

~~~~~ **Nine new studies identified** ~~~~~

**CIVIL PSYCHIATRIC – No new studies**

**FORENSIC PSYCHIATRIC – 4 new studies**

**Dowsett, J. (2005). Measurement of risk by a community forensic mental health team. *Psychiatric Bulletin*, 29, 9-12.**

The predictive validity of the HCR-20 (version 2) was evaluated prospectively among a complete caseload of patients ( $N = 47$ ) managed by a community forensic team. The sample primarily was male ( $n = 11$ ; 91%) and African-Caribbean ( $n = 35$ ; 74%). Many participants had a history of violence in the community ( $n = 43$ ; 92%) or in an inpatient setting ( $n = 23$ ; 49%).

Data for all participants were collected over a three-month period by the author, who had worked clinically with some of the patients, via file review and an interview with each participant's keyworker (who typically was a community psychiatric nurse). No direct contact with the participant occurred in the course of data collection. The PCL-R was completed for a subset of participants ( $n = 33$ ). Mean HCR-20 scores were: Total ( $M = 21.65$ ,  $SD = 6.15$ ); Historical ( $M = 13.40$ ,  $SD = 3.31$ ); Clinical ( $M = 4.11$ ,  $SD = 2.32$ ); Risk management ( $M = 4.33$ ,  $SD = 2.27$ ). The range of mean item scores on the Historical scale was 1.19 (H10) to 1.87 (H6). The range of mean item scores on the Clinical scale was .54 (C3) to 1.22 (C1). The range of mean item scores on the Risk management scale was .41 (R1) to 1.48 (R2).

Recidivism data were collected 2.5 years after the HCR-20s were scored. Outcome data were based on file records and information collected from clinical staff. Eight participants were charged or convicted of a new offence. Mean total scores of recidivists ( $M = 29.4$ ) and non-recidivists ( $M = 21.2$ ) were statistically significant ( $p < .05$ , independent  $t$ -test). Re-offending of two participants appeared to be linked closely to deteriorated mental state. Among the other six participants, all of whom maintained their mental stability, re-offending appeared to be related to instrumental violence, substance misuse, and antisocial personality characteristics. Implications for targeting specific types of patients for forensic services (versus generic services) were discussed.

**Skipworth, J. (2005). Rehabilitation in forensic psychiatry: Punishment or treatment? *The Journal of Forensic Psychiatry & Psychology*, 16, 70-84.**

To investigate whether care of forensic psychiatric patients in Auckland, New Zealand was more related to treatment for their illness or punishment for their offending, this study examined whether clinical progress (operationalized as access to unsupervised leave) was associated more with clinical factors or with criminological factors (e.g., time served proportional to the severity of offending). A non-experimental cross-sectional study design was used with this sample that comprised all mentally disordered offenders in the Auckland region under forensic care (96 patients, 74 of whom were inpatients).

Participants' mean age was 35.7 years ( $SD = 9.23$ , range 18-62). Most participants were men ( $n = 88$ ; 91.7%). There were no significant differences in mean age or gender between participants who were or were not granted unsupervised leave. More than half (52.1%) of the sample was New Zealand Maori (36.4% European; 11.5% Pacific Islanders). Maori (56.0%) and Pacific Islanders (81.8%) were significantly more likely to be restricted than Europeans (34.2%;  $\chi^2 = 8.59$ ,  $p = .01$ ).

To quantify severity of offending, a Crown prosecutor assisted in calculating a theoretical custodial sentence and date of parole using information from an offence summary or the police summary of facts. A treating psychiatrist made DSM-IV diagnoses. Severity of mental disorder was assessed with the Health of the Nation Outcome Scale (HoNOS; Wing et al., 1998). General functioning was measured with the Life Skills Profile (LSP-39; Rosen, Hadzi-Pavlovic, & Parker, 1989), which comprises five categories: self-care, non-turbulence, social-contact, communication, and responsivity. Clinicians who gathered the data were not blind to patients' leave status. Inter-rater reliability was assessed before the data were collected (values not reported). The psychopathy item (H7) was omitted when scoring the HCR-20.

Eighty-four participants were diagnosed with psychotic-spectrum disorders. Of five participants who did not have a diagnosis on Axis I, three had personality disorder diagnoses and two had mild mental retardation. There were no significant differences on Axis I diagnoses between the two leave groups ( $\chi^2 = 1.87$ ,  $p = .76$ ).

There was not a victim in 16.7% of cases. Strangers (28.1%), acquaintances (28.1%), and family members (27.1%) were victimized in similar proportions. Victim type did not differentiate the two leave groups ( $\chi^2 = 4.38$ ,  $p = .22$ ).

Inspection of HCR-20 scores indicated that scores on the total measure and on the Clinical and Risk management scale scores, but not on the Historical scale, differed significantly between participants who were or were not granted access to unsupervised leave. Mean HCR-20 scores were as follows: Total (detained = 25.23,  $SD = 7.11$ ; released = 18.26;  $SD = 5.06$ ;  $p < .01$ ); Historical (detained = 13.67,  $SD = 3.30$ ; released = 12.94;  $SD = 3.51$ ;  $p = .30$ ); Clinical (detained = 5.56,  $SD = 2.81$ ; released = 2.83;  $SD = 2.28$ ;  $p < .01$ ); Risk management (detained = 5.88,  $SD = 2.72$ ; released = 2.49;  $SD = 1.88$ ;  $p < .01$ ). ROC analyses were consistent with these results and revealed that historical risk factors were not discriminatory of leave status (AUC = .56, SE = .06,  $p = .31$ , 95% CI: .45-.68). The Total (AUC = .77, SE = .05,  $p = .00$ , 95% CI: .68-.87), Clinical (AUC = .76, SE = .05,  $p = .00$ , 95% CI: .67-.86), and Risk management (AUC = .85, SE = .04,  $p = .00$ , 95% CI: .78-.92) scales were predictive of leave status.

The two leave groups did not differ significantly in terms of severity of offending ( $t = -.03$ ,  $p = .97$ ), time served ( $t = -.65$ ,  $p = .52$ ), or time served relative to offending severity ( $t = -.63$ ,  $p = .53$ ). Offence type significantly differentiated the groups ( $\chi^2 = 13.63$ ,  $p < .05$ ), with sex offenders being significantly more likely to be detained compared to other types of offenders.

Binary logistic regression was used to examine the ability of demographic (i.e., age, gender, and ethnicity), clinical (i.e., scores on HoNOS, HCR-20, and LSP-39), and criminological (i.e., legal status, type of offence, offence severity, time served, proportion of time served relative to

offence severity) variables to predict leave status. None of the criminological factors reached statistical significance and of the demographic variables, only ethnicity reached significance ( $R^2 = .12, p = .01$ ). Clinical factors – especially those assessed by the HCR-20 Risk management scale - were most predictive. Values for the HCR-20 indices were as follows: Total ( $R^2 = .32, p < .01$ ); Historical ( $R^2 = .02, p = .27$ ); Clinical ( $R^2 = .29, p < .01$ ); Risk management ( $R^2 = .45, p < .01$ ).

In summary, results indicated that dynamic clinical and risk assessment variables had improved among participants granted release, whereas static and criminological variables were not significantly different between the two leave groups.

**Smith, H., White, T., MacCall, C. (2004). A comparison of special hospital patients and other admissions to a regional low security unit. *Journal of Forensic Psychiatry & Psychology*, 15, 660-668.**

The goals of the present study were: (1) to identify if patients in a low security forensic psychiatry unit in Scotland who were admitted from a high security hospital were inpatients for a longer period of time than patients admitted from other sources (e.g., prison, other hospitals, and police custody) and (2) to examine whether any individual factor could predict a length of inpatient stay of more than 2 years (i.e., the length of time recommended by a local policy report). Using a retrospective cohort design, all patients ( $n = 17$ ) transferred from a special security unit in Scotland ( $n = 16$ ) and in England ( $n = 1$ ) between 1990 and 2002 were compared to a control group that comprised 17 consecutively admitted patients from any other referral source. File information was used to code demographic details and offending history. The last clinical diagnosis recorded on the multidisciplinary team review was coded for the present study. The HCR-20 was completed, with the psychopathy item (H7) omitted, for all participants with four exceptions in the control group - for two participants, only the Historical scale was completed because they had died (one from natural causes and one from suicide), and for another two participants, insufficient documentation prevented scoring of all HCR-20 indices.

There was no difference in age between participants transferred from the special security unit ( $M = 40.5$  years) and participants in the control group ( $M = 36.8$  years). The average HCR-20 total score was significantly higher for the special hospital group ( $M = 27.5$ ) than for the control group ( $M = 20.7$ ),  $p < .005$ . There was a significant difference in diagnosis between the two groups,  $\chi^2 = 7.7, df = 4, p = .01$ . Ten special hospital patients were diagnosed with schizophrenia compared to 4 control patients. The type of index offence also differed significantly between the two groups,  $\chi^2 = 9.6, df = 6, p =$  “invalid due to small numbers,” << *that actually is what was written...* >> with violent index offences being more common in the special hospital group.

The outcome of inpatient stays was significantly different between the two groups, ( $\chi^2 = 16.6, df = 5, p < .005$ ). Among the 17 patients transferred from special hospitals, 11 remained inpatients in forensic service, compared to only one participant in the control group. The mean length of stay for the special hospital group was 2.41 years ( $SD = 2.9$  years, range = 2 weeks-11 years). The mean length of stay for the control group was 0.55 years ( $SD = 1.4$  years, range = 1 day-6 years).

A regression analysis to predict length of stay was completed with the following variables: HCR-20, age, age at first symptoms, diagnosis, index offence, and previous offences. Although the overall model was significant (adjusted  $R^2 = .04$ ,  $F = 1.11$ ,  $p < .05$ , 95% CI: 0.18-10.64), no single factor was significant in predicting length of stay.

In summary, patients transferred from special hospitals to the low security forensic unit were more likely to have a diagnosis of schizophrenia, a more serious index offence, a lengthier criminal history involving violence, and a higher HCR-20 score compared to patients admitted from other sources. They also were more likely to remain as inpatients in forensic service.

**Tyrer, P., Cooper, S., Seivewright, H., Duggan, C., Rao, B., & Hogue, T. (2005). Temporal reliability of psychological assessments for patients in a special hospital with severe personality disorder: A preliminary note. *Criminal Behaviour and Mental Health, 15*, 87-92.**

The purpose of the present study was to gather reliability data on assessments of patients who were considered potentially suitable for the specialist dangerous and severe personality disorder (DSPD) programme in the United Kingdom. A random sample of patients ( $N = 32$ ) at Rampton high security hospital who had been assessed by clinical staff (usually psychologists) at the hospital between April 1997 and November 2002 were selected. Two participants already had left the hospital, which yielded a final sample size of 30 men.

The data compared for reliability analyses were scores on the HCR-20, PCL-R (Total, Factor 1, and Factor 2), and each DSM personality dimension on the International Personality Disorder Examination (IPDE). With respect to the original ratings, it was unusual for a single assessor to complete the entire assessment. With respect to the research ratings, a single psychologist completed all ratings between February 2002 and April 2002. Another researcher who was blind to the research interview data obtained details of the original assessments from records.

Of the 30 participants, 11 refused to participate in an interview and one other was not contacted for other reasons. Participants who were interviewed were similar to participants who were not interviewed in terms of mean duration of admission (120 months vs. 177 months for interviewees vs. refusers, respectively) and mean age (38 years vs. 45 years for interviewees vs. refusers, respectively). Of the interviewed men, 12 had IPDE ratings on both occasions, 15 had PCL-R and HCR-20 ratings, and one did not have any previous assessment identified. There was substantial variation in time intervals between the original and research assessments: HCR-20 ( $Md = 15$  months, range = 1-25 months); PCL-R ( $Md = 11$  months, range = 6-60 months); IPDE ( $Md = 9$  months, range = 1-18 months).

Intra-class correlation coefficients ( $R_1$ ) for all indices examined ranged from 0.38 to 0.73. For the HCR-20 total score,  $R_1$  was 0.57,  $p < .01$ . Values for the PCL-R indices were as follows: Total ( $R_1 = 0.59$ ,  $p < .01$ ); Factor 1 ( $R_1 = 0.49$ ,  $p < .05$ ); Factor 2 ( $R_1 = 0.44$ ,  $p < .05$ ). All values for the HCR-20 and PLC-R indices were based on 15 participants and would be considered to represent fair levels of clinical significance according to criteria outlined by Cicchetti and Sparrow (1981).

Rater bias was assessed separately from intra-class correlation coefficients so that systematic differences in scoring between raters could be identified independently of agreement. Significant rater bias was observed for the HCR-20 total score and the IPDE antisocial and avoidant scales, but not for any PCL-R index. The significant  $F$ -ratios for rater bias were as follows: HCR-20 ( $F = 13.1, p < 0.01$ ); IPDE antisocial ( $F = 9.0, p < 0.05$ ); IPDE avoidant ( $F = 5.7, p < 0.05$ ). Higher scores were recorded at the second assessment for the HCR-20 (26.8 vs. 22.9), for the IPDE antisocial scale (19.0 vs. 13.9), and for the IPDE avoidant scale (3.6 vs. 1.7), which makes it unlikely that improvement in clinical state would explain the rater bias.

The authors concluded that their results supported the need for better training in the use of standardised instruments.

### **CORRECTIONAL – 3 new studies**

**Dahle, K.P., 2005, Psychologische Kriminalprognose [Psychological prediction of re-offence], Herbolzheim: Centaurus.**

The ability of the HCR-20, PCL-R, and LSI-R to postdict officially recorded convictions was examined among male prisoners in Berlin ( $N = 307$ ) who survived at least ten years at risk following release from prison. All instruments were coded retrospectively by psychologists who were trained how to use them. The mean length of follow-up after release was 19.6 years ( $SD = 1.74$  years). At the time the study started in 1976, participants' mean age was 30.52 years ( $SD = 5.38$  years; range = 21-42 years).

Descriptive information for the measures was as follows: HCR-20 Total ( $M = 16.52, SD = 6.31, \alpha = .84$ ); HCR-20 Historical scale ( $M = 8.32, SD = 3.51, \alpha = .69$ ); HCR-20 Clinical scale ( $Md = 3, range = 8, \alpha = .49$ ); HCR-20 Risk management scale ( $Md = 5, range = 10, \alpha = .80$ ); PCL-R Total ( $M = 12.03, SD = 4.70, \alpha = .71$ ); PCL-R Factor 1 ( $Md = 3, range = 12, \alpha = .59$ ); PCL-R Factor 2 ( $Md = 6, range = 17, \alpha = .71$ ); LSI-R Total ( $M = 24.65, SD = 7.35, \alpha = .84$ ). The intercorrelations between the three measures were high: HCR-20/LSI-R (.80); HCR-20/PCL-R (.76); LCI-R/PCL-R (.61).

Inter-rater reliability was examined on a sub-sample of participants ( $n = 30$ ) using two independent raters. Values were as follows: HCR-20 Total (ICC = .91;  $r = .91$ ; 95% CI = 83-.96); HCR-20 Historical scale (ICC = .92;  $r = .92$ ; 95% CI: .83-.96); HCR-20 Clinical scale (ICC = .82;  $r = .83$ ; 95% CI: .65-.91); HCR-20 Risk management scale (ICC = .78;  $r = .79$ ; 95% CI: .59-.89); PCL-R Total (ICC = .94;  $r = .94$ ; 95% CI: .88-.97); PCL-R Factor 1 (ICC = .80;  $r = .81$ ; 95% CI: .63-.90); PCL-R Factor 2 (ICC = .89;  $r = .89$ ; 95% CI: .77-.94); LSI-R Total (ICC = .93;  $r = .93$ ; 95% CI: .86-.97).

For each measure, predictive validity data were collected for different lengths of time at risk. All of the values that follow correspond to a criterion of violent reconviction. Predictive validity for the HCR-20 Total score was: 2 years at risk ( $r = .21, p < .001$ ; AUC = .75,  $p = .06$ , 95% CI: .61-

.85); 5 years at risk ( $r = .28, p < .001$ ; AUC = .71,  $p = .04$ , 95% CI: .63-.80); total time at risk ( $r = .28, p < .001$ ; AUC = .69,  $p = .04$ , 95% CI: .62-.76). For the HCR-20 Historical scale: 2 years at risk ( $r = .18, p < .05$ ); 5 years at risk ( $r = .26, p < .001$ ); total time at risk ( $r = .27, p < .001$ ). For the HCR-20 Clinical scale: 2 years at risk ( $r = .18, p < .05$ ); 5 years at risk ( $r = .22, p < .001$ ); total time at risk ( $r = .25, p < .001$ ). For the HCR-20 Risk management scale: 2 years at risk ( $r = .16, p < .01$ ); 5 years at risk ( $r = .18, p < .01$ ); total time at risk ( $r = .17, p < .01$ ). <<no AUC reported for the scales>>

Predictive validity for the PCL-R Total score was: 2 years at risk ( $r = .14, p < .05$ ; AUC = .67,  $p = .06$ , 95% CI: .55-.78); 5 years at risk ( $r = .25, p < .001$ ; AUC = .70,  $p = .04$ , 95% CI: .63-.78); total time at risk ( $r = .27, p < .001$ ; AUC = .68,  $p = .04$ , 95% CI: .61-.75). For Factor 1, values were: 2 years at risk ( $r = .01, p = \text{ns}$ ); 5 years at risk ( $r = .13, p < .05$ ); total time at risk ( $r = .16, p < .05$ ). For Factor 2, values were: 2 years at risk ( $r = .15, p < .01$ ); 5 years at risk ( $r = .24, p < .001$ ); total time at risk ( $r = .23, p < .001$ ).

Predictive validity for the LSI-R Total score was: 2 years at risk ( $r = .15, p < .01$ ; AUC = .68,  $p = .06$ , 95% CI: .56-.79); 5 years at risk ( $r = .21, p < .001$ ; AUC = .67,  $p = .04$ , 95% CI: .60-.75); total time at risk ( $r = .20, p < .001$ ; AUC = .64,  $p = .04$ , 95% CI: .57-.71).

**Dunbar, E., Quinones, J., & Crevecoeur, D. A. (2005). Assessment of hate crime offenders: The role of bias in examining violence risk. *Journal of Forensic Psychology Practice, 5*, 1-19.**

This study investigated criminal histories and risk for violence among hate crime offenders. All hate crime offences ( $N = 814$ ) reported during 1999 to a large metropolitan area in the U.S. were reviewed. Of these, demographic information was available for 581 (71%). Of these 581 cases, 204 resulted in the apprehension of a suspect of the hate offence. These 204 cases comprised the current sample. The police classified an offence as a hate crime only after a multi-step evaluation process.

Demographic details were gathered from the crime report. Criminal histories were recorded from state and federal databases for all crime activity prior to commission of the hate crime. The criminal history was used to score the Cormier-Lang Crime Index (Quinsey, Harris, Rice, & Cormier, 1998), which was used to quantify severity of criminal history. A content analysis of the criminal records was used to score the HCR-20. The evaluation of the criminal histories and scoring of the HCR-20 were completed by raters blind to details about the index crime (other than knowing that the crime had been classified as being a hate crime).

Participants mostly were male (87%) and White (48%; 26.2% Latino; 15% Black, 7.2% multiracial; 2.6% Asian-Pacific). Participants' mean age was 32.69 years ( $SD = 14.04$  years, range = 12-81 years). Most (57.6%) of the offences were crimes against the person (24.5% verbal threats of harm to the person; 17.9% property crimes). Thirty-one participants (16%) were identified from the crime reports as being members of a hate-oriented criminal gang or group.

Mean scores on the HCR-20 scales and their alpha reliability coefficients were as follows: Historical (8.21,  $SD = 4.74$ , range = 0-19,  $\alpha = .94$ ); Clinical (5.39,  $SD = 2.46$ , range = 0-10,  $\alpha =$

.90); Risk management (5.53,  $SD = 2.97$ , range = 0-10,  $\alpha = .95$ ). The Cohen kappa for inter-rater agreement on the HCR-20 was .58 (range = .33-.90).

The total number of prior arrests and convictions, respectively, were significantly correlated with scores on all scales: Historical ( $r = .60, p < .001$ ;  $r = .67, p < .001$ ); Clinical ( $r = .53, p < .001$ ;  $r = .48, p < .001$ ); Risk management ( $r = .55, p < .001$ ;  $r = .62, p < .001$ ). Scores on all HCR-20 scales were significantly correlated with severity of prior violent and non-violent crimes, respectively: Historical scale ( $r = .64, p < .001$ ;  $r = .66, p < .001$ ); Clinical scale ( $r = .49, p < .001$ ;  $r = .57, p < .001$ ); Risk management scale ( $r = .56, p < .001$ ;  $r = .63, p < .001$ ).

The bias intent classified in the crime reports comprised 116 (54.4%) due to racial or ethnic bias, 56 (26.5%) due to the victim's sexual orientation, 25 (11.3%) due to religious bias, and 6 (2.9%) due to gender bias. ANOVA results indicated no statistically significant differences in mean scores on HCR-20 indices as a function of bias intent.

Finally, comparisons were made between bias offenders who were classified on the crime reports as having been a member of a hate-oriented group or racially motivated criminal gang and the other offenders in the sample. Relative to the other offenders, hate gang members had higher scores on the HCR-20 Historical ( $t = 3.41, p < .001$ ), Clinical ( $t = 2.01, p < .01$ ), and Risk management ( $t = 4.91, p < .001$ ) scales.

Findings were discussed in terms of their implications for clinical assessment and intervention.

**Warren, J. I., South, S. C., Burnette, M. L., Rogers, A., Friend, R., Bale, R., & Van Patten, I. (2005). Understanding the risk factors for violence and criminality in women: The concurrent validity of the PCL-R and HCR-20. *International Journal of Law and Psychiatry*, 28, 269-289.**

The potential usefulness of the PCL-R and HCR-20 in determining level of risk for violent behaviour and other forms of criminality was investigated. Participants were part of a larger study that examined DSM-IV personality disorders using the SCID-II. In conducting PCL-R and HCR-20 interviews, all 261 inmates who had completed the SCID-II interviews approximately 12 months earlier and who were still housed at the maximum-security prison were approached and invited to participate in this subsequent stage of data collection. The final sample comprised 132 women. Sixty percent of the women were under the age of 32 years and 65% were of minority status. Seventy-seven percent of the sample was serving sentences of greater than 5 years and 83% had criminal histories containing at least one conviction for a violent crime.

Each inmate's file was reviewed by six coders who summarized information about the inmate's family history, psychiatric history, employment history, and criminal record. The PCL-R and HCR-20 coders reviewed these summary files before they conducted their assessment interviews. Scores on three HCR-20 items were obtained from alternative sources that were thought to be superior to those obtained through a clinical interview: H5 was coded from data obtained for the administration of the Diagnostic Interview Schedule (DIS-IV) for the Alcohol and Substance Abuse module; H9 was scored based upon data obtained in the SCID-II interview; C1 was coded

as 0 if inmates received a total Barratt Impulsivity Scale score below 40, 1 if they scored between 40 and 79, and 2 if scoring above 80.

Reliability coding of 28 cases yielded the following intra-class correlation coefficients (ICCs): HCR-20 Total (0.94); Historical scale (0.92); Risk management scale (0.60); Clinical scale (0.76); PCL-R Total (.95); PCL-R Factor 1 (.88); PCL-R Factor 2 (.99).

Information for both the instant offence and prior offences was obtained from inmates' prison files. Violent crimes were defined as murder, assault, and battery. Potentially violent crimes included robbery, kidnapping, and arson. Crimes against persons were defined as negligent homicide, contributing to the delinquency of a minor, hit and run, coercion, unlawful restraint, harassment, criminal possession of weapon, menacing, and reckless endangerment. Property crimes included breaking and entering, tampering, trespassing, larceny, auto theft, shoplifting, possession of stolen property, forgery, fraud, uttering, bribery, and conspiracy. Minor crimes were considered to include parole and probation violations, driving while intoxicated, public drunkenness, failure to appear, gambling, resisting arrest, loitering, public lewdness, traffic infractions, and prostitution. General categories of sex crimes (rape, sexual assault) and drug crimes (possession) also were coded. An overall category of total violent crimes subsumed the violent, potentially violent, crimes against persons, and sex categories, and an overall category of total non-violent crimes subsumed the property, drugs, and minor crime categories.

Descriptive characteristics and inter-rater reliability for the HCR-20 indices were as follows: Total ( $M = 20.36$ ,  $SD = 6.87$ ,  $SEM = 0.60$ , range 2-35,  $ICC = .94$ ); Historical scale ( $M = 11.21$ ,  $SD = 3.62$ ,  $SEM = 0.32$ , range 2-19,  $ICC = .92$ ); Clinical scale ( $M = 3.53$ ,  $SD = 1.90$ ,  $SEM = 0.17$ , range 0-9,  $ICC = .60$ ); Risk management scale ( $M = 5.61$ ,  $SD = 2.52$ ,  $SEM = 0.22$ , range 0-10,  $ICC = .76$ ).

Descriptive characteristics and inter-rater reliability for the PCL-R indices were as follows: Total ( $M = 22.80$ ,  $SD = 6.98$ ,  $SEM = 0.61$ , range 3-36,  $ICC = .95$ ); Hare Factor 1 ( $M = 9.31$ ,  $SD = 3.82$ ,  $SEM = 0.33$ , range 1-16,  $ICC = .88$ ); Hare Factor 2 ( $M = 10.82$ ,  $SD = 3.89$ ,  $SEM = 0.34$ , range 0-18,  $ICC = .99$ ); Cooke Factor 1 ( $M = 4.89$ ,  $SD = 2.09$ ,  $SEM = 0.18$ , range 0-8,  $ICC = .70$ ); Cooke Factor 2 ( $M = 4.41$ ,  $SD = 2.37$ ,  $SEM = 0.21$ , range 0-8,  $ICC = .88$ ); and Cooke Factor 3 ( $M = 6.73$ ,  $SD = 2.42$ ,  $SEM = .21$ , range 0-10,  $ICC = .78$ ).

Correlations between indices of the HCR-20 and PCL-R ranged between .20 ( $p < .05$ ; Historical scale and Cooke Factor 1) and .81 ( $p < 0.001$ , HCR-20 Total and Hare Factor 2). All correlations were significant at least at the  $p < .05$  level.

The relation between mean HCR-20 and PCL-R total scores and conviction for different types of violent and non-violent crimes was examined. Both measures demonstrated a similar pattern on these crime characteristics. Compared to inmates who had not been convicted of murder, women with such convictions scored significantly lower on the PCL-R ( $M = 19.77$  vs. 24.22),  $p < .001$ , and HCR-20 ( $M = 17.50$  vs. 21.69),  $p < .01$ . In contrast, compared to inmates who had not been convicted of property crimes, women with such convictions scored higher on the PCL-R ( $M = 25.06$  vs. 21.76) and HCR-20 (22.95 vs. 19.17), both  $ps < .01$ .

Minor crimes showed a similar pattern to property crimes, with women who had such convictions scoring significantly higher than women without such convictions on the PCL-R (24.23 vs. 19.17) and HCR-20 (22.05 vs. 16.16), both  $p$ s < .001. The only other significant difference observed was that women who had been convicted of a potentially violent crime had higher PCL-R scores than women without such convictions (24.75 vs. 22.03,  $p$  < .05). The HCR-20 did not differentiate women with and without convictions for potentially violent crimes. Neither measure significantly differentiated women in the remaining community crime categories (i.e., violent, sex, and drug). Further, there were no significant differences between high and low scorers on either measure in terms of whether they had been involved in institutional (prison) violence. In terms of the HCR-20 scales, the only crime category in which a significant difference was observed was for minor crimes: women with such convictions had higher mean scores on the Historical scale (12.11 vs. 9.00,  $p$  < .05).

ROC analyses demonstrated a similar pattern of results for the HCR-20 and PCL-R in predicting various types of criminal charges. Both measures were most accurate in predicting minor charges: HCR-20 (AUC = .74, SE = .05, 95% CI: .64-.84,  $p$  < 0.01), PCL-R (AUC = .71, SE = .05, 95% CI = .61-.81,  $p$  < .01). For both measures, the lowest AUC value obtained was for first-degree murder: HCR-20 (AUC = .30, SE = .05, 95% CI: .20-.41,  $p$  < 0.01); PCL-R (AUC = .30, SE = .05, 95% CI: .20-.41,  $p$  < .01). That is, higher scores on both measures were a better predictor of not having first-degree murder charges. Finally, results (which may seem somewhat counterintuitive) demonstrated that neither measure was significantly better than chance in predicting violent charges: HCR-20 (AUC = .49, SE = .05, 95% CI: 0.38-0.59,  $p$  = ns), PCL-R (AUC = .46, SE = .05, 95% CI = .36-.56,  $p$  = ns). The authors discussed the implications of these findings for rehabilitation and treatment.

### **SEXUAL OFFENDER – 1 new study**

**Stadtland, C., Hollweg, M., Kleindienst, N., Dietl, J., Reich, U., & Nedopil, N. (2005). Risk assessment and prediction of violent and sexual recidivism in sex offenders: Long-term predictive validity of four risk assessment instruments. *Journal of Forensic Psychiatry & Psychology, 16*, 92-108.**

The long-term predictive validity of the HCR-20, Static-99, SVR-20, and PCL-R was examined among 134 male sex offenders in Germany. Participants included contact and non-contact sex offenders, none of whom had an Axis I diagnosis. Exclusion criteria included being found to be not guilty by reasons of insanity, or with diminished capacity due to severe mental disorders; being dead; or having emigrated. Some inclusion criteria included having been released from prison up to the year 2000 or never having been imprisoned.

The sample comprised three groups. The *assessment only group* consisted of 46 participants who were accused of sexual crimes and who were assessed for criminal responsibility in the forensic psychiatry department between 1975 and 1995. The *treatment group* consisted of 73 incarcerated sex offenders who underwent a two-year specialized psychosocial prison-based treatment program between 1972 and 1995. The *treatment refuser and treatment drop-out group* comprised the 15 individuals who did not complete this treatment program for a variety of

reasons. Most participants were single (46.3%) and White Germans (94.2%). Participants' mean age was 30.7 years.

Two individuals trained in the administration of the measures coded all cases. Assessments were completed retrospectively between 2001 and 2003 on the basis of file information. All measures were coded for the treatment and drop-out groups, but only the Static-99 was coded for the assessment group because of missing data. Recidivism data were obtained from the National Conviction Registry and were coded for the period following the completion of the assessment. Four types of re-offences were considered: (1) any non-sexual and non-contact criminal offence; (2) any non-sexual violent offence; (3) any non-contact/"hands-off" sexual offence; and (4) any contact/"hands-on" sexual offence. All analyses were calculated for the worst re-offence (i.e., type 4). The mean follow-up time was 9 years (range: 1 - 340 months). Time at risk ended at the first entry into the National Conviction Registry for any kind of recidivism.

None of the total scores on the four risk assessment measures was significantly better in predicting violent recidivism. AUC values for the total sample without the treatment drop-out group were as follows: HCR-20 total (AUC = .65,  $p = .01$ , SE = .05, 95% CI: .55-.75); Historical scale (AUC = .68,  $p = .01$ , SE = .05, 95% CI: .57-.78); Clinical scale (AUC = .58,  $p = .16$ , SE = .06, 95% CI: .47-.68); Risk management (AUC = .48,  $p = .68$ , SE = .06, 95% CI: .37-.59); PCL-R total (AUC = .64,  $p = .01$ , SE = .05, 95% CI: .54-.74); SVR-20 total (AUC = .68,  $p = .00$ , SE = .05, 95% CI: .58-.78); Static-99 total (AUC = .72,  $p = .00$ , SE = .05, 95% CI: .62-.82). Values for the Static-99 for the total sample including the treatment drop-out group were: (AUC = .71,  $p = .00$ , SE = .05, 95% CI: .62-.80).

AUC values predicting all re-offences for the total sample excluding the treatment drop-out group were: HCR-20 total (0.669,  $p < .01$ ); PCL-R total (0.649,  $p = \text{ns}$ ); SVR-20 total (0.681,  $p < .01$ ). The AUC value for the Static-99 for the total sample including the treatment drop-out group was 0.733 ( $p < .001$ ).

AUC values predicting all non-contact sexual re-offences (which were included in the "all re-offences" category) for the total sample excluding the treatment drop-out group were: HCR-20 total (.41,  $p = \text{ns}$ ); PCL-R total (.65,  $p = \text{ns}$ ); SVR-20 total (.54,  $p = \text{ns}$ ). The AUC value for the Static-99 for the total sample including the treatment drop-out group was .74 ( $p < .05$ ).

AUC values predicting all contact sexual re-offences (which were included in the "all re-offences" and "all violent re-offences" categories) for the total sample excluding the treatment drop-out group were: HCR-20 total (.67,  $p < .01$ ); PCL-R total (.60,  $p = \text{ns}$ ); SVR-20 total (.68,  $p < .01$ ). The AUC value for the Static-99 for the total sample including the treatment drop-out group was .66 ( $p < .01$ ).

Finally, the assessment and treatment groups were analyzed separately for predicting violent re-offending. In the assessment group, the accuracy of the Static-99 was numerically superior (AUC = .79,  $p = .00$ ) than the other measures. In the treatment group, the Static-99 (AUC = .67,  $p = .028$ ) performed better than the HCR-20 (AUC = .63,  $p = .07$ ), PCL-R (AUC = .61,  $p = .10$ ), and SVR-20 (AUC = 0.65,  $p = .03$ ).

Kaplan-Meier survival analysis demonstrated a significant difference between the three groups, with earlier relapse observed among the treatment group (Log Rank 0.0000; Mantel-Cox 0.0000). When only the four risk levels on the Static-99 were compared, there was a marked association between faster relapse and the higher risk categories (Log Rank 0.000; Mantel-Cox 0.000).

### **MIXED – 1 new study**

Lincoln, T. M., Hodgins, S., Müller-Isberner, R., Jöckel, D., Freese, R., & Born, P. et al. (2005). Sind sie gefährlicher?--entlassene patienten des psychiatrischen Maßregelvollzuges und der allgemeinpsychiatrie im vergleich. *Krankenhauspsychiatrie*, 16(2), 48-56.

\*\*\*ILL sent 02Dec05, but looks to be non-English...

#### ABSTRACT FROM ONLINE:

Background: The aim of this study was to compare the risk of violent behaviour of forensic patients and patients from a general psychiatric hospital in Germany after discharge. Patients and methods: 50 forensic patients and 29 patients from the general psychiatric system were assessed at discharge and at four further follow-ups during the course of two years. Differences in the psychopathology, the use of psychiatric aftercare, violent incidents, and the risk of acting violently according to the HCR-20 were calculated. Results: Forensic patients were shown to have more frequent contacts to psychiatrists or clinical psychologists as well as more frequent supervised activities. The larger amount of clinical symptoms presented by patients from the general psychiatric patients during the course of six months after discharge. The risk of violence decreased during the follow-up period in both groups with no significant differences between groups. The forensic patients showed no more violent incidents than the patients from general psychiatry. Conclusion: Existing aftercare seems to be sufficient to decrease the risk of violence after discharge in both patient samples investigated. Most important, our data do not support widespread fears that patients discharged from a forensic hospital pose an increased risk to others. (PsycINFO Database Record (c) 2005 APA, all rights reserved)