlighted that having a clear narrative of the offense can also be therapeutic for the service users. There were, however, differences observed in that some participants (*n* = 2) endorsed the need for a good offense account. Otherwise, the work that is conducted can't be made explicit, whereas others (n = 2) suggested that this was not the case. This may indicate alternative ways of achieving the same thing, an understanding of the individual and the antecedents to their offense. Participant 2 explained, "I think that usually index offense assessment and analysis is what they are talking about there so, at the most basic level that would be something about do we have a happy story about what happened around the offense." Participant 16 shared, "I see so many patients who've had to trot out the details of the actual offense to umpteen people again and again and its sort of this rehearsed story and it's just irrelevant really, because it's all the stuff that led to it in the first place that's the important thing."

Challenges to Process. Participants also highlighted a number of challenges in relation to the process surrounding obtaining a narrative of the offense (*n* = 10). These

challenges included difficulties met in regard to actually completing the process, such as collecting historical information. This may indicate a lack of organizational policy in relation to accessing patient files, as in practice it shouldn't be as difficult to get access to these. Additionally, the introduction of electronic records in many services could also have impacted upon this.

Challenges were implied as being as a result of a lack of clarity regarding what IOW entails. This included one participant identifying a difficulty in relation to a lack of literature on IOW in general but specifically, for working with service users with learning disabilities, notably users on the Autistic Spectrum Disorder (ASD). This emphasizes the complex and diverse nature of service users that practitioners conduct IOW with and may indicate a feeling of being ill-equipped to do so:

Participant 1 shared,

> I think one of the things I am learning about is that I work in a ward for people with learning disabilities and ASD, is that there seems to be even less written about how to approach a piece of work with that population. There isn't a great deal written about index offense work.

> Participant 2 explained that "There are gaps in existing formulations or gaps in the assessment. Even though there could be volumes of notes it doesn't necessarily translate into volumes of useful information."

Tools Used to Assess Risk. A comparatively small number of participants spoke about the role of assessment tools in the process of conducting IOW (*n* = 9) in comparison to other subthemes. Typically, participants spoke about the selection of tools

being dependent on the service user that they were working with. Within these factors, determining tool selection such as practitioner preference and offense type, highlighted the idiographic nature of IOW. Strengths and limitations of actuarial and clinical judgment approaches to assessment in IOW were also discussed as well as the role of assessment tools in the assessment of risk.

A more prevalent discussion across the participants (*n* = 11) was unsurprisingly the role of tools in assessing risk. Common themes surrounded the use of psychometric and other actuarial tools to inform assessment as well as distinguishing this from conducting specific risk assessments. Participants (*n* = 6) described the use of psychometric tests to inform IOW during the assessment and formulation stages and also in therapy in order to measure progress. Some explicitly spoke about not having a standard battery of psychometrics that they would use in IOW, and this linked to views presented by other participants, indicating selection is based on the individual service user, offense type, and the preference of the practitioner. Participant 15, for example, explained, “I suppose in terms of assessments, there are certain psychometrics you might use during your assessment and formulation period and then also during therapy as you may use measures to look at progress.”

Participant 3 shared,

> We would probably if we were going to do a personality assessment would mostly do the PAI, or if you wanted something that was kind of slightly more diagnostic it might be the MCMI, but I think we would probably use that less, so we might have ones that we favor within the department, but we still have access

to a whole range of things, I think if you're dealing with a sex offender we would use some of the standardized measures."

When discussing the use of tools in IOW, one area which was referenced was risk assessment and the fact that this is a standard process within IOW. In particular, a number of practitioners (*n* = 6), indicated completing an HCR-20, or alternative risk assessment, is standard within IOW. One participant highlighted the fact that such risk assessments combine the actuarial and clinical judgment approaches and as such are more useful. Participant 14 explained, "It's part of standardizing for the HCR-20, so every patient will have that a formulation for the most prevalent violent behavior." Speaking on the same matter, Participant 18 shared, "I think there's enough evidence in the literature to be fairly flexible, it depends on kind of the individuals experience and skills, we do have an initial guide which says use the HCR-20, the SVR-20."

Limitations. A number of limitations of actuarial approaches were highlighted by participants during discussions. These surrounded the lack of applicability of actuarial assessment methods to the client group within secure forensic mental health services and, therefore, IOW. It was acknowledged that clinical judgment approaches are less accurate than actuarial assessment tools. Participant 2 suggested,

> It's finding a comparison data group for a guy with frontal lobe injury, who raped his wife and has substance misuse problems which never happens, so you might be able to be quite precise, but whether or not it relates towards the person you're working with is something that I don't find easy."

Participant 1 noted that "It also gives you a number, but it doesn't give you the why's or wherefores as to what you should do to try and help minimize the risk."

A unique discussion was opened, which pertained to the view that practitioners work within secure settings goes beyond the actuarial (*n* = 8). Highlighting, therefore, the superior role of clinical judgment and the need for dynamic risk assessment in IOW, Participant 3 shared,

> It depends if you're writing a report and what purposes you're writing it for, so I suppose in our general clinical work with this population it goes a bit beyond the actuarial and you've got bits of that incorporated in the HCR-20 which you may not agree is the best methodology, but if somebody was to come to us and say look for this specific report we need to have an actuarial judgment and ok to do this, or this is very basic and there are usually four points to the question and that's it, but for us clinically because most of our job is about the dynamic assessment."

Similarly, Participant 8 shared,

> Depending on as we have just discussed in terms of what makes index offense work, what that means, what that looks like, it can be about anything, so we use an awful lot of psychometrics that assess all sorts of different things which form part of the index offense work, then there's loads of it.

Implications for Practice

Across the practitioners' discussions it was often surrounded the implications of IOW in terms of its practical implementation. These viewpoints ranged from the

importance and centrality of IOW to practitioners' roles, to the characteristics considered as important for practitioners to possess, to effectively conduct IOW. Due to the range of areas discussed in relation to this overarching theme, it was further delineated into a total of four subthemes.

Intrinsic to Practice. A number of participants (*n* = 15) described IOW in the context of their role as psychologists and the embodiment of work that they do in their everyday job role. This ranged from participants endorsing that IOW is intrinsic to being a psychologist, to going beyond the individual and relating to their role in the context of the wider team. This is exemplified by Participant 21 who stated, "its risk that's the remit of the psychologist, mental health is the remit of the psychologist, everything else is the remit of the psychologist." This indicates that there may be a common view held within secure services, that the psychologist deals with a wide range of factors relating to the individual, and that it is expected that they will do this. This may further indicate a lack of understanding by other professionals within secure services as to what such work involves.

Specifically characterizing what IOW involves as a practitioner working within a secure setting appeared difficult for most participants. They endorsed the idea that it is difficult to view IOW as a standalone piece of work and most participants provided information which indicates that IOW is a broad area. Such comments from participants would suggest that IOW is difficult to define and comprises a number of different components. It also indicates a view that it is difficult to separate out IOW from

somebody's entire treatment pathway, instead running intrinsically through everything that both the psychologists and the service users do. Participant 20 shared,

> I find it difficult to think that the work that we do isn't index offense work, because whatever decisions sort of happen within that are all based on whatever's happened before. If it's regarding coping skills in some cases it may be that coping skills fit in with the commission of that offense, if it's about relationships, if it's about attachment, so index offense work to me is just the work because that's how I have always viewed it.

Organizational Issues/Influences. Practitioners (*n* = 14) spoke about the influence of the organization on decisions regarding intervention type (group or one-to-one) when conducting IOW. It was highlighted that decisions are made on a need-led basis, and group work is often not suitable for all service users, but timescales also influence practitioner decisions. One participant also accentuated the monetary impact and how this influences intervention type, as one to one work is often more costly, with another illustrating the influence of the wider organization such as other professionals and anxieties held regarding offense focused groups. Discussions on this topic were conducted mostly in focus groups one and two, this may indicate that offense focused groups are newer concepts within these services. An interesting idea proposed by Participant 19, suggested that the concept of whether groups or one to one work is most effective is always changing, and this may imply a periodic changing in the wider organization's preferences for the format of offense focused work. Participant 19 explained, "But groups aren't suitable for everyone, or it might not at that particular time,

so I agree its needs led but groups can be really powerful. It's cost effective as well to do group work as opposed to individual interventions." Participant 19 suggested,

> I think it's both and I think from my understanding is we move often through cycles of going towards more manualized approaches to then rebelling against it and thinking after you know that didn't work so let's go back towards the individual stuff, go back towards group interaction."

A discrete aspect of this subtheme also extracted from participants' accounts (*n* = 11) related to the difficulties relating to the wider organization and this being a barrier to IOW. Participants alluded to a lack of understanding of the wider team, often resulting in splits within teams. There was a particular consensus amongst participants, of the regular debates regarding the completion of IOW and service users' release from services within the wider clinical team and disagreement over service users' treatment pathways. Participant 3, for example, explained, "They very much appreciate our work, but they don't necessarily relate to what is happening and what it is that we're holding." Participant 5 added, "You can also get splitting in the team especially when you get people thinking why they are still here."

Barriers to Conducting IOW. When reflecting on personal challenges to conducting IOW, most participants (*n* = 18) identified barriers to conducting it. They expressed opinions which indicated challenges because of the service user's presentation, as well challenges personal challenges. Sub-subthemes which comprised the barriers to conducting IOW, included challenges relating to the service user and personal challenges as a practitioner.

Challenges Relating to the Service User. A moderately sized sub-subtheme was extracted from the data relating to barriers when conducting IOW, with 11 out of 21 participants expressing views which pertained to this. The participants described a level of resistance from the service users, who are often unwilling to think about their risk and regularly view IOW as no more than a tick-box exercise. This led on to other participants who identified other challenges as being related to elevated levels of shame, a lack of emotional readiness and the trauma relating to the index offense. Participant 2 shared, "I guess a lot of other people in the system there might be lots of reasons not to think about someone's risk when they really don't want to, and it makes them very upset, and it might make everyone's job harder at that time."

Participant 9 said,

> It can be draining work to do. It's challenging for myself as a psychologist. I think it depends what level, how motivated someone is to do the work because I've certainly worked with someone before who felt they needed to sort of "kick" to get through and do the index offense work and it was a real struggle because they felt sort of forced into doing it.

Personal Challenges as a Practitioner. This was a larger sub-subtheme which was endorsed by a greater number of participants (*n* = 16), participants spoke about different individuals impacting upon them in diverse ways, and the challenge of needing to maintain rapport with the service user despite this. For example, the impact of transference and countertransference and the emotional challenges as a result of this. Some participants highlighted the fact that practitioners become desensitized to the

content of IOW. Interestingly, one participant highlighted that these practitioners receive a lack of training in regard to how to manage aspects of IOW. This was the only participant who highlighted this factor as being a personal challenge in conducting IOW, but it evidences possible further training needs relating to IOW. Participant 19 shared, "That's really interesting, I've totally gone the other end. If I'm going to get attacked, I'm going to get attacked, I might as well go out since he's going to blindside me anyway, so I'll carry on doing whatever I'm doing." Participant 14 added,

> I think it's such a difficult thing to do for lots of different reasons. I think you're often aware of other people's embarrassment and their view of themselves, while also trying to maintain the rapport with somebody under those circumstances and also knowing when it's the right time to approach certain issues with patients.

Practitioner Processes and Skills. All participants (*n* = 21) attested this subtheme and discussed topics relevant to the skills and processes which they utilize in their practice, relating to IOW. Within this theme the need for involvement of the service users themselves in conducting IOW was identified as being of paramount importance.

Participants articulated the need for IOW to have a focus on the individual (*n* = 17). This included the importance of interventions being individualized, in order to meet service users' needs, and be meaningful to them. Simultaneously, participants emphasized the need to be responsive to the individual, working with whatever the presenting difficulties are for that individual, irrelevant of the approach used. One participant, a consultant clinical and forensic psychologist, articulated that this should be done regardless of there being the presence of an offense. This may indicate a more

clinical as opposed to forensic take on IOW, as it suggests a broader focus than just risk, a prevalent view of the forensic mental health settings. It was also emphasized that acknowledging the impact of IOW on service users, and taking a flexible and creative approach to the work is necessary, particularly when working with client groups which present with complex needs. Participant 1 shared,

> I think it's being creative, but it's also thinking about what skills does someone need to have to be able to provide an account of what are your expectations, so for example things like sequencing is a big problem for people with learning disabilities and ASD.

Participant 16 noted that "It's very individualized as it has to be."

The salience of the therapeutic engagement of service users was also a prevalent aspect of this subtheme (n = 14). Participants articulated the importance of collaborative working in encouraging this and enabling service users to understand the need to complete the work. The importance of the therapeutic relationship in conducting such work and promoting this was also made clear. Participant 1 shared,

> I guess that in an ideal scenario what one would hope but not always achieved is if you're able to share your formulation of the index offense and have that be at least partially collaborative where possible, then there can be something therapeutic in itself in terms of people having some understanding of they ended up in that situation.

Participant 9 suggested, "I think some service users may not see the sort of relevance of doing that particular piece of work and it's our job to sort of be able to engage them, to sort of do that piece of work with meaning."

Modes of Support

Participants (n = 14) reported accessing different modes of support in order to manage the personal challenges relating to IOW. Sub-subthemes focused on different modes of support were categorized into supervision and reflection and being part of a supportive team.

Supervision and Reflection

A highly prevalent part of the overall subtheme (n = 16), within participants' responses, emphasized the need to access supervision and utilize reflective practice to manage IOW. Perceptions which characterized this included the need to be reflective when carrying out this work in order to manage what you experience when working with clients with complex presentations. Participant 7 suggested, "We have clinical supervision which is one of the ways you can reflect on your work but a lot of the time it is like informal peer support as well." Participant shared that the IOW is "like an informal de-brief." Participant 21 suggested, "Absolutely, I suppose for us that's what we get in certain elements of our supervision sessions, if that's what we want to use it for."

Being Part of a Supportive Team

A small number of participants (n = 4) described being part of a supportive team as being important in managing the impact of IOW. These participants referred to the role of a dedicated team, with strong leadership, in helping practitioners to hold the emotions

that IOW often provokes. One participant highlighted the necessity of team resilience, and this may have been highlighted particularly due to the fact that she is the service lead for a service who has recently gone through restructuring. This may indicate that psychology teams may not only need to be resilient in relation to IOW, but also to other issues within the wider organizations in which they work. Participant 14 shared, “In terms of coping I think it helps when you are part of a team and can talk to people, I think that really is critical and just acknowledging that what we do isn’t normal, it’s not the sort of thing that most people go to work and do.” Participant 3, similarly, shared, “I think what I’ve rediscovered which has been really pleasing to me, is that strong leadership is actually quite important as well for how you manage the job. We’ve had some real challenges. I think how we’re viewed or how our role is viewed, and I think the resilience of the team is not a surprise.”

Characteristics Important in Index Offense Work

Clinicians (n = 13) identified a number of important characteristics of practitioners conducting IOW. They spoke about the need to be self-aware, objective, and motivated when carrying out such work, as well as the need to have robust coping strategies, such as planning activities in order to be able to leave work at work. In particular, recognizing one’s own difficulties appeared to be an important characteristic and was endorsed by a number of participants (n = 10). Participant 6 shared, “There are some cases where I’ve found it really hard to switch off. I’ve seen that person on the Friday afternoon, and it’s ruined my weekend away because that’s all I’ve thought about.

You have to be careful that the job doesn’t consume you.” Participant 3 echoed Participant 6 saying,

“I think here for me as a supervisor hearing some of this really difficult stuff makes you realize how important this work is and the reason why psychologists do it. You can’t get to be a psychologist unless you’re massively motivated.”

Summary

Within the forensic psychology practice, there have been developments in empirically validated tools and the publication of specialized guidelines (Committee on Professional Practice and Standards, 1994). Despite this, I suggest that there remain considerable inconsistencies in the quality of research and my findings within this current study would support this.

While there are guidelines (APA, 2022) which indicate the need for forensic practitioners to conduct such work, there remains vast inconsistencies in forensic practitioners understanding and execution of such work.

The results of this study indicate that within forensic practitioners' mental health settings do carry out some form of IOW, however this has the propensity to be different because of a variety of factors. It is emphasized within the workplace that forensic practitioners are ethically obliged to provide treatment regardless of the individual and the extent of their offense. It is likely that this blurs the priorities within forensic mental health settings as to what exactly the primary focus of the work should be. As such, forensic practitioners' understanding of what constitutes IOW is much broader than the offense itself. It is evident that there is a lack of understanding about the scope and

purpose of IOW and what it constitutes. The processes used by forensic practitioners identified by this study suggest that they possess good assessments and intervention skills in line with models working with violent offenders. However, the breadth and differing opinions as to what constitutes IOW would suggest that individuals and departments do things differently. While it may be difficult to define, IOW does need to be defined, otherwise this may very well result in failures to accurately diagnose future violence from the offender and the management of the offender in the future. The necessity to complete a proper and complete an individualized assessment, formulation, and intervention was evident thus making the development of specific guidelines for IOW difficult if not impossible. By not including specific formulations of an individual's offense, forensic practitioners risk their assessments being fundamentally flawed and thus rejected for their overall credibility within a court setting. Therefore, specific guidelines which can help form all aspects of the offender's situation will ensure a higher quality offender assessment for all involved.

A key focus for future research should aim to explore IOW and IOA across other forensic settings in order to provide further evidence of the similarities or differences in the assessment of offenders. Additionally, research which tests out the use of formal guidelines in relation to offense analysis would provide evidence of its practical utility and specific information as to whether it would make the practice of assessing offenders more robust. There remains no formal definition regarding IOW/IOA, and there remains a lack of research evidence regarding what it specifically involves. This study has been

successful in broadening the research base yet vast improvements in the area can still be made.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This dissertation provided a greater insight and understanding regarding the clinical utility of historically used approaches and tools in the assessment of offenders and newer concepts that have been suggested within the literature. Through the completion of this work, I highlighted that there are mixed findings regarding appropriate assessment approaches in clinical practice. Despite this, findings showed that assessment tools currently utilized within forensic practice do have limitations. However, at present, they are all that exists, and further empirical research evidence that assists in the development of better and more accurate tools is required. Outcomes of the systematic review indicate that overall, actuarial assessment approaches perform better in accurately predicting risk of recidivism than clinical judgment; however, they also indicated that clinical judgment has a significant role to play. Therefore, SPJ tools such as those discussed in Chapter 3 may have the most clinical utility for offender assessment. It was also illustrated through the research study that clinicians take a responsive and individualized approach to offender assessment; however, within forensic mental health settings, this does not always include a specific analysis of offense information.

Interpretation of the Findings

Issues Regarding Understanding of Index Offense Work/Index Offense Analysis and Implications for Practice

The salient finding of this research across themes was an obvious lack of consistency in understanding related to IOW in general and IOA specifically. Findings

highlighted the importance of the assessment process in IOW. The centrality of IOW to their general practice was acknowledged by practitioners, and this is consistent with the literature, which identifies that work focusing on a service user's offense is a core task of forensic clinicians (West & Greenhall, 2011). Across the interviews, however, inconsistencies in what constitutes IOW were observed, and as such, findings indicated some lack of knowledge or understanding amongst professionals, which may indicate training needs. Different services focused on varied factors as priority components of the work that may indicate a lack of consistency across forensic practice. However, the required characteristics and requirements for support when completing such work were consistent.

A widely endorsed theme derived from the data and seen across focus groups was that participants had issues regarding the terms and definitions used. Participants appeared to struggle in providing any clear definitions regarding IOA or IOW. They conveyed difficulty in defining the work they complete with service users as IOW as the work that they do is much broader than just focusing on the index offense. Additionally, a lack of understanding or a different understanding of the concept and content of IOW from other professionals was identified by participants as inherently problematic, particularly when making decisions as part of the wider team regarding service users' risks or treatment pathways. Within forensic mental health services, there remains inconsistency in the definitions of IOW used, and while practitioners complete IOW as part of their practice, what it involves is down to the individual's understanding. As a result of this, IOW has the potential to look different and be conducted differently

depending on what terminology the professional is using, making it a subjective concept and resulting in work with offenders being inconsistent.

Some researchers highlight that forensic practitioners analyze the patterns of crime for risk factors in order to predict recidivism as part of the assessments that they conduct with their clients (Moore & Drennan, 2013). Others have suggested that this is done in a comparable way to investigative psychologists, who analyze crimes to predict offender characteristics in order to prioritize suspects (Alison et al., 2010). Within the field of forensic psychology itself, researchers are increasingly emphasizing the importance of crime scene analysis for risk assessment. For example, Copeland and Marsden (2020) highlighted that functional analysis, including the identification of modus operandi, is one of the four major components of risk assessment. Further to this, Fazel et al. (2016) emphasized that one of the main reasons for low levels of predictive accuracy in offender recidivism is the lack of examination of the index offense. Contributing to this issue is that the index offense practitioners within the current study viewed IOW as broader than this. The failure of practitioners to make clear links between offense information and the accuracy of their risk assessments further emphasizes gaps in knowledge and understanding relating to IOW.

These gaps in knowledge are further exemplified by the fact that while IOW, in general, was spoken about by all participants, IOA was only spoken about by a portion of these, indicating a more limited understanding. While these participants did advocate that IOA relates to formulation or functional analysis, only one participant noted that IOA is a specific formulation of an individual's offense. This disconnect emphasized the limited

knowledge of practitioners in general in regard to IOA. This may indicate a significant lack of training or understanding in this area and may suggest that there are gaps in the assessments that practitioners in forensic mental health settings currently conduct. The BPS (2016) emphasized that the quality of a practitioner's formulations is dependent on the quality of the assessment and information derived from it. Therefore, if practitioners are failing to utilize essential information regarding a service user's index offense in the assessments that they conduct, it is likely that there may be gaps in both their formulations and assessments.

The IOA was highlighted by many clinical psychologists as something that is better understood by forensic psychologists. While these practitioners did agree that IOA is functional analysis, they did not clearly demonstrate that they would utilize such skills in understanding an individual's offense. This may suggest that there are differences in training across the different disciplines. It could also be as a result of the higher proportion of clinical than forensic psychologists in this sample. Despite this, the sample is reflective of clinicians working within forensic mental health settings and as such demonstrates limited understanding of specific offense analysis and its incorporation into wider assessment. Arguably, this could indicate that practitioners working within these settings are ill-equipped to carry out such work, and findings from questionnaire data supported this. Future research examining and comparing forensic and clinical psychologists' use and understanding of IOW/IOA would be useful in exploring this further.

A less prevalent but important finding and one that may provide further insight into the differences in understanding and use of IOA/IOW was the concept that bringing risk and mental health together is problematic. Participants spoke about it being two separate models trying to fit together coherently, which is not always possible. As a result, participants shared that in forensic mental health settings, mental health becomes the focus as opposed to risk. This causes problems within wider teams, regarding disagreements as to what takes priority, but it could also have wider and more problematic implications. If there is a lack of clear understanding of IOW within secure forensic mental health settings and work surrounding mental health is viewed as meeting this need, this may result in other risk factors remaining "untreated" and offenders' risk needs failing to be met. The differences of opinion as to what should be the focus of IOW further exemplify the need for clearer guidelines and training in order to ensure that the work is consistent across services. There are also issues for service users on 37/41 sentences who go between hospital and prison settings. If IOW has not really addressed their needs, and it is stipulated that they have already completed offense-focused work, they may miss out on opportunities to complete offense-focused groups or other risk-focused work. As such, offenders may be re-released into the community with outstanding treatment needs, making it more likely that they will offend again.

This finding is consistent with the wider literature that has suggested practitioners working within forensic mental health settings are tasked with delivering services to two clients, both the service user themselves and the organization and the wider general public. Falzer (2013) highlighted the potential struggle of working within health systems

or criminal justice systems, in seeing the perspective of the other. For example, failing to see risk as the primary issue or failing to see the broader issues such as mental health and, instead, just focusing on risk could create systematic problems. Heilbrun et al. (2016) argued that the challenges relating to this are greatest in forensic mental health settings where treatment and risk perspectives attempt to converge into one coherent system. This results in considerable debates within teams, as found within this study, regarding the purpose of “treatment” and may have an impact on assessment procedures that are utilized. Consistent with the findings of the current study, Naughton et al. (2020) noted that questions have been raised as to whether the focus of interventions should be to reduce the risk of reoffending or to address symptomatic distress and an individual’s other psychological needs. Such debates are likely to cause tensions within the wider team, and differences of opinion are likely to impact upon the format and focus that IOW takes.

A lack of understanding and differences in opinion regarding the focus and processes used in such work may cause significant splits within teams and could be problematic for the smooth running of organizations. Hart et al. (2011) suggested that sharing with the wider team between all professionals, including relevant nonclinical team members, is critical to safe offender management. It is important to have agreement amongst the wider team. If a definition could be agreed upon with clear guidelines for all professions to follow in relation to the conduct of IOW, this may be beneficial. Findings also indicated that such differences in understanding may vary across different services. There was a view held across participants that other forensic settings such as prisons hold

a restricted view in relation to what IOW is, with practitioners identifying that within forensic mental health they are better able to cater to individuals' needs. There are different processes used to conduct such work across settings; for example, there is much more offense-focused group work conducted within prison settings. Such a finding would indicate that conducting similar research across settings would provide interesting findings about the consistency in process or differences across forensic settings.

In summary, the findings of this research support what the literature base already indicates, that there is some lack of understanding amongst professionals working within forensic settings regarding IOA/IOW. It is possible that this issue could be rectified through additional training; however, more needs to be known about the differences in understanding from specific professionals in order to identify what training needs should be targeted and where in clinicians' development. It is also possible that it could be the language of the work itself that is unhelpful, as findings from this research indicate a good understanding of practitioner roles.

Content, Processes, and Format of Index Offense Work and Implications for Practice

Despite prevalent themes relating to a mixed understanding of the necessity and use of IOW and IOA, data treatment resulted in several pertinent subthemes relating to the content, processes, and format that practitioners currently use as part of their understanding of IOW within forensic mental health settings. Regardless of issues pertaining to consistencies in understanding, practitioners understood that work surrounding a service user's index offense is viewed as core part of their role. These

findings are consistent with other research that has suggested that IOW should be a core task of forensic practitioners who are engaged in working with and assessing offenders (Monahan & Skeem, 2016).

Content and Goals of IOW

The most prevalent theme to emerge from the data regarding what IOW involves for practitioners working within forensic mental health settings was related to skills and processes utilized by them. Participants' discussions surrounded the need for participants to focus on the individual in order to fully meet their needs and for the work to be meaningful to them. In particular, they noted the need for the client to "buy in" to the work and to work collaboratively with the practitioner, thus developing a strong therapeutic alliance. Patton (2015) suggested that collaborative working is key when working with service users on offense-focused work. He indicated that this work is highly valued by service users due to the fact it enables more transparency in process and allows for agreed goals and methods between practitioner and service user, thus enhancing the therapeutic alliance.

Other themes that were widely endorsed further evidenced the need to work in a responsive way when conducting IOW. Factors were largely related to the service user themselves and included treatment readiness and resistance, engagement, cognitive and social functioning, mental state, and the impact of trauma. It is likely that such factors impact what must take priority in terms of the focus of the work and imply that conducting IOW with complex individuals can be difficult. Poor cognitive functioning as a result of psychosis, substance misuse, or other mental health issues have previously

been shown to impact service users' engagement in such work (Singh et al., 2018). Factors identified by practitioners are likely to impact service users' engagement in such work and, thereby, the content and focus of the work. This would indicate that developing standardized ways of conducting IOW is difficult. In addition to service-user-centered factors, a key theme was the influence of the wider organization on such work. For example, the backgrounds of practitioners and their preferences for the ways in which they conduct their work influenced their approach. This links to a smaller theme surrounding the influence of the team and the idea that IOW should promote teamwork in order to have a wide understanding of the individual. Such ways of working are likely to increase understanding and thus allow the team to better manage and contain service users (Hart et al., 2011).

There is a wealth of research that considers the need for practitioners' work with offenders to be as much offender focused as offense focused (Andrews et al., 2011). The complex psychological and social problems of the population within forensic mental health settings mean that individualized assessment and treatment formulations are necessary. Treatment programs need to have multiple components in order to address such problems, and the findings of this research exemplify this. Themes were drawn from the data that related to IOW being conducted on a one-to-one and group basis by practitioners in these settings. While practitioners acknowledged the significant role of group work for enhancing service user understanding, they highlighted reasons for this being problematic in practice. Reasons included the negative impact of offense disclosure and responsivity issues. Participants emphasized that the majority of work regarding

service users' index offenses is at present carried out on a one-to-one basis, as it was highlighted that group work often fails to address the real causes of an individual's offense, and, therefore, risks not meeting their needs effectively. Due to the diverse population, it is often difficult to get a group of individuals at the same level to run a group such as this. Issues relating to IOW may be specific to the diverse population in forensic mental health settings. Melton et al. (2018) highlighted that offense-focused programs for mentally disordered offenders are seen as an adjunct to working with an individual offender and their needs. This is further supported by the findings of the current research, which identified that groups that focus on more peripheral factors relating to offending can be a useful aside to one-to-one offense-focused work.

While such ways of working are in line with models for offender rehabilitation and have good validity (Tully et al., 2016), it is possible that within these settings, the index offense becomes more peripheral, resulting in the offense virtually disappearing (Wolf et al., 2018). Some researchers have identified that failing to identify specific information regarding service users' risks in assessment and intervention and instead attributing behavior to internal, cognitive deficits can be problematic (Murphy, 2020). While the current study's findings are in line with previous research and argued against a "one-size-fits-all approach" to offense-focused work, they did raise questions regarding the consistency of IOW conducted across forensic settings. Questions regarding the sufficient flexibility of the manualized and closely audited programs within the criminal justice system are raised (Hart et al., 2011). It is possible that what participants exemplified within this study in relation to the way they conduct work with offenders is a

more complex and adapted forensic RNR model, as suggested by Robertson et al. (2011). Such a model, however, is theoretically underdeveloped at present and lacks empirical support. Therefore, while forensic mental health practitioners may be effectively meeting the responsivity principle, they cannot be meeting the risk principle if they are not effectively assessing and targeting this through specific offense-focused intervention. However, it could be argued that the RNR model fails to account for the unique set of variables that culminate in a mentally disordered individual's offending.

In general, participants shared that they take an individualized and all-inclusive approach to the IOW conducted with offenders. There was no evidence provided that a coherent and detailed exploration of a service user's offense is conducted, and by not considering the more exact details of an offense, it is possible that the offense gets lost completely. However, this is dependent on the nature of the offense and the driving factors within this. For example, substance abuse work alone could potentially reduce an individual's risk. While practitioners through their interventions may conduct a more systematic exploration of an offense, this will rely heavily on a service user's ability to self-report, and this is problematic within itself (Siontis, 2015). It is possible that in practice the offense itself just becomes a tick box within the wider intervention and as such aspects of it which may provide information regarding an individual's thinking, feeling, and behavior are lost. Given the importance of such assessments, this is inherently problematic.

Processes Utilized in IOW

A number of themes surrounded the idea of having a standardized process for conducting IOW. Participants indicated that care plans, risk assessments, and formulation are all standardized processes which make up part of conducting IOW; however, a lack of guidelines or formal protocols for specifically conducting IOW was evident. However, given the broad nature of IOW, it is difficult to determine what such guidelines would look like. In line with participants' views of the need to conduct work in a responsive way and to best meet all service user's needs, they suggested that a standardized approach for such work would be impossible given the complex nature of the population within forensic mental health services. Some participants shared that standardized processes were utilized only when services had a lack of resources. This begs new questions regarding the differences between offense-focused work conducted across settings, which require further exploration. There was, however, some standardization in processes relating to IOW, in that practitioners stated that they will utilize risk assessments and other tools in order to inform their assessments and formulations for this work. Such ways of working are in line with what the research has suggested. For example, Ward et al. (2015) outlined the characteristics of an ideal treatment program. They asserted that such a program would: appraise risk of recidivism using actuarial devices, deliver services at an intensity which matches a service user's level of risk, and be focused on criminogenic needs as treatment targets. At present, there is no such device which provides reliable risk estimates, or which predicts with complete accuracy whether an individual will reoffend. In addition to this, they suggested the use of psychotropic

medications and CBT therapies would be another important component. While practitioners spoke broadly about looking at antecedents to a service user's offense, they focused much more widely on other factors which if targeted through intervention will indirectly reduce risk. A lack of specific focus on the index offense may result in important risk factors which relate to the service user being missed, although more specifically, this may ultimately come down to the quality of the clinician's assessment or report. Ramesh et al. (2018) suggested that a formal risk assessment should be conducted by practitioners in conjunction with a functional assessment approach to understand behavior in mentally disordered offenders. Conducting IOA as suggested by West & Greenhall (2011) would allow for such an approach, but the findings from indicate that practitioners do not do this.

Gaining a narrative of the offense was a key theme extrapolated from the data, occurring in the context of a broader psychological assessment, the importance of formulation as a key process within IOW was also seen. The purpose of the assessment is to make sense of the individual and their treatment needs, and this includes offense behaviors. Practitioners stated that gleaning a clear picture of an individual's offense can often be difficult as there can be gaps in patient history. Gaps in collateral information are likely to result in practitioners relying on the offender in order to gain a narrative of the offense. Aside from the issues this highlights, this also indicates that there may be issues with the information that practitioners review as part of the assessment process. This patient-led information gathering puts the robustness of such assessments in jeopardy. Different services give a different priority to the necessity to gain such an account, with

some individuals suggesting that an offense account is irrelevant, and some suggesting that the IOW should focus on larger details. Due to the complex nature of the client group, it may be that there is a need to take a broader approach and, as Murphy (2020) suggested, intervention arguably comprises the bulk of the clinical work undertaken with this population. However, this contradicts participants' views that the primary goal of such work is to target risk and may demonstrate issues pertaining to organizational culture.

The collection of third-party information such as medical, criminal, educational, and employment records and statements from witnesses and victims have been identified as a central characteristic of forensic assessment, distinguishing it from other assessment types (Monahan et al., 2014). Information like this is essential in order to corroborate information taken from the accounts of offenders, who tend to distort responses (Murphy, 2020). Moore and Drennan (2013) highlight that in forensic clinical practice, there is often missing data within multiple contexts and perspectives regarding what happened in an individual's index offense. Within the current research, participants identified that collecting historical information can be difficult and highlighted that in practice there could be gaps in assessments. Shapiro et al. (2015) suggested that gaps in formulations and assessments may be as a result of the "accessibility effect". This stipulates that the more readily available the information is, the more likely that it will be incorporated by practitioners into their forensic assessments of service users. Within forensic services there is often information which fails to be included in clinical records or databases. This may make the assessments conducted inherently bereft. This could be an explanation as

to why practitioners currently fail to complete IOA and a formal analysis of an individual's offense, as crime scene data and/or depositions may be unavailable to them. Police have access to crime scene data, and this may highlight another issue regarding a lack of sharing between the police, prisons, and health services. This could indicate wider organizational issues, in that such information needs to be made more readily available in order to ensure that practitioners' assessments of offenders are robust and ensure that all risk factors are identified.

Formulation was accentuated to be key within IOW, and the first component in the process, directing everything which follows. Formulation was spoken about as being important for the practitioner, service user, and the wider team in allowing everyone to understand their difficulties and what can be realistically achieved. Participants evidenced that such information is vital in directing the service user's treatment pathway, both in terms of intervention and directing a service user's release. This communication enables practitioners and service users, as well as the wider team, to think about working towards release as suggested by Monahan and Skeem (2016). These findings highlight the importance of effective formulation and assessment in IOW.

Findings of the current research indicate that practitioners working in forensic mental health settings do conduct formulation as part of IOW; however, they indicate a specific formulation of the offense is not conducted. Naughton et al. (2020) proposed that case formulation should organize practitioners' hypotheses regarding the causes, precipitants, and maintaining factors relevant to an individual's difficulties. The way in which practitioners explained their use of formulation is consistent with this approach,

while they may use models such as functional analysis to assist in formulation, participants did not generally speak about this in developing a formulation of the offense. Moore and Drennan (2013) highlighted that case formulation goes beyond the application of a single model, and this is consistent with practitioners' view in relation to this. They identified that a case formulation allows for the inclusion of a risk assessment but does not wholly rely upon it. Only one participant spoke about the inclusion of a specific offense formulation which contributes to the broader formulation which may also include a risk assessment.

These findings further highlight that there may be components missing from practitioners' assessments and the development of formal guidelines may assist in ensuring consistency and the inclusion of all important components as suggested by West & Greenhall (2011). However, this relies on good research to assist practitioners in understanding the key components. While there is consensus generally that mental health professionals should conduct formulation as a core competence of their practice, as indicated by Hart et al. (2011), there is no agreement concerning how practitioners should conduct or evaluate it. Logan and Johnstone (2019) suggested that formulation might be particularly important when working with individuals who fail to respond to medication, who present with complex problems, or who may pose a risk of harm towards themselves or others. This makes sense, given the population that practitioners who took part in focus groups work with. However, a specific analysis of offense behaviors may assist in telling practitioners more about these individuals and allow them to assess and treatment plan more effectively.

Findings indicate that practitioners complete IOW within forensic mental health settings and that this has a number of key components. What is clear, however, is that the work is extremely broad in nature and requires an individualized approach. As such, this would make specific criteria and guidelines difficult. Despite this, the lack of inclusion of specific offense analysis was evident, and this may mean that the assessments conducted with offenders have significant gaps and fail to identify all relevant treatment needs. Guidelines, therefore, relating to the inclusion of a specific offense formulation and the collateral information which should be reviewed as part of this may be more useful.

Limitations of the Study

The current research is not without its limitations. First, it is possible that the present study suffers from being unable to generalize findings due to the relatively small sample size. The sample size was deemed suitable for use with a qualitative methodology (Braun & Clarke, 2013). Due to the broad nature of the research question, however, it is conceivable that other factors relating to practitioner's use and understanding of IOW/IOA remain unexplored. This study may also be limited due to its reliance on purposive sampling methods and strict inclusion criteria. The inclusion criteria were qualified psychologists working within secure forensic mental health settings. This may have resulted in the population being studied not being completely representative of all psychologists working with offenders across secure settings. During text analysis, differences were observed between the opinions of forensic and clinical psychologists as well as indications that practitioners viewed IOW being conducted in a different manner in other forensic settings—prisons for example. Also, the sample comprised of qualified

psychologists only, the majority of whom were clinically and not forensically trained. As such it may not be appropriate to draw conclusions regarding IOW and IOA practices and processes across psychologists' work with offenders in different services, as problems may be specific to those working in secure forensic mental health services. Despite these limitations, the findings have been useful in beginning to highlight diverse ways of working and discrepancies in training and understanding. They provide a clear focus for future research where practitioners' understanding and use of IOW and IOA could be explored across disciplines and services. In addition, the inclusion of trainee psychologists could provide valuable information regarding further differences in training.

Finally, some questions may arise regarding the treatment of data in this study. TA is content driven and was chosen by the author since it is theoretically neutral. Despite this, there remains a risk that when applying codes to the data and when deriving the thematic hierarchy, the author could have imposed some subjective bias. It is possible that the themes derived from the data were biased by what I (a trainee forensic psychologist) already knew about the theoretical concept of conducting IOW/IOA, and the practical application of it in the role of a forensic psychologist. Such potential issues were, however, addressed through the development and use of a novel codebook and also through completing IRR checks. Guidelines for conducting TA were also strictly adhered to (Braun & Clarke, 2013).

Within forensic practice, there has been a development of empirically validated tools and the publication of specialized ethical guidelines (Committee on Ethical

Guidelines for Forensic Psychologists, 2020; Committee on Professional Practice and Standards, 2020). Despite this, many researchers have suggested that there remains considerable inconsistency in the quality of assessment practice (Heilbrun et al., 2016). Findings from the current study would support this. There is limited substantiated or regulatory guidance for many forensic professional activities, one of which would appear to be IOW. While there are guidelines (RMA, 2016; DOJ, 2018) which indicate the need for practitioners to conduct such work, there remains inconsistencies in practitioners' understanding and execution of such work.

The results of this study indicate that practitioners within forensic mental health settings do carry out some form of IOW; however, this has the propensity to be different, as a result of a variety of factors. It should be emphasized that practitioners are ethically obliged to provide treatment of distress or disability, whether or not this is the cause of offending. It is likely that this obligation blurs priorities within forensic mental health settings as to what the primary focus of the work should be. As such, practitioners' understanding of what constitutes IOW is much broader than just an offense. It is evident from the findings of this research that there is a lack of understanding across teams about the scope and purpose of IOW as well as what it constitutes. The processes utilized by practitioners as identified by this study would suggest that practitioners possess good assessment and intervention skills, which are in line with models for working with offenders. However, the breadth and differing opinions of what constitutes IOW would suggest that individuals and services do things differently. While it may be difficult to define, IOW does need to be defined. Otherwise, this may result in failures of offender

management due to essential information regarding offenses being lost. The necessity to complete individualized assessment, formulation, and intervention was evident, thus making the development of specific guidelines for IOW difficult. However, through not including specific formulations of an individual's offense, practitioners risk their assessments being fundamentally flawed. Therefore, guidelines which assist in the formulation of this, which could contribute to the wider assessment, may be useful.

A key focus for future research should aim to explore IOW and IOA across other forensic settings in order to provide further evidence of the similarities or differences in the assessment of offenders. Additionally, research which tests out the use of formal guidelines in relation to offense analysis, would provide evidence of its practical utility and specific information as to whether it would make the practice of assessing offenders more robust. There remains no formal definition in regard to IOW/ IOA, and there remains a lack of research evidence regarding what it specifically involves. This research has been successful in broadening the research base and thus achieved some of the aims; however, improvements in this area can still be made.

The fact that Chapters 2 and 4 only consider forensic mental health settings and the assessment of mentally disordered offenders, however, is an overall limitation of the current study. As a result, this limits the ability of findings and conclusions to be generalized to the assessment of offenders in general. Previous research has indicated (Melton et al., 2018), that mentally disordered offenders present with more complex problems and require different approaches to assessment and treatment. This could mean that findings from the research study would not be applicable to the assessment of

offenders in other settings. Overall, this project has provided evidence that greater research is required, both regarding the efficacy of specific assessment tools to aid clinicians in understanding what it most appropriate and accurate with mentally disordered offenders and also regarding the offender assessment process, including the use of IOW/IOA in a variety of other forensic settings. Such research would inevitably assist practitioners in conducting more robust assessments across offending populations, which would, in turn, result in more consistency across settings and ensure more effective offender management.

Recommendations

Findings from this dissertation may be extended in several ways through future research. First and foremost, researchers need to conduct relevant research which directly compares assessment approaches and clinical tools used in forensic practice on a variety of offending populations to enhance their clinical utility further. Secondly, researchers need to further explore practitioners' understanding and use of IOW/IOA across professional disciplines and settings, researchers could. Research such as this would assist in generating a more robust and reliable understanding of offender assessment, it would allow for terminology to be clearly defined, and in the case of IOW/IOA, it could assist in working towards clearer guidelines for the conduct of this work, making assessments more consistent. This would then further assist with the standardization of processes across settings and help ensure more effective offender assessment and management.

Additionally, a national database should be created where each assessment finding by a licensed forensic psychologist which has been determined by the courts to be a "qualified expert" could be easily viewed for its record/success concerning offenders' long term predictive violence results. This will keep "score" of the various and relevant data in every incident and the tools used. This database would keep the "record" of the forensic psychologist regarding their assessment that was admitted as "expert" testimony, how each resulting case was adjudicated, and the human results. In addition, and more importantly the database would keep an account of the "expert," their tools, and their process in the long-term prognostication of future violence for the specific individual (offender) being evaluated.

Will my vision ever happen? I suppose if enough time goes by and if the courts become more transparent, society will see the injustices that I, in my last role as a public defender, viewed on a daily basis. This "conveyor belt" of decisions (future offender violence) was "swept under the rug" as the individual being arrested was viewed as a statistic. They were not viewed as a real person with complexities and nuances that were not and never will be properly calculated by a "qualified" forensic psychologist and his/her fallible, highly biased offender future "predictive" (violence) model that was never held to any standard.

Implications

Based on findings from Chapters 2 and 3, this dissertation supports the idea that tools utilized by practitioners are valid, dependable, and have good predictive accuracy to a limited extent. Given these flaws, findings suggest that such tools should be used as

part of a broader psychological assessment, which utilizes several tools and/or psychometrics to inform a formulation and arrive at a judgment of risk. This may enable practitioners to make the most accurate and robust assessment of offenders, although further research is needed in order to further validate these conclusions. Previous research has suggested that low levels of predictive accuracy in offender recidivism is a result of a lack of examination of the index offense (Pinals, 2021). One way of achieving such an examination would be for practitioners to include an analysis of the individual's offense within their assessments or as part of their IOW. Future research could look at the types of assessments and reports carried out by clinicians and the quality of these in order to explore this further.

While formulation is acknowledged as being an important aspect of offender assessment (Logan & Johnstone, 2019), there remains, at present, no agreement on how it should be conducted. This coupled with inconsistencies in the understanding and interpretation of IOW/IOA across disciplines, professions, and settings, could result in practitioners' assessments having key components missing. A lack of understanding could be due to a number of factors. First, it may indicate that practitioners working within forensic mental health settings are ill-equipped to conduct such work, this may be due to a lack of understanding and overemphasis on mental health needs. Training aimed at the wider multidisciplinary team may increase awareness of the importance of targeting risk, as well as mental health needs, during assessment and intervention. It is also possible that clinicians may not have direct access to the index offense information needed for such an analysis, or that there are gaps in the information they have access to.

With records held on offenders moving increasingly towards an electronic format, it is possible that this may be the case.

Findings from this dissertation support an argument that providing guidelines to assist clinicians in assessing offenders may be useful in assisting their practice and how to include IOW/IOA within this. What is evident from the findings of this dissertation, however, is that this would be difficult due to the complex nature of offenders and the need to be responsive to everyone's needs. This includes the tools selected by practitioners to assess risk being appropriate to the client group. It is important that particularly in forensic mental health settings that mental health as opposed to risk does not become the focus of assessments.

In summary, without further research relating to the assessment processes used with offenders, in particular the use of tools for specific offender subgroups and the inclusion of IOW/IOA, this could result in the accuracy of clinician's assessments not being as robust and comprehensive as they could be. In the case of mental health settings, if priority is given to mental health over risk issues, this could result in outstanding treatment needs. In the general assessment of offenders, it could also result in risks and needs not being accurately assessed and understood, resulting in offenders not undergoing appropriate treatment, resulting in risk management failures. Offender assessment remains a prominent issue in forensic practice as more empirical research evidence is required to further validate tools and assessment approaches and help further clinicians' understanding and use of them.

Conclusion

While there is evidence of common areas of good practice across services in relation to index offense work, understanding regarding what the work involves was inconsistent. Index offense work within forensic mental health settings requires an individualized approach, and specific guidelines, while useful, may be difficult to implement. Findings indicate that at present IOW is not routinely implemented by practitioners. Areas for future research are discussed within each interview.

This dissertation examined different approaches to assessment utilized by clinicians in forensic practice. This was achieved through exploring and evaluating historical and widely used assessment methods, clinical judgment, actuarial assessment, and SPJ approaches. In addition, newer ideas for inclusion in the assessment of offenders (IOW/IOA) were also examined through an original research study.

Within the literature the importance of offender assessment and its impact on important decisions has been widely discussed (Monahan & Skeem, 2016). Clinicians working with offenders clearly have a legal and ethical responsibility to identify factors relating to offenders' criminal behavior, which place them at future risk of reoffending (Melton et al., 2018). Risk assessment tools have been widely reviewed within the literature (Singh et al., 2018). Despite this, questions remain regarding which approaches are most appropriate to use with different offender populations in forensic practice. Therefore, the current research was conducted to explore this in more detail, in order to understand which existing approaches and new concepts are most useful in increasing the

accuracy and utility of offender assessment, allowing clinicians to carry out more robust assessments.

In order to consider the accuracy of clinical judgment and actuarial assessment approaches, which are widely used by practitioners to predict risk of recidivism within mentally disordered offending populations, a systematic literature review was conducted. Findings indicated that generally actuarial tools performed better than clinical judgment when predicting risk of recidivism and are therefore most useful for clinicians when assessing risk. Despite this, researchers who assessed clinical judgment still found it to be useful. Few of the studies found directly compared clinical and actuarial approaches, making it difficult to categorically conclude which approach is most useful, although overall findings would indicate that the integration of both approaches may be most successful in accurately assessing offenders. Practice reflects how ideas about risk and its assessment have changed, and while there are now risk assessments which assist practitioners, it would seem that these have failed to have a significant impact on recidivism rates. Furthermore, predictive estimates (AUCs) only provide us with estimates above chance levels for entire samples. This limits the utility of such actuarial measures, meaning that clinicians are still dependent on their clinical judgment, again highlighting how approaches in practice cannot be distinct.

As indicated in Chapter 2, using both clinical judgment and actuarial approaches in the assessment of risk may be most useful. The SPJ (Hart et al., 2011) approach combines actuarial scales with structured professional judgment by clinicians. An example of a tool using this approach and widely adopted within forensic settings is the

HCR-20 (Logan, 2014). It is important to understand its reliability and validity as this has impact upon the clinical utility of the measure. In Chapter 3, I presented an overview of its most recent revision (version 3.0) and considered literature relating to its validity and reliability in relation to its ability to predict long-term violence.

The newest version of the HCR-20 framework does meet criteria for having good psychometric properties to an extent. However, its validity and reliability are lacking in a number of areas, including concurrent validity. Much of the literature exploring this concept is conducted by the authors of the framework and fails to compare it to other structured tools used to assess violence risk, such as the VRAG. Therefore, further empirical research evidence is required that should compare the newest version to other measures of violence risk and validate it on other populations and forensic settings. As with Chapter 2, it may also be particularly useful to assess the tool's predictive accuracy with mentally disordered offenders, to assess its use specifically with this population. Furthermore, current research indicates that the clinical scale is not that dependable; this is possibly due to the fact it fails to consider the individual nature of disorders and their impact upon risk. The clinical utility of such a tool within forensic mental health settings is, therefore, questionable given the complex nature of clients. The individualized approach to assessment that is required does not lend itself to the use of a structured tool. Also, research indicates that the tool is often used improperly (Barabas, 2019), and this could mean that it ignores risks related to other offense types or specific populations. Without further research, however, it will continue to be used widely by practitioners since there is arguably nothing better at present.

Chapters 2 and 3 explored existing tools utilized by practitioners in their assessment of offenders. Both chapters highlighted the limitations and strengths of such tools and the role they play in assisting clinicians in accurately assessing offenders. It was considered important to build on this further and explore additional approaches proposed within the literature to be useful in enhancing clinicians' assessments of offenders. Some literature (Harris & Rice, 2015) indicates that IOA/IOW would enhance clinicians' assessment of offenders. Existing research also indicated that at present this is often not well understood or incorporated by the clinical team (Barabas, 2019). As something which has been seen to increase clinicians' understanding of an individual, their complex needs and their risk (therefore having potentially important implications for forensic practice), it was deemed appropriate for further investigation through a research study.

A qualitative research study was carried out to explore clinicians' understanding and use of IOW/IOA in their clinical practice. A thematic analysis of practitioners' discussions was conducted, and a variety of themes were extracted from the data. Findings were consistent with previous research with regard to the processes used by practitioners, for example, collaborative working (Fazel et al., 2019) and responsivity (Andrews et al., 2011), and highlighted the centrality of IOW within the practice of assessment. The importance of assessment and formulation was also highlighted as a key process, something which has been widely discussed within literature (Berk et al., 2018).

Interestingly however, it was evident that a specific formulation of the index offense is not necessarily included in practitioners' assessments. As research in this area develops further, it may be useful for professional bodies to develop guidelines pertaining

to this, which would assist its implementation by practitioners. Findings were consistent with research literature pertaining to "what works" in offender assessment (GLM and RNR). The results argue against a one-size-fits-all approach to offender assessment but did raise questions regarding the consistency of processes utilized as part of IOW across different services. While practitioners do conduct some form of IOW within their practice, this did not appear to consistently include an analysis of an offender's index offense.

A salient finding was a lack of consistency in understanding IOW and more specifically IOA. While it was found that such work was viewed as central to practitioners' roles and to the assessment process, terminology and definitions used were viewed as problematic. Finally, another key finding which possibly has broader implications for practice, was difficulty in forensic mental health settings of bringing together risk and mental health. This finding supports the wider literature (Knauer et al., 2017), which suggests that the complex needs of a mentally disordered offender group mean that an individualized approach to assessment and treatment is necessary—in line with the "what works" literature. It became evident however, that on occasion this could result in the index offense being lost completely, presenting wider issues in terms of risk management failures.

Legalized Betting

Another year, another set of analyzing humans and their propensity to commit future violent acts. That's the name of the game in the dynamically erratic world of predictive behavior (violence), and it means things will never go as expected.

No matter how many high-priced academic credentials one has obtained or the numerous courts/judges that claim one as a “expert” you are going to be wrong thanks to the highly complex nature of humans and the randomness of the very triggers, scenarios, situations, etc. that can set even the most mild-mannered of us in to an uncontrollable and sometimes unstoppable rage. That’s not a cop-out, it’s just a reality that more within academia, the medical community, and the public alike need to become comfortable with the fact that luck plays an enormous role in the way every subject’s future potential violence prediction is shaped.

This reality all leads to increased variability for each analyzed individual’s future chance of violence and accepting that is half the battle when it comes to making predictions; the other half is illustrating that uncertainty. That’s something that should be a big focus of forensic psychologists, and it starts with understanding the process behind the projections.

To begin with, who makes the standard of whom will or will not be violent in the future? How is the data compiled and disseminated? Is my algorithm the same and/or better than the thousands of supposed “experts” within the forensic psychologist community, all with their unique proprietary models which they all personally claim is the standard by which all future offender violence models should be judged? As you can see, we have opened quite the Pandora’s box. This approach would be acceptable if we used the models to analyze the future of the stock market, a startup business’s chance of success, or even what I do to supplement my income (sports betting), but do we want this

same vague randomness and chance when we are talking about a person's freedom and/or the safety of society itself? I surely don't!

What needs to be done is that all agencies/jurisdictions need to mandate and enforce that all forensic psychologist's projections begin with the same template across all jurisdictions to maintain at least the illusion of conformity. This will ensure each subject will be given a probability of violence. Then we can have a foundation that will allow the forensic psychologist to incorporate their own intrinsic knowledge and techniques into a review and assessment of each unique subject. This will allow the ability for psychologists to incorporate context, culture, age, scenarios, etc. into the overall assessment.

Like any analysis of humans, the results are both expected and unexpected. Even though the Ivy League student or the stay-at-home mother of two were not the "typical subject" prone to future bad acts, they still managed to engage in violence thanks entirely to random variation. The same thing goes for high-risk subjects who were seen to be "prime candidates" for future violence (gang members) yet have refrained from the violence what was perceived and predicted. In the world of predictive future violence, the spread between the best and worst predictive success is so thin that it's a 60/40 split or closer. With the success rate so negligible, how then can we as a forensic psychologist community who are supposedly the most "intelligent" within the field of future predictive violence be called upon as "experts" and dictate the future of a person's life?

What I have found out throughout this long and laborious study is that the more we think we know (aided by a multitude of highly complex models about whom will or

will not partake in future violent acts), we know less than before. With this enlightenment, it has become evident to me that in the forensic psychologist world analyzing subjects results in a wide range of outcomes, and its why future predictive violence predictions will always be wrong (sometimes wildly) no matter where they come from. So, simply put, the ultimate task at hand is to be less wrong than everyone else. Now isn't that comforting!?

The only guarantee found within this study is that in the world of attempting to predict future violence in humans anything is possible, and while I tried my best to convey that in this study, I feel it will not be enough to get the point across. I'm almost sure that the nation's courts will undoubtedly continue to play "tennis" with dueling "experts" as these thespians try in vain to show a bewildered court who the is the smartest of them all is with no real resolution except for a highly confused and disillusioned jury who simply shrugs their shoulders and draw straws on a subject's future.

In the end, people only have one chance at this thing we call life. Do we want it left up to the vague, variable, and discriminatory dots on a scale which are systematically interpreted by someone (forensic psychologist) the offender has never met, who is only involved (in many instances) to display their "expert" testimony for a $250 hour retainer, who couldn't care less about what happens to the accused in the future as there is no oversight and/or accountability? This question and many others not included within this study are certainly "above my pay grade." Yet if these (and many more) questions are not addressed, the lives of the accused along with their friends/families and all associated with the individual will be severely and forever affected with no remedy and/or solution

in sight. Without drastic risk assessment reform that I proposed and invite others to add to, we will have to continually pick up the pieces of broken lives dictated by nothing other than a proverbial "flip of a coin?"

The bottom line is that you should expect the unexpected. "Good people" might falter, and "bad people" might surprise. Anything can happen so let the unpredictability reign. What could possibly go wrong!?

Wild Card

Humans have always been the most intelligent creation on Earth. With the emergence of Artificial Intelligence (A.I) (Parmigiani et.al., 2022) this distinction may no longer be true.

Predicting future offender violence in forensic settings is a continual challenge for forensic practitioners. The current risk assessment tools show negligible benefits in clinical practice, are time consuming, and forgo context and individualization in assessing offenders

In my time doing research for this study, the unveiling of a revolutionary concept (Artificial Intelligence) has exploded into society. Can this be implemented in the forensic world to predict future offender violence? To date, there are some that are just beginning to find out if this approach can change the way forensic practitioners approach their work.

With something new there are major questions and concerns about how A.I would be used. The strengths of any argument for are that it can increase the percentage of correct analysis to such a degree that the tools of today would become obsolete overnight.

Like anything the appearance of greatness can sometimes cloud the underlying issues that can come with such an extreme change in what has been established.

The main argument to counter the positives would be the fact that by using A.I it will be taking any individualization and context of the offense itself out of the picture; thus, the duties and decision making of the trained forensic practitioners would become no longer needed.

Another negative would be whoever created the data would control the entire process as the A.I decision making process for be the final say in any proceedings. By allowing A.I to have this power, it will make all human decisions irrelevant thus making the profession itself over time be in danger of extinction.

In the end, more research will need to be performed to increase our comprehension of how to implement A.I in a forensic setting and decipher if A.I can be a valuable addition in future predictive offender violence. A.I is something that not only we in the forensic field will have to address, but our entire society will also have to answer as well. Soon, we, along with society, will have to decide if we want to keep control of the process or allow the data to control us all.

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Appendix: Participant Questionnaire

Background

Participant Information:

- Age
- Gender
- Length of time you have been a licensed psychologist.
- Length of time you have been conducting offender evaluations.
- How many offender evaluations have you completed in the last five years?

Education, Licensing, and Specialized Training Approach to Predictive Future Violence Evaluations:

- What type of degree(s) have you obtained?
- Do you hold any specialized forensic training and/or certifications?
- What judicial standards of admissibility do you operate under?

Semi-Structured Interview Questions:

1. What is your general approach to conducting offender evaluations?
    - What are the specific steps you take?
    - What standards/guidelines do you follow for offender evaluations?
2. What types of tests do you employ?
    - What constitutes the psychological testing you employ?
    - Do you evaluate for malingering and exaggeration? When, why, and how?
    - When structuring your test strategy, do you have a fixed battery of tests or a flexible customized battery of test?

3. What are some familiar challenges and/or oversights you have encountered during offender evaluations?

- What are some of the ethical challenges and how are they addressed?
- What are some of the diversity factors and how are they addressed?

4. What are your experiences surrounding the current assessment tools?

- Positive experiences?
- Negative experiences?

5. What are your thoughts about implementing a standard of universal protocol in future predictive violence evaluations?

- In your experience, what should be included in the protocol for an offender evaluation?
- In what ways do you believe your assessment might be beneficial to judicial proceedings?
- In what ways do you believe your assessment might complicate judicial proceedings?

6. How does index offence work fit into treatment planning for the offender?

- How does it assist the offender's recovery?

7. What challenges are there personally when engaging in this work?

- How do you overcome these?

8. General personal view concerning the forensic psychology profession as a whole and your part within it now and for the near future?

9. Guidelines set out by the Department of Health (2018) suggest that as practitioners working in secure settings, you should carry out some form of ‘index offense work/analyses.” As a practitioner what does this entail for you?

10. What do you think are the goals of index offense work?

11. Do you carry out this work on a one-to-one basis with the offender or within a group setting with several service users?

- What determines your choice?
- What are the benefits/difficulties of both?

12. How would you define or describe the work you carry out with offenders regarding their index offense?

13. In your opinion are index offense work and index offense analysis different things?

- If so, how do they differ?

14. Does the work carried out with offenders surrounding index offense differ depending upon offender and/or offense type?

- Is there a pre-defined process/protocol that you work to with all offenders?
- If so, why?

15. What tools do you use to assist you in this work?

Closing Questions and Remarks:

- Is there anything else you would like to add (open forum/off the record)?
- Thank the participants for taking the time to participate.