Sexual violence risk assessment:

An investigation into the inter-rater reliability of the RSVP in Scotland

AND CLINICAL RESEARCH PORTFOLIO

Part 1

(Part 2 bound separately)

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CHAPTER ONE: SYSTEMATIC LITERATURE REVIEW

The role of attachment in the aetiology sexual offending:

A systematic review

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Abstract

Background: Attachment theory is central to prominent multi-factorial models of sex offending and within forensic mental-health settings, widely informs assessment, formulation and intervention with sex offenders. However, the role of attachment in the aetiology of sex offending has not been well established or understood. This study aims to systematically review research that has investigated attachment in sex offenders. ***Method:*** A literature search was performed using MEDLINE, EMBASE and PsychInfo databases. Thirteen studies met inclusion criteria. All were case-control studies published after 1996. Studies were then reviewed using a standardised quality assessment tool. ***Results:*** There was considerable variation in study quality, methods used, and findings obtained. Studies consistently found that sex offenders had a higher representation and severity of attachment deficits than the general population. There was partial and inconsistent evidence that sex offenders are less securely attached than non-sexual offenders, or that types of sex offending are associated with particular attachment styles. However, there was some limited evidence that offenders with child victims display higher anxious/preoccupied attachment features whereas offenders with adult victims display higher avoidant/dismissive features. ***Conclusions:*** Due to methodological weaknesses, variability in methods used and inconsistency in results, it was not possible to draw strong conclusions about the role of attachment in the aetiology of sex offending. Findings were broadly consistent with current multi-factor pathway models of sex offending. However, studies were of insufficient quality or scope to assert that attachment deficits are a causal factor in sex offending or that attachment is related to sex offending behaviours, more so than criminal offending in general. Recommendations for further research are discussed.

Keywords: *sexual violence, sex offending, attachment* and *systematic review.*

1. Introduction

1.1. The aetiology of sex offending

Current research implicates a number of variables in the aetiology of sex offending. Particular importance has been placed upon the combined influences of: social norms (Gil, 1995), sexual deviance (Lalumiere & Quinsey, 1994), offence supportive cognitive distortions (Abel, Becker & Cunningham-Rathner, 1984; Ward, 2000; Mann & Beech; 2003), empathy deficits (Joliffe & Farrington, 2004) and biological determinants (Blanchard, Cantor, & Robichaud, 2006).

Specific risk factors for sex-offending have been identified and can be grouped into the following four categories reflecting the extent to which they are changeable over time (Hanson & Harris, 2000; Beech & Ward, 2004): *static* (e.g. nature of previous offences, psychosocial problems), *stable-dynamic* (e.g. social and sexual self-regulation problems, level of interpersonal functioning, cognitive distortions), *stable-acute* (e.g. sexually deviant thoughts and fantasies, need for intimacy and affective states) and *contextual* (e.g. access to victims and substance misuse).

These risk factors have been incorporated within prominent multi-factor theories of sex-offending (see Ward, Polaschek & Beech, 2006) that have advanced sex-offending research, risk assessment (Beech & Ward, 2004) and clinical practice.

1.2. Attachment

In the last 20 years, increasing attention has also been paid to the role of attachment in the aetiology of sex offending (Marshall, 1989; Rich, 2006). Attachment theory (Bowlby, 1973) proposes that humans have an innate 'attachment system' which aims to promote security through proximity and closeness with others. The availability and quality of affectional

bonds between infant and caregivers is hypothesised to be formative in social and emotional development. Specifically, attachment has been associated with the development of self and other internal representations; emotional security in relationships with others; ability to develop trust in others; self-esteem; capacity to cope with and recover from stress; quality of emotional experience; capacity for perspective taking; capacity to reflect on one's own thinking; capacity to self-soothe and regulate emotion; capacity to communicate in relationships, and degree of comfort with closeness (Fonagy et al, 2004; Aiyegbusi, 2004).

Studies by Ainsworth & Bell (1970) using the Strange Situation test revealed four patterns of attachment behaviour in childhood: (1) *Secure* attachment is characterised by a secure and responsive bond between child and caregiver from which the child is able to explore with a degree of autonomy. (2) *Anxious-avoidant* attachment is characterised by an unresponsive and dismissing parental style. The child is noted to be passively dismissive of affection from the main caregiver and others. (3) *Ambivalent-resistant* attachment is characterised by an inconsistent parenting style with the infant being preoccupied with the caregiver's availability; seeking contact, but resisting angrily on the caregiver's return. (4) *Disorganised* attachment is characterised by highly inconsistent and conflicting care-giving styles. Disorganised infants display contradictory and disorientated attachment behaviours. These attachment categories have been shown to be stable over time (Waters et al, 1995; Main, 1997) and to be related to attachment styles in adult relationships.

A significant body of research in adults suggests that insecure attachment is a vulnerability factor for a range of clinical and forensic sequelae. The role of attachment has been implicated in the aetiology of depression (Reis & Grenyer, 2004), anxiety disorders (Mhyr, 2004), PTSD (Muller et al, 2000), personality disorders (Fossatti et al, 2003), eating disorders (Cole-Detke & Kobak (1996), and psychosis (Berry, 2007). Attachment disturbance has also been investigated in the development of Psychopathic Personality

Disorder (Frodi et al, 2001), aggression (Lyons-Ruth, 1996) and stalking (Tonin, 2004). The concepts of reflective function, mentalization, emotion regulation and internal working models (discussed in Fonagy et al, 2004) have considerable explanatory power in describing the meditative processes between early attachment experiences and these negative sequelae. In describing the protective importance of secure attachment bonds, Holmes has described the attachment system as the 'psychological immune system' (Holmes, 2001).

1.3. Measurement of attachment in adults

A number of interview and self-report measures have been developed for measuring attachment in adults (Ravitz et al, 2009). Several measures have received popularity amongst researchers in the field of sex-offending and are briefly discussed here.

The *Adult Attachment Interview* (AAI; George, Kaplan & Main, 1985) is a semi-structured interview that allows the assessor to examine the coherence and consistency of participant narratives about childhood attachment experiences. This method reveals unconscious elements of the individual's attachment representation and results in four attachment classifications: *Secure* (balanced and valuing of childhood attachment relationships), *Dismissing* (denying, devaluing or idealizing of childhood attachment relationships), *Preoccupied* (accounts characterised by confusion, anger or passivity), *Unresolved* (accounts characterised by unresolved trauma or loss) and *Cannot Classify* (highly incoherent and insecure). The AAI has excellent psychometric properties that have been established through rigorous psychometric testing and meta-analyses (Ravitz et al, 2009).

Using a two dimension, four category model of adult attachment Bartholomew (1990) and Bartholomew & Horowitz (1991) developed the *Relationships Questionnaire* (RQ). The RQ requires participants to self-rate the extent to which they perceive themselves as resembling four attachment descriptions. Participants are categorised into one of four prototypes that

reflect their representation of self (perceived self-worth) and representation of others (perceived value of others). These categories are: *Secure* (positive self and others), *Preoccupied* (negative self, positive others), *Dismissive* (positive self, negative others) and *Fearful* (negative self and others).

The 30-item *Relationship Styles Questionnaire* (RSQ; Griffin & Bartholomew, 1994) yields one of four attachment prototypes (above; Bartholomew & Horowitz, 1991) and scores on attachment dimensions security, avoidance, ambivalence, closeness, anxiety, and dependency. Roisman et al, (2007) indicate that the dimensions of anxiety and avoidance are the most reliable, with studies using the RSQ applying these dimensions in a two dimensional model.

The 40-item *Attachment Style Questionnaire* (ASQ; Feeney et al, 1994) reveals five attachment subscales: *discomfort with closeness*, *need for approval*, *preoccupation with relations*, *viewing relationships as secondary (to achievement)* and *lack of confidence*. The RQ, RSQ and ASQ have been shown to have adequate reliability and validity (Ravitz et al, 2009).

The 36-item *Experiences in Close Relationships* (ECR; Brennan et al, 1998) *Experiences in Close Relationships-Revised* (ECR-R; Fraley & Shaver, 2000) instruments were developed from a principal components analysis of 60 self-report measures of attachment. The instrument produces factors related to attachment avoidance and anxiety within the context of romantic relationships. The instrument has been shown to have adequate reliability and excellent validity (Ravitz et al, 2009).

As can be seen from the descriptions of assessment tools above, the term 'attachment' can refer to various facets of an individual's functioning (e.g. discourse about attachment bonds, views of self in relation to others, and behaviour in romantic relationships). Interchangeable terms are used to describe different aspects of attachment. Whilst popularly conceptualised

in the literature as a categorical construct, there is debate amongst researchers in this field as to whether attachment is more appropriately conceptualised as dimensional. There are arguments to support both categorical and dimensional models of attachment. However, it is not clear that data support one method of classification over the other. Rich (2006, pg 120) comments that "the principles of attachment theory are believed to be sound and do not depend on classification models to prove their validity as descriptions of social functioning and psychological development".

1.4. Attachment and sex offending

Marshall (1989) is widely credited as being the first to offer an attachment perspective on the aetiology of sex offending (Ward, Ploaschek & Beech, 2006). He theorised that difficulties arising from insecure childhood attachment (mainly: emotional loneliness, low self-esteem and deficits in interpersonal competency) present a barrier to establishing consensual and socially-appropriate intimate relationships. He hypothesised that for some insecurely attached individuals, sex offending arises as a dysfunctional means of achieving intimacy.

Marshall and colleagues later proposed a further, more comprehensive attachment based theory of sex offending (Marshall & Barbaree, 1990, Marshall, Anderson, & Fernandez, 1999a; Marshall & Marshall, 2000). This theory proposes that dysfunctional family relationships and insecure attachment place the individual at greater risk of childhood sexual abuse and a subsequent inappropriate adolescent sexual history. Such individuals may engage in frequent masturbation to self-soothe, and increase their use of deviant fantasies as a method of self coping. Marshall has also proposed that sex can become 'fused' with intimacy, with sexual deviancy and promiscuity escalating as the offender experiences only temporary fulfilment of intimacy through his offending behaviour. Marhsall's theories have

given rise to other multi-factorial models of sex offending that also emphasize the role of attachment deficits (reviewed in Ward, Ploaschek & Beech, 2006 and Rich, 2006).

There is growing evidence in support of Marshall's theories. Compared to community controls and other (non-sex) offenders, sex offenders have been shown to report greater intimacy deficits, feelings of loneliness and fear of intimacy (Bumby & Hansen, 1997). Fisher, Beech and Browne (1999) reported that child sexual offenders had significantly lower self-esteem, higher emotional loneliness and higher personal distress than non-offenders. Marshall & Hambley (1996) found that loneliness and intimacy deficits were related with willingness to endorse attitudes supportive of rape and hostility towards women. Other studies have found similar findings (Garlick, Marshall & Thornton et al, 1996; Marshall, Champagne, Brown, & Miller, 1997). Awad, Saunders and Levene (1984) reported that a significant proportion of adolescent sex offenders' parents were rejecting, abusive or emotionally detached. McKibben, Proulx & Lusignan (1994) found that loneliness was a prominent emotional state preceding sexually deviant fantasies.
A meta-analysis of fourteen studies by Dreznick (2003) concluded that sex offenders (particularly child molesters) had significant impairments in 'heterosocial competency' (defined as the ability to competently interact with members of the other sex). This suggests that poor self esteem and heterosocial competency may increase an individual's propensity towards a sexual interest in children.

Ward et al (1996) proposed a reformulation of Marshall's original theory, applying the Bartholomew & Horowitz attachment prototypes (1991; discussed above). Ward and colleagues further theorised that different types of sex offending may be predicated by specific attachment styles in the offender. A preoccupied style of attachment (negative perception of self, positive perception of others), is suggested as being most likely to correspond to offending against children, that is non-aggressive in nature and considered

loving or mutual by the offender. Ward et al suggest that this type of offence may arise as the preoccupied offender seeks to meet his strong needs for approval, security and mutual affection. A fearful style of attachment (negative perception of self and others) may correspond with sex offending that is impersonal and potentially aggressive in nature. This type of offence may arise as the fearful individual seeks intimacy and gratification whilst avoiding emotional closeness (including empathy and guilt) and the risk of rejection. The dismissive style of attachment (positive perception of self and negative perception of others) may be most likely to correspond to sex offending that is actively hostile, aggressive and potentially sadistic in nature. This type of offence may arise due to the dismissive individual's lack of empathy, and desire for sexual gratification whilst trying to maintain his sense of autonomy and independence. Ward's theory has been investigated in several of the papers covered in this review.

Assumptions of these theories are that insecure attachment will be prevalent amongst sex offenders, and that attachment difficulties are causally linked to the individual's motivation to offend. Attachment is a central factor in multi-factorial theories of sex offending and within forensic-mental health settings, widely informs psychological assessment, formulation and intervention with sex offenders (e.g. Rich, 2006; Marshall et al, 2006). However, despite having clinical utility and popularity, the role of attachment deficits in the aetiology of sex offending is not well understood. This study aims to systematically review studies that have investigated the link between attachment and sex offending and to offer a detailed and constructive discussion from which to inform clinical practice and future research in this area.

2. Research questions

Question 1. Are there differences in the attachment status of sex offenders compared to non-sex offenders or the general population?

Question 2. Is there an association between specific attachment styles and specific types of sex offending?

3. Method

3.1. Search strategy

The abstracts of relevant online databases were searched for all possible permutations of the combined key concepts, attachment and sex offending. *Attachment* was combined with: *Sex$ AND Aggress$, Sex$ AND Offen$, Sex$ AND Violen$, Paedophil$* and *Child Mol$.* Terms were used to search abstracts of Ovid MEDLINE ® (1950 to November 2009), EMBASE and EMBASE Classic (1947 to November 2009) and Web of Science (1989 - November 2009). Following the removal of duplicates, a total of 272 studies were identified as being possibly relevant. On reading the title and abstracts of these studies, the following inclusion and exclusion criteria were applied.

Inclusion Criteria:

1. Studies published in English.
2. Studies published in peer-reviewed journals.
3. Studies that included adjudicated sex offenders.
4. Studies that used a recognised measure of attachment.
5. Experimental studies including longitudinal studies and case-control studies.

Exclusion Criteria:

1. Studies not published in English.
2. Studies not published in peer-reviewed journals.
3. Studies that did not include adjudicated sex offenders.
4. Studies that did not use a recognised measure of attachment.
5. Reviews, discussion articles, single case-studies and intervention studies.

85 studies were excluded because they did not include a sample of sex offenders. 58 studies were excluded because they did not address the research question (e.g. not relevant or relevant but did not measure attachment). 63 studies were excluded because they were discussion articles or narrative reviews. 3 were excluded because they were intervention studies and a further 3 because they were single case studies. 47 dissertations were also excluded. The reference sections of the remaining 13 studies were searched by hand. This search and a further search of the PsychINFO (1894 to December 2009) database identified no further relevant studies that met the inclusion and exclusion criteria. The remaining 13 studies were all case-control studies published between 1996 and 2010. One of the studies was published online within the search period (November 2009) but was cited as being published in March 2010. Figure 1 outlines the process of arriving at the final studies.

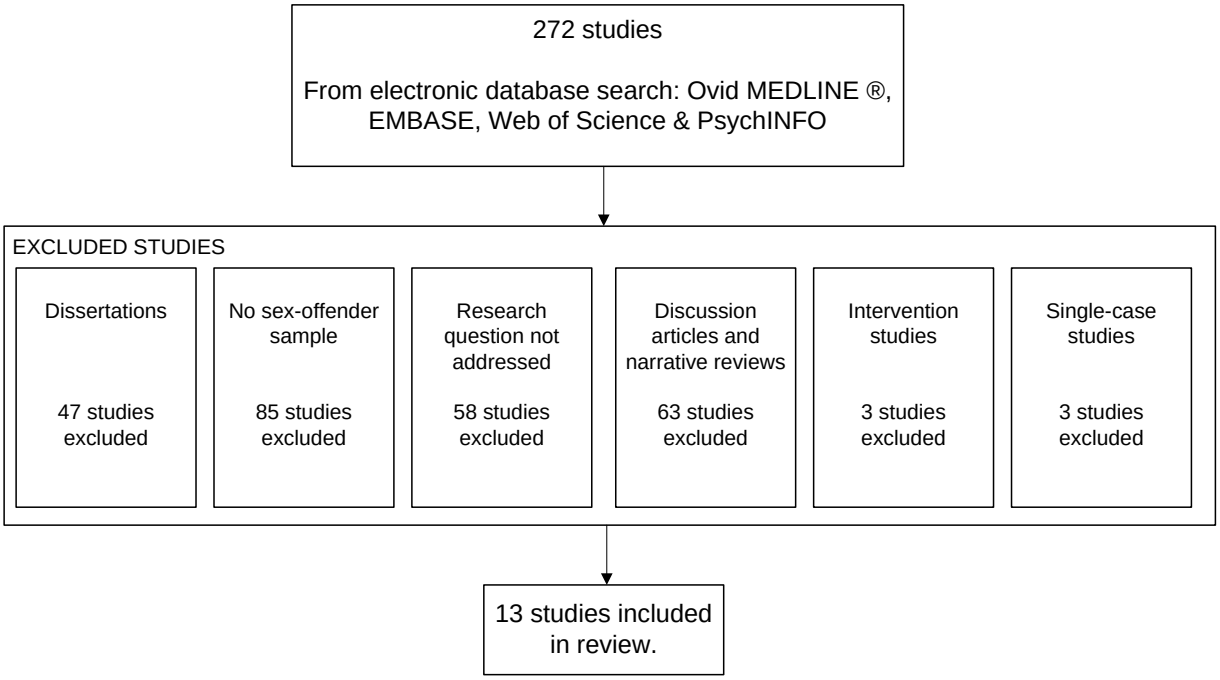

Figure 1. Flowchart of literature search and study exclusion.

3.2. Assessment of study quality

The 13 remaining studies were assessed by the principal author using a quality rating instrument (shown in appendix 1.1). A random sample of eight studies were also reviewed by a second quality assessor (also a 3rd Year Trainee Clinical Psychologist), who had been briefed on the review's aims and guidelines for using the quality assessment tool. The second assessor was blind to the ratings given by the principal assessor.

3.2.1 Quality Assessment Tool

In order to assist the author in establishing study quality in a standardised way, a 14 item quality rating tool was developed. The tool was developed by combining items from the SIGN (Scottish Intercollegiate Guidance Network) 50: Methodology Checklist for Case Control Studies (A Guideline Developer's Handbook, 2008) and additional items that were considered particularly relevant to this study area. Items and scoring guidelines for each item are detailed in appendix 1.1.

Quality assessors rated the extent to which they perceived each of the above criteria to be fulfilled (possible ratings included 'not addressed', 'poorly addressed', 'adequately addressed', 'not reported' or 'not applicable to design'). After rating each of the items, the rater appointed one of the following codes: 'A' - all or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions of the study or review are thought very unlikely to alter; 'B' - some of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions; 'C' - few or none of the criteria fulfilled. The conclusions of the study are thought likely or very likely to alter; or 'R' - this study should be rejected because it fails to address a fundamental criteria.

There was 100% agreement between the primary author and secondary rater on the final quality categorisation of the sample (n=8) of studies. Four of the studies were given a rating of 'A', seven were given a rating of 'B' and two were given a rating of 'C'.

4. Results

4.1 Overview of studies reviewed

Table 1 (appendix 1.2) provides an overview of each study with respect to: *research question(s) addressed*, *participant characteristics*, *measurement of attachment*, *relevant findings, methodological weaknesses* and *quality rating.*

Of the thirteen studies included, six addressed both Questions1 and 2. Six studies addressed Question 1 only and one study addressed Question 2 only. All studies recruited males who had been convicted of sexual offences. With the exception of one study which recruited adolescent offenders (aged 9-18), the studies recruited adult offenders (aged 18 and above). Studies had a breadth of sample characteristics, recruiting from community and prison (low, medium and high secure) settings.

Two studies used an attachment interview, whilst the remaining eleven were based on self-report instruments. Studies using interview methodology are reviewed as distinct from studies using self-report methodology. In order to minimise repetition of these studies, results are presented in order of quality.

4.2 Studies rated as high quality 'A'

The following four studies were rated as being of high quality (A). They have few of the methodological limitations outlined above and provide reliable findings in relation to research questions 1 and 2.

Simons et al, (2008) compared incarcerated rapists (n=137) with incarcerated child molesters (n=132) on attachment categories (secure, anxious and avoidant) from a modified version of the Childhood Attachment Questionnaire (Hazan & Shaver, 1987). This measure required participants to consider attachment in relation to both male and female caregivers. Participants were volunteers from a prison treatment programme and were assigned to groups on review of commitment crimes and "available histories".

Child molesters reported significantly more anxious attachment bonds compared to rapists (62% vs. 20%, $\chi 2$ $p<0.005$) and rapists reported significantly more avoidant attachment bonds (76% vs. 27%, $\chi 2$ $p<0.05$). Amongst child sex offenders, there was a non-significant difference between paternal and maternal bonding scores. Rapists reported significantly poorer attachment bonds to paternal figures in comparison to maternal figures ($P<0.005$).

This study gathered a comprehensive range of data on participants, and was able to provide evidence that results were independent of social desirability in responding, sample crossover, race, age, marital status and income. However, there were a substantial number of participants (46%) who had some offence crossover[1] (defined as a minimum of 80% offending). This study relied upon a self-report measure of attachment, and did not provide an adequate description of how the CAQ was modified.

[1] 'Offence crossover' refers to the inclusion of participants that belong to two or more offending groups, by virtue of diversity in their offending histories.

Wood & Riggs (2008) compared child molesters (n=61) to community controls (n=51) on anxiety and avoidance dimensions derived from the Experiences in Close Relationship Inventory (Brennan, Clark and Shaver, 1998). Logistic regression modelling indicated that attachment anxiety was the most significant predictor of child molester status. Other variables included in the model were demographic factors, cognitive distortions supportive of child sex offending and empathy (general and victim). Together with attachment, cognitive distortions regarding adult-child sex, and inconsistent empathic attitudes predicted a substantial degree of variance in child molester status. Furthermore, increasing levels of attachment anxiety raised the odds of sex offender status by 56%. Analyses also indicated that between group differences appeared to be independent of race, age, income, marital status, and social desirability in responding.

This study is commended for its inclusion of a number of important factors in analysis and screening to exclude participants with previous abuse histories and criminal convictions from the control group. This study is limited by its reliance on self-report assessment of attachment. Unfortunately, this study did not include a sample of other (non-sex) offenders, and therefore these results cannot be used to make inferences about sex offenders, as distinct from other offenders.

Miner et al (2010) compared convicted adolescent sex offenders (child victims, n=107; peer/adult victims n=49) and non sex offending delinquents (n=122) with respect to attachment dimensions (anxiety and avoidance) and a range of psycho-social variables (including self-reported measures of social isolation, hyper-sexuality, sexual preoccupation and social adequacy). Participants were recruited from residential and outpatient sex offending treatment programmes, juvenile probation departments and juvenile detention centres. They were assigned to group based on commitment crimes and available histories.

ANOVA revealed that sex offenders against children had the lowest levels of attachment avoidance and significantly higher attachment anxiety than did non-sex offending delinquents ($d=4.1$, $p<0.001$). Attachment avoidance was not a significant discriminator between groups. Offenders against children were also distinguished from offenders against peers or women in that that they reported greater masculine inadequacy and a less impersonal attitude toward sexuality.

Relevant non-significant findings were that: sex offenders with peer / adult victims had higher attachment anxiety than non sex-offending delinquents and greater attachment avoidance than non sex-offending delinquents or sex offenders with child victims.

Logistic regression modelling was applied to attachment and other psychosocial data. Anxious attachment in adolescence was related to expectation of rejection from peers, over-sexualisation and feelings of interpersonal inadequacy. Authors suggest that these results support an indirect association between anxious attachment and sex offending against children. They hypothesise that this may occur through a developmental pathway including fear of rejection, social inadequacy and desire for intimacy.

Strengths of this study are its clearly defined methodology, rigorous data analysis and use of independently rated attachment interviews using the History of Attachments Interview (Bartholomew & Horowitz, 1991). Unfortunately, sampling reliability is compromised by the inclusion of 'crossover cases' (authors report that 20 % of peer/adult offenders had a child victim in their history).

Stirpe et al, (2006) compared a range of sex offender sub-samples with respect to attachment state of mind classification using the AAI (George et al, 1996). Samples were extra-familial child molesters (n=22), intra-familial child molesters (n=19), rapists (n=20), non-violent offenders (n=21), violent offenders (n=19) and published AAI normative data (George,

Kaplan and Main, 1985). Offenders were recruited from prison populations and assigned to groups based on conviction histories.

All sex offenders were less likely to be securely attached than normative samples (However, there was no significant difference between groups when a five-factor (dismissing, secure, preoccupied, unresolved and cannot classify) model of attachment was used. When a three factor (secure, dismissing and preoccupied) model of attachment was used, extra-familial child-molesters were significantly more likely to be preoccupied ($\chi 2 = 26.59$, $p<0.001$). Rapists, violent offenders and to a lesser degree incest offenders were more likely to be dismissing.

This study is commended for its use of the AAI, matching of participants with non-participants, and comparison of offender sub-types. However, it must be noted the conclusions are drawn from data based on samples which are small relative to the other studies reviewed here (all groups, $n \leq 22$).

4.3 Studies rated as medium quality 'B'

Each of these studies used self-report measurement of attachment and had several notable methodological limitations.

Abracen et al (2006) compared adjudicated rapists (n=48), child molesters (n=43) and violent (non-sex) offenders (n=21) on four attachment dimensions (secure, preoccupied, fearful and dismissing) from a modified form of the RSQ. Participants were recruited from a prison treatment programme and assigned to groups based on review of police records. Sex offenders (rapists and child molesters combined) were significantly more pre-occupied than violent non-sex offenders ($F=4.18$, $p<0.05$). There was no difference between combined sex offenders and non-sex offenders who were securely vs. insecurely attached. Post-hoc analysis (using the Scheffe method) found that child molesters were significantly more

preoccupied than rapists and violent offenders (mean difference= 1.94, $p<0.05$). Authors do not provide sufficient information on how the RSQ was shortened, and unlike most other studies that used self-report measures of attachment, they failed to include a measure of social desirability in responding.

Lyn & Burton (2005) compared imprisoned sex offenders (n=144) with imprisoned non-sex offenders (n=34) using a modified version of the ECRI. Participants were recruited from a low security prison, and assigned to groups based on self-report data. Insecurely attached participants were 5.53 ($p<0.05$) times more likely than securely attached individuals to be in the sex offender group. There was no significant relationship between attachment designation and relationship with victim (known vs. not known). This study has several methodological limitations, namely: insufficient descriptions of recruitment and screening procedures, failure to exclude crossover cases, use of self-report to determine group assignment, and insufficient information on the modification of the ECRI.

Marsa et al, (2004) compared child sex offenders (n=29), violent non-sex offenders (n=30), non-violent non-sex offenders (n=30) and community controls (n=3) on the ECRI and Parental Bonding Instrument (Parker et al, 1979). Offenders were recruited from prison treatment programmes and assigned to groups based on conviction history. Community controls were recruited from a training centre, university and business. They found that sex offenders had the lowest proportion of cases with a secure attachment style ($\chi 2 = 20.05$, $p<0.05$). Fearful attachment style was over-represented amongst the child sex-offenders. This study was limited by its small sample sizes and failure to match participants with non-participants. The authors recognise that for these reasons, samples may not have been representative of the populations from which they were derived.

Marshall et al (2000) compared child molesters (n=30), non sexual offenders (n=24) and non offenders (n=29) on paternal and maternal dimensions (secure, anxious/ambivalent and

avoidant) of the CAQ. Offenders were recruited from prison. Controls were recruited through a government employment agency. There were no significant differences between groups with respect to maternal and paternal attachment scores. Child molesters reported higher mean anxious/ambivalent attachment, but this finding did not reach significance. In light of the findings of other studies reviewed here, it is conceivable that these findings may have reached significance, with more adequate sample sizes and thus sensitivity to smaller effect sizes. This study provided insufficient detail on participant recruitment, screening and assignment to groups.

Smallbone & Dadds (1998) compared rapists (n=16) familial child molesters (n=16), property offenders (n=16) and non-offenders (n=16) on attachment categories (secure, anxious/ambivalent and avoidant) derived from the RSQ and a modified form of the CAQ. Offenders were recruited from prisons and assigned to groups based on offence histories. ANOVA revealed that sex offenders combined (n=48) were significantly less secure in their maternal and paternal attachments than were correctional officers or property offenders. They were also less secure in their adult intimate relationships than either of the comparison groups. There were no significant differences between subtypes of offenders with respect to attachment scores. However, it must be noted that these sample sizes were small.

A significant limitation of this study was its use of extremely selective comparison groups (correctional officers and property offenders). Study findings may have been influenced by uncontrolled variables associated with differences in these highly selective samples (e.g. education, sexual abuse). It must also be noted that this study relied upon self-report data, without attempting to measure social desirability in responding.

Ward et al, 1996 compared child molesters (n=55), rapists (n=30) and non-violent offenders (n=30) on four attachment categories and dimensions (secure, fearful, preoccupied, and dismissing) derived from the RSQ. Child molesters were recruited via a prison treatment

programme. Other offenders were recruited via the same prison (but not in treatment). Offenders were assigned to groups based on offence histories. The majority of all groups were insecurely attached with significant differences between groups $\chi 2 = 19.68$, $p<0.02$. Child molesters had higher scores for preoccupied and fearful attachment style than did rapists. They also had the lowest scores for the dismissing attachment dimension. In relation to dismissing attachment, rapists and violent offenders were approximately equal, but both were significantly higher than child molesters and non-violent offenders. This study is limited by its failure to include a measure of socially desirable responding.

Baker & Beech (2004) compared adjudicated sex offenders (n=20), non-sexual offenders (n=15), and a community sample (n=21) on continuous anxiety and avoidance scores derived from the RSQ. Offenders were recruited from prison and assigned to groups based on review of prison records. There was no significant differences between groups in either anxiety or avoidance sub-scales. Compared to violent offenders, sex offenders did no show greater variability in responding over time. Authors suggest that multiple representations of self in relation to others, leads to impulsivity and lack of empathy, which in turn increases vulnerability to violent and sexual offending. Limitations of this study are its small sample sizes and reliance on self-report data.

4.4 Studies rated as low quality 'C'

Low quality ('C') studies used self-report measurement of attachment and all had several notable methodological limitations. They provide evidence in relation to both research questions although this evidence is considered to be of limited reliability.

Sawle and Kear-Colwell (2001) compared paedophiles (n=25), non-offending victims of sexual abuse (n=22) and student controls (n=23) on five attachment dimensions (secure, preoccupied with relationships, need for approval, discomfort with closeness and relationships as secondary) derived from the ASQ. Offenders were recruited from custodial

and community based treatment programmes. Victims were recruited from community based treatment programmes. Controls were recruited from a university. Controls and victims had significantly higher scores on the confidence (secure) scale than paedophiles, $F=29.49$, $p<0.01$. Paedophiles scored significantly higher than controls and victims with respect to relationships as secondary (form of avoidant attachment). This study is seriously limited due to the high risk of sample crossover, and failure to use any methods of corroboration or social desirability in offending.

Jamieson & Marshall (2000) compared incest offenders (n=20), non-familial child molesters (n=20), non-sexual offenders (n=20) and community controls (n=21) on four attachment categories derived from the RQ. All offenders were recruited from prisons. Non-familial child-molesters were 4.85 times more likely to report a fearful avoidant relationship style than a secure style compared to the community group. Incest offenders did not significantly differ from the community sample with respect to attachment style. This study was limited by its insufficient description of recruitment, screening and group assignment procedures. The risk of sample crossover did not appear to be sufficiently addressed.

5. Discussion

This is the first study to systematically review research exploring the relationship between insecure attachment and sex offending. Thirteen case-control studies have been reviewed in relation to key questions arising from attachment informed theories of sex offending. Below, the findings of this review are discussed in response to these questions and implications for further study. Methodological strengths, weaknesses, and recommendations for further study are then discussed.

5.1. Are there differences in the attachment status of sex offenders compared to non-sex offenders or the general population?

5.1.1. Sex offenders compared to general population

Data from across studies of all quality levels provide consistent evidence that secure attachment is significantly less common amongst sex offenders than in the general population. This is the strongest finding from this review and has been replicated in eleven of thirteen studies reviewed. Studies used: self-report and interview measures of adult and child attachment (dimensional and categorical); adult and adolescent offenders; offenders with adult and child victims (familial and non-familial); control samples recruited from various community settings and control samples matched for key demographic and socio-economic variables.

This overall finding is consistent with other studies that have investigated the psycho-social presentations of sex offenders (reviewed in Rich, 2006). The reviewed studies contribute to the growing evidence that sex offenders are less likely than the general population to have had adequate childhood attachment experiences or to have secure and emotionally fulfilling relationships in adulthood.

It is of note that this conclusion was not reached by two of the reviewed studies rated as being of medium quality; Baker & Beech (2004) or Marshall et al. (2000). In both of these studies, sex offenders had lower scores on the secure attachment dimension than did non-offenders, although this finding did not reach significance. In light of findings from the other studies, it is conceivable that these results might have reached significance if they used more adequate methods (e.g. larger sample sizes and samples more representative of populations being investigated).

5.1.2. Sex offenders compared to non-sex offenders

Some of the reviewed studies have included samples of non-sex offenders (violent and non-violent) to investigate whether attachment insecurity is more prevalent in sex offenders than it is amongst offenders in general. Results from these studies have revealed inconsistent findings.

Two studies rated as high quality (Miner et al, 2010 and Stirpe et al, 2006) and two studies rated as medium quality (Marsa et al, 2004 and Lyn & Burton, 2005) indicate that sex offenders (adult and child victims) are significantly less likely to be securely attached than non-sex offenders. Samples of non-sex offenders included property offenders and violent offenders.

Medium quality studies by Abracen et al (2006), Baker & Beech (2004), Jamieson & Marshall (2000), Smallbone & Dadds (1998), Marshall et al (2000) and Ward (1996) found that there was no significant difference between sex offenders and non-sex offenders with respect to attachment security vs. insecurity. Inspection of these non-significant results revealed inconsistencies. Jamieson & Marshall (2000) and Smallbone & Dadds (1998) found that sex offenders were less secure in measures of attachment than were non-sex offenders, whereas Marshall et al, (2000) found the opposite to be true. The inconsistencies

in these findings may be a result of great variation in the sample sizes, attachment measures, and sample characteristics (sex offenders and non-sex offenders).

The reviewed studies provide insufficient evidence to suggest sex offenders with adult or child victims are any more or less likely to be securely attached than individuals who commit non-sexual offences. The evidence therefore does not support the suggestions of some authors such as Lyn & Burton who have proposed that "insecure attachment is not a characteristic of criminality in general… it appears more likely that insecure attachment status is specific to sexual offending" (Lyn & Burton, 2004, pg. 155). Whilst this may be true in comparisons of some sex offenders vs. some non-sex offenders, none of the reviewed studies are of sufficient quality or scope to draw this conclusion. Thus far, the available data is more supportive of the hypothesis that disturbed early attachment experiences are a vulnerability factor for criminality in general.

One of the studies (Jamieson & Marshall, 2000) found that non-familial child molesters were differentiated from community and non sex-offending men by significantly higher attachment anxiety, yet intra-familial child molesters were not. This is an interesting finding which is consistent with other research finding incest offenders to be less recidivistic than extra-familial offenders (Larsen, Hudson & Ward,1995) and to be more like non sex-offending men in their clinical and social presentation (discussed in Parton & Day, 2002). Sawle & Kear-Colwell (2001) also found that sex offenders against children were less likely to be securely attached than victims of sexual abuse.

5.2. Is there an association between specific attachment styles and specific types of sex offending?

5.2.1. Child sex offenders and anxious/preoccupied attachment

There was moderate evidence that sex offenders with child victims were differentiated from sex offenders with adult victims (and control samples) in that they had the highest scores relating to attachment anxiety and preoccupation, and were more likely to be categorised in this way in categorical assessments. This finding was reported by three studies rated as high quality (Miner et al, 2010; Wood & Riggs, 2008; Simons et al, 2008), two studies rated as moderate quality (Stirpe et al, 2006 and Abracen et al, 2006) and one study rated as low quality (Jamieson & Marshall, 2000).

These studies provide some evidence that, in comparison to offenders against adults, child sex-offenders have the most negative views of themselves in relation to others and are more anxious and preoccupied in their attachment relationships. Such evidence does add some support to Ward's theory that for some offenders, sex-offending against children may be at least partly predicated by an anxious/preoccupied style of attachment (Ward et al, 1996). Using logistic regression modelling, Miner et al (2010) found some evidence that this pathway might be mediated by expectation of rejection from peers and feelings of interpersonal inadequacy.

5.2.2. Sex offenders with adult victims and avoidant/dismissive attachment

A less consistent finding of these studies was that rapists were more likely to have an avoidant/dismissing style of attachment. Two studies rated as high quality (Stirpe et al, 2006 and Simons et al, 2008) and one rated as moderate quality (Ward et al, 1996) found that sex offenders with adult victims were more likely to be avoidant/dismissive and to score higher on this attachment dimension. Results are based on interview of adult attachment (Stirpe et

al, 2006), self-reported childhood attachment (Simons et al, 2008) and self-reported adult attachment (Ward et al, 1996).

These results are consistent with Ward's speculation that avoidant/dismissive attachment might predicate offending that is actively hostile, aggressive and potentially sadistic in nature. This type of offence is hypothesised to arise through the offender's lack of empathy, and desire for sexual gratification whilst trying to maintain his sense of autonomy and independence.

Two other studies (Miner et al, 2010 and Smallbone & Dadds, 1998) also found that sex offenders with adult victims had higher scores on avoidant/dismissive attachment. However these results did not reach significance. One study (Jamieson & Marshall, 2000) did not support this conclusion. It is important to note that this study has been inconsistent with the broader literature, and this may be attributable to numerous methodological weaknesses (discussed on page 26).

5.3. Methodological strengths, weaknesses, and recommendations for further study.

A weakness of this overall body of research is that there is considerable variability in the assessment methods, attachment classifications and samples used. This has made it difficult to make comparisons and draw conclusions from study findings. Others have also criticised the theory driven nature of these studies and risk of bias potentially associated with this (Rich, 2006). This review found studies to be of variable quality with common methodological weaknesses that should be remedied in future research in this area.

It is important that future studies use large heterogeneous samples of offenders that represent variation in sex-offender characteristics. To achieve this, it will be necessary to recruit samples of adjudicated and non-adjudicated offenders from across clinical, prison and community settings. The reviewed studies were predominantly based on offenders from

prison populations. It would be desirable for researchers to attempt to match study samples with data on the characteristics of sex offenders in general. None of the reviewed studies did this. Also, many of the reviewed studies used small samples with few providing sample size justifications.

Where community control groups are used, it is essential that they are recruited from a broad range of community settings, and where possible matched with offenders on socio-demographic factors. Many of the reviewed studies used very selective control samples and did not clearly explain recruitment strategies. These failings may increase the risk of confounding and limit the extent to which results of comparisons are representative. Similarly, it is necessary for future studies in this area to adequately limit or statistically control the presence of offence crossover cases. In particular, it is often not clear that participants classified as being non-sex offenders have a history of sexual offending.

Further studies should aim to use well-established assessments of attachment, preferably validated interview methods such as the AAI. Where self-report methods are used, these should be standardised versions (without modification) and accompanied by an assessment of social desirability in responding. Many of the reviewed studies used modified versions of self-report instruments that were adapted to be more applicable to clients in forensic settings. Modification of standardised instruments is not normally justified. Where self-report instruments are used, it may be helpful to develop a standardised, psychometrically validated tool for use with offenders.

Multivariate statistical analyses should be used to control for a range of possible confounders and to also to identify potential mediators in the associations between attachment and sex offending. Some of the studies (e.g. Miner et al, 2010; Wood & Riggs, 2008) used such an approach with interesting findings (page 20). It is important to recognise that there are many possible motivators and disinhibitors for sexual offending. Studies

should try to capture information on offence motivation and offenders state of mind before and during offences. This may lead to a more sophisticated understanding of the role of attachment in the aetiology of sex offending and attachment related processes underlying sexually violent behaviours.

6. Conclusions

Research has revealed partial and inconsistent findings in relation to the role of attachment in the aetiology of sex offending. Methodological weaknesses, variability in methods used, and inconsistency in results limit the extent to which reliable conclusions can be drawn. However, all of the available data strongly suggest that sex offenders are a group with a higher representation and severity of attachment deficits than the general population. At present, there is insufficient evidence to assert that these deficits are a causal factor in sex offending or that they are a risk factor for sex offending behaviours, more so than criminality in general. However, recent studies with improved methodological quality have provided data that is consistent with multi-causal pathway theories to sex offending (e.g. Marshall & Barbaree, 1990) that include the combined influences of insecure attachment, intimacy deficits, and feelings of personal inadequacy. There is insufficient evidence that specific types of offending are predicated by specific attachment deficits in the manner that was outlined by Ward (1996). However, there is moderate evidence for part of this theory, that sex offenders with child victims are often found to display more anxious and preoccupied attachment traits than are offenders with adult victims. There is some minimal, inconsistent evidence that avoidant and dismissive attachment traits may be over-represented in offenders with adult victims. Attachment theory offers promising and attractive new avenues in research and clinical practice. However, in order to establish and understand the nature of this relationship, there is a need for this field to develop more rigorous methods and to adopt new, more incisive research approaches.

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CHAPTER TWO: MAJOR RESEARCH PROJECT

Sexual violence risk assessment:

An investigation into the inter-rater reliability of the RSVP in Scotland

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Abstract

Background: The RSVP (Risk of Sexual Violence Protocol; Hart et al, 2003) is a structured professional judgement tool for assessing risk of sexual violence. Despite being widely used in forensic mental health settings, the reliability and validity of the RSVP has not been established. There is an urgent need to investigate the inter-rater reliability of the tool in a multi-disciplinary clinical context. ***Method:*** Clinicians (n=28) with varying professions, levels of experience and training, used the RSVP to evaluate six case vignettes with varying offence characteristics, clinical-complexity and risk. ICC (Intra-class Correlation Coefficient) and percentage agreement statistics were used to evaluate inter-rater reliability of RSVP items, domains and steps. Items included additional forced-choice judgements relating to Scenario Planning and Case Management steps. Clinician responses were also compared to 'gold-standard' judgements developed by experts in the field of forensic risk assessment. ***Results:*** Inter-rater reliability was 'fair' overall with individual items ranging from 'poor' to 'excellent'. Importantly, there was a 'good' level of inter-rater reliability on Summary Judgements and Supervision Recommendations. Inter-rater reliability was highest when used by professionals who were highly trained in forensic risk-assessment. On average, professionals with lower levels of specialist training agreed less with their colleagues and experts, and provided higher estimations of sexual violence risk. Lower levels of agreement were found in cases with moderate levels of complexity and risk. ***Conclusions:*** The RSVP can be used to attain adequate levels of inter-rater reliability. However this is dependant on the training and expertise of professionals who use the tool. Methodological strengths and limitations are considered, followed by a discussion of implications for training, practice and future research.

Keywords: *forensic risk assessment, sexual violence, inter-rater reliability, structured professional judgement, sexual offending* and *Risk of Sexual Violence Protocol.*

1. Introduction

1.1. Clinical-forensic risk assessment

Violence risk assessment is a core responsibility of all professionals working in forensic mental health services. It is an important and substantial clinical process that can be fraught with complexity and confusion. The consequences of risk assessment are serious: if risk assessment is carried out incorrectly, people may be harmed or killed; perpetrators may lose their liberty and professionals may be held to account for their decisions. Whilst research has identified a range of factors that are associated with risk of offending, individual offending behaviour remains an intrinsically unpredictable phenomenon. For these reasons, it is crucial that professionals use valid and reliable procedures that enable the effective identification, understanding and management of risks posed by clients who offend. A variety of tools have been developed for this purpose. Doyle & Dolan (2002) identify three distinct generations of risk assessment: (1) The unstructured clinical judgement approach; (2) the actuarial approach and (3) the structured clinical judgement approach.

Actuarial and structured clinical judgement approaches have been developed in response to the shortcomings of unstructured clinical judgement. The expert opinion of experienced professionals (unstructured clinical judgement) was once accepted as a sufficient basis for legal and clinical decision making. Whilst having the potential to be highly adaptable and cost-efficient, this approach has numerous failings. It has no reliability, validity, transparency or evidence base and is highly susceptible to the biases inherent to individual subjectivity. Several authors including Hart et al (2003) and Maden, (2007) have also criticised its reliance on 'charismatic authority' as a dangerous cause of bias and opacity. Much can be learned from this era of risk assessment; it is evident that risk assessment procedures should be designed to address these criticisms whilst incorporating the value of

clinician knowledge and experience. However, there is a longstanding debate amongst some clinicians and researchers as to the role of clinician judgement and the extent to which it should inform contemporary risk assessment (reviewed in Boer, 2006).

The actuarial approach includes assessment tools such as the VRAG (Violent Risk Appraisal Guide; Quinsey et al, 1998), the SORAG (Sexual Offender Risk Appraisal Guide; Quinsey et al, 1998), Static-2002 (Hanson and Thornton, 2003), the LSI-R (Level of Service Inventory – Revised; Andrews & Bonta, 1995) and the SONAR (Sex Offender Needs Assessment Rating; Hanson & Harris, 2000). These measures adopt actuarial principles, using group projections based on empirical evidence to make individual predictions about risk of future violence. In practice, this requires evaluators collating information on risk factors of assigned weight, which are then combined in an algorithm to estimate level of risk. Advantages of this approach include being evidence based, transparent, systematic, objective, standardised and cost-effective. For these reasons, actuarial measures have an important function. However, there are disadvantages of basing risk assessment on these methods alone. Most problematically, it is simply not possible to predict future offending behaviour. As has been commented by Hart et al. (2007), the error margins in applying associations from massed offender data to individuals are unacceptably large. Other obstacles to prediction include changeability of offender and environment factors and the problem of inaccurate and missing information at time of measurement. Furthermore, actuarial methods are of limited practical value as they do not aid risk understanding or management. Whilst these methods are valuable aids to risk assessment, it is crucial that they are interpreted with caution and do not form the sole basis of risk judgements.

The extant empirical and professional literature support the use of the structured clinical judgement approach to violence risk assessment. This approach is used to provide comprehensive risk assessments that are based on scientific and professional literature.

However, it allows freedom of clinician decision making whilst maintaining consistency, transparency and a degree of objectivity. The first structured clinical judgement approach to violence risk assessment was developed by Kropp and colleagues. They produced the SARA (Spousal Assault Risk Assessment Guide; Kropp et al, 1995). Shortly afterwards, the HCR-20 (Historical Clinical Risk -20; Webster et al, 1997) was published to aid clinicians assess risk of interpersonal violence. Thereafter followed the SVR-20 (Sexual Violence Risk - 20; Boer et al, 1997) and other tools such as the SARN (Structured Assessment of Risk and Need; Thornton, 2002), B-SAFER (Brief Spousal Assault Form for the Evaluation of Risk; Kropp et al, 2005) and SAM (Stalking Assessment Manual; Kropp et al, 2008).

Using these tools, evaluators are systematically guided through the process of risk assessment, formulation and management. These methods have an emphasis on understanding and managing risk as opposed to predicting future offending. Disadvantages of these tools are that they are often time consuming to complete and are susceptible to a greater degree of clinician bias than actuarial instruments. Ultimately, they require clinicians to make difficult decisions, albeit with the help of standardised guidelines. Within Scotland, the Risk Management Authority stipulates that structured clinical judgement tools should be used to aid legal decision making for offenders being subject to an Order of Lifelong Restriction - a sentence developed to manage the most exceptional and difficult dangerous offenders (see Risk Management Authority, 2009; Criminal Justice (Scotland) Act, 1995).

1.2. Risk of Sexual Violence

Sexual violence has been defined by Hart and colleagues (2003) as “the actual, attempted, or threatened sexual contact with another person that is non-consensual”. This definition would

include acts of rape, sexual touching, exhibitionism, obscene communications and voyeurism. Broader definitions such as that suggested by the World Health Organisation (2009) would also include acts such as forced abortion and exposure to pornography.

Within mental health settings, there is a paucity of data on the prevalence, background, and treatment outcomes of sex offenders (Sahota & Chesterman, 1998). In a study of patients receiving high security in-patient care at the State Hospital, Scotland, Baker & White (2002) identified that 22.5% had committed a sexual offence or sexually motivated assault. These patients often had multiple diagnoses including mental health problems, personality disorder and intellectual disability. Clinicians working with mentally disordered sex offenders are required to assess the risk posed by this client group and make decisions relating to their treatment, discharge, and supervision. Empirical evidence suggests that there are a number of factors that must be considered when evaluating risk of sexual violence. In studies of sex offender recidivism (Hanson & Bussière 1998 and Dempster & Hart, 2002) numerous static and dynamic risk factors have been identified. Static risk factors for sexual offending include history of offending, nature of offences, major mental illness, diagnosis of psychopathy, and personal history of abuse. Dynamic risk factors include attitudes towards offending, suicidal / homicidal ideation, substance addiction, deviant sexual interests and cognitive distortions (such as beliefs about sexual entitlement).

A prominent structured clinical judgement tool for assessing risk of sexual violence is the Risk for Sexual Violence Protocol (RSVP; Hart et al., 2003). The RSVP has evolved from the lessons learned from the use of the earlier structured clinical judgement tools such the HCR-20 and SVR-20. The RSVP involves six stages in the assessment process (see figure 1 for overview) which, as well as facilitating the assessment of risk, includes a set of guidelines for producing risk management interventions. These stages are: Step 1) Data collection; Step 2) Evaluation of risk factor presence; Step 3) Evaluation of risk factor

relevance; Step 4) Identification and description of most likely future risk scenarios; Step 5) Recommendations for case management and Step 6) Summary judgements of case.

The RSVP is based on systematic review of the research evidence and aims to guide professionals in providing risk assessments that are evidence-based and comprehensive. It also aims to help clinicians characterise risks and make judgements relevant to risk management. Important features of the RSVP manual are that it provides an evidence-based rationale for each item, clear assessment guidelines and detailed operationalization of terms and ratings.

The RSVP manual stipulates that clinicians using this tool meet three user qualifications: 1) knowledge of sexual violence (i.e. relevant scientific and professional literature); 2) expertise in individual assessment (interview and review of collateral information) and 3) expertise in mental disorder (training and experience in assessment and diagnosis of mental disorder). Users who do not meet the third criterion may assess risk factors by drawing upon the expertise of more experienced professionals or referring to prior evaluations of mental disorder.

Anecdotal evidence suggests that the RSVP is widely used amongst forensic mental health professionals in Scotland and in the rest of the world. Hart & Boer (2009) report that the RSVP and its predecessor the SVR-20, have sold several thousand copies worldwide and are published in over seven different languages. It is therefore vital that it is shown to be a valid and reliable measure of assessing risk.

Figure 1: Stages involved in RSVP administration and data type for each stage.

1.3. Reliability

Various methods of assessing the utility of risk assessment are available. For example, predictive validity is a commonly used method. However, there is a growing awareness of the limitations of this approach to validation. Predictive judgements are meaningful when applied to groups of offenders. However, at an individual level predictions are not precise (Hart et al, 2007). For example, in a natural study of offenders released from high security hospitals in the USA, researchers found that only 4% of the 246 'high risk' offenders committed a felony after four year follow-up (Steadman & Cocozza, 1974). Whilst there are important considerations to be borne in mind when interpreting this study (e.g. predictions were based on unstructured clinical judgement) it illustrates the unpredictability of offending behaviour.

Whilst we cannot predict the future with precision, we can attempt to ensure that risk assessment tools are used fairly and consistently by assessors and that they are used in a manner to inform risk management and to ensure that interventions are proportionate to the risks posed. Clinical judgement is central to risk assessment, and therefore the evaluation of inter-rater reliability should be a particular focus of research.

Some published studies have evaluated the inter-rater reliability of structured clinical judgement approaches to sexual violence risk, namely the SVR-20 (Sjostedt &Langstrom, 2003; de Vogel & de Ruiter, 2004; Hildebrand et al, 2004; Rettenberger & Ehler, 2007; Barbaree et al, 2008 and Hill et al, 2008) and SARN (Webster et al, 2006). These studies used different methods of statistical analysis (percentage agreement, Cohen's Kappa and ICC) and samples of varying sizes and characteristics (experience, profession, training etc). With the exception of Webster et al (2006), studies used only two independent raters. Overall these studies achieved very high reliability with ICC and Kappa coefficients ranging from 'good' to 'excellent', with the majority 'excellent'. However, Webster et al (2006) in

one of two studies found 'moderate' reliability for the SARN when a large sample (n=88) of assessors was used. This was notably higher when a smaller sample of expert evaluators (n= 7) was used. Sjostedt & Langstrom (2003) found 'poor' reliability (Cohen's K =.36) for the SVR-20, and this was attributed to variation in the experience of the two raters used. Following further training of the raters, the study was repeated and found 'fair' inter-rater reliability (Cohen's K =.50).

A recent literature review (Hart & Boer, 2009) identified three very similar unpublished studies that investigated the inter-rater reliability of the RSVP (conference posters: Hart, 2003; Watt et al, 2006 and Watt & Jackson, 2008). All of the studies were conducted in Canada and were based on file review data from convicted sex offenders. Two of the studies used high risk offenders only (Hart, 2003; Watt et al, 2006). All studies used Case 1 ICC ('ICC1'- mixed effects model) to calculate absolute agreement between two experienced evaluators and a large numbers of offenders ($n \geq 50$).

All studies found that inter-rater reliability of ratings for individual presence and relevance factors was 'good' (ICC1 .5 – ICC1 .74) to 'excellent' (ICC1 $\geq$ .75), with the majority 'excellent' They also derived domain ratings from individual factors; their inter-rater reliability was 'excellent', although the most recent study by Watt & Jackson (2008) found that for Sexual Violence History and Mental Disorder domains ICCs were 'good'. Agreement on Summary Judgments including Case Prioritization ratings (low, moderate or high) were also all in the 'excellent' ranges.

Whilst these studies successfully indicate that the RSVP *can* be used to make reliable judgments using structured clinical judgment, they fail to establish the validity of the measure within actual clinical settings. The use of ratings from only two highly experienced raters and data from groups of high risk offenders is not representative of the heterogeneous characteristics of risk assessors and offenders in the general forensic-clinical population. In

reality, offenders present varying levels of risk and risk assessors have varying professional backgrounds, experiences and levels of training. It is also important to consider that these studies did not include data from the Scenario Planning and Case Management steps of the RSVP. Whilst not as amenable to statistical analysis, the qualitative data from these steps include important and complicated judgments that should be included in further inter-rater reliability studies.

In addition, none of the above mentioned studies has investigated potential case or clinician factors that are associated with variance in inter-rater agreement or any other aspects of risk assessment judgements. Yet, these are important questions that may help to develop our insight into the risk assessment process and identify targets for improving inter-rater reliability. One study of the HCR-20 (de Vogel & de Ruiter, 2004) found that treatment supervisors had more 'low risk' judgments than researchers, and perceived risk was associated with assessor's attitudes to the offender (feeling relaxed vs. feeling controlled and manipulated).

Studies in other domains of clinical practice have investigated predictors of accuracy and inter-rater reliability of clinician judgements. By establishing an index of inter-rater agreement (e.g. correlation or percentage agreement) for individual clinicians it is then possible to explore relationships between this index and inter-rater reliability. For example, Persons & Bertognolli (1999) used this method and found that professional variables (including experience and level of training) did not predict level of inter-rater reliability in a CBT case-formulation exercise. However, they did find that level of professional training (PhD trained or not) was the only predictor of clinician accuracy in judgements.

The Risk Management Authority Scotland publishes RATED, the Risk Assessment Tools Evaluation Directory, which provides an overview of the evidence in support of risk assessment instruments. RATED (Version 2, 2007) indicates that there is a dearth of empirical evidence to support the use of the RSVP in Scotland and other countries. This manual evaluated all known sexual violence risk assessment procedures according to the following criteria: (1) validation history; (2) empirical grounding; (3) inter-rater consistency; (4) sensitivity in identifying risk level and (5) sensitivity in identifying risk factors. The RSVP was rated as fully satisfactory only in relation to (2) empirical grounding. There was insufficient data to address the other criteria.

In RATED, the RMA differentiate between instrument development studies conducted in Scotland, the UK and elsewhere in the world. These distinctions are important, because results of instrument development studies are reflective, not only of the instruments evaluated, but variables associated with the participants, settings and materials used. Studies will have greatest clinical relevance when the experimental conditions have ecological validity to clinical settings.

1.4. RSVP assessors in Scotland

The RSVP is designed for use by multi-disciplinary professionals. Within Scottish forensic mental health settings, it is used by a range of professionals including Clinical Psychologists, Psychiatrists, Psychiatric Nurses, Social Workers and Occupational Therapists, all with different backgrounds, competencies, levels of knowledge and experience. Further specialist training workshops (RMA accredited) are often provided to clinicians using this tool, and therefore risk assessors will also vary with respect to their level of formal training in using the RSVP. Anecdotal evidence suggests there is significant variance in level of training with some assessors having had no formal training whilst others will have been trained on numerous occasions. Formal training in the use of the

RSVP is recommended (Hart et al, 2003) and there is considerable evidence that such user training programmes enhance inter-rater reliability of assessment measures (Reichelt at al, 2003; Muller &Wetzel, 1998). Consensus decision making is a method of enhancing assessment reliability, although risk assessment is often carried out without discussion amongst clinicians.

1.5. Rationale for study

As has been outlined above, the RSVP is used in Scotland for assessing risk of sexual violence. Across the forensic mental health and criminal justice setting in Scotland, it is accepted as an appropriate method of informing opinions on risk (Directorate of Forensic Mental Health Policy on Assessing Risk of Harm to Others, 2007; The State Hospital Policy on Risk Assessment; 2008). At present, information regarding its reliability and validity in Scotland is not available. The need for reliability and validity data is ever more apparent when one considers that the RSVP is a structured clinical judgement tool that is used by a diverse professional group, with different levels of training, supervision and models of working. Key questions exist about the inter-rater reliability of the RSVP, thus setting a clear rationale for this study.

The primary aim of this study is to evaluate the inter-rater reliability of the RSVP when used by trained multi-disciplinary professionals within Scottish forensic mental health settings. The study also aims to investigate clinician agreement with 'gold-standard' judgements developed in consultation with experts in forensic risk assessment. Secondary aims are to explore and identify any clinician and case specific associations with variability in reliability and estimation of risk.

2. Research questions

2.1. Primary research questions

Question 1: What level of inter-rater reliability does the RSVP achieve when used by multi-disciplinary forensic mental health clinicians?

Question 2: To what extent do clinicians using the RSVP agree with 'gold-standard' ratings developed in consultation with experts in forensic risk assessment?

2.2. Secondary research questions

Question 3: Are self-reported clinician variables[2] associated with average estimation of risk and level of agreement (amongst clinicians and with 'gold-standard')?

Question 4: Are case-specific variables (*risk of sexual violence* and *clinical complexity*[3]) associated with average estimation of risk and level of agreement (amongst clinicians and with 'gold-standard')?

[2] *Professional variables are:* Profession, length of clinical experience, length of forensic experience, number of days formal RSVP training received, perceived confidence in accuracy of judgements, perceived objectivity in decision-making, and perceived level of adherence with the RSVP manual.

[3] Throughout study materials, *sexual violence* is defined as the "actual, attempted or threatened sexual contact with another person that is non-consensual" (Hart et al, 2003). *Risk* is broadly defined in terms of the "nature, severity, imminence, frequency and likelihood of future sexual violence" (Hart & Boer, 2009). *Clinical Complexity* reflects the severity and co-morbidity of clinical problems.

3. Design

This study employs a 'fully crossed' design, also called a factorial or 'rater x subject' design. Qualified forensic mental health professionals (n=28) provided brief mock risk assessments to six fictitious case-vignettes of varying offence characteristics, risk of sexual violence and clinical complexity. There were three sets of response variables:

1) **Standard RSVP items:** Items from Step 2 (*evaluation of risk factor presence*), Step 3 (*evaluation of risk factor relevance*) and Step 6 (*summary judgements*) were administered as published in the RSVP manual.

2) **Research items:** Forced-choice questions were developed for this study to capture key items from RSVP Step 4 (*risk scenario planning*), Step 5 (*risk management strategies*) and an additional research item: *overall estimation of risk*.

3) **Professional information:** Self-reported professional variables were: *profession, length of clinical experience, length of forensic experience, number of days formal RSVP training received, perceived confidence in accuracy of judgements, perceived objectivity in decision-making and perceived level of adherence with the RSVP manual.*

Primary questions were addressed using Case 2 Intra-Class Correlation Coefficients (ICC2) and percentage agreement statistics. Data analyses also included evaluation of agreement with 'gold-standard' judgements that were developed in consultation with experts in forensic risk assessment. Secondary questions were addressed using correlations between professional variables and participant agreement on standard RSVP items, comparison of professional variables between upper reliability and lower reliability sub-groups, and comparison of average rates of agreement across cases.

4. Participants

Twenty-eight clinicians volunteered to participate in this study. All were fully qualified in their profession and were employed by NHS Health Boards throughout Scotland[4]. The study employed two recruitment strategies: 1) an RSVP training event and 2) distribution of study information and invitation to participate via e-mail.

4.1. RSVP training event

An RMA accredited training workshop in using the RSVP was delivered by Dr Lorraine Johnstone. The one and-a-half day event was held in Glasgow and attended by thirty-five clinicians from across NHS Scotland Health Boards (Greater Glasgow & Clyde, the State Hospital, Tayside and Grampian). Details of the training event and this optional study were distributed to health boards by e-mail. Clinicians attended as part of their continuing professional development. Clinical Psychologists and Psychiatrists requested to attend the training directly, whilst Nurse Managers nominated Nurses to attend on the basis that the RSVP was/would become relevant to their clinical work.

The training workshop used didactic teaching, group exercises and discussion to build client familiarisation with the RSVP (background, rationale and guidelines) and competency in completing each step and item of the RSVP. Following the workshop, twenty-one attendees agreed to participate in the study. Fifteen sets of study materials were completed in the afternoon following the training event. All participants worked at individual stations in the training centre, with each taking approximately four hours to complete the materials. The remaining six participants returned completed materials by post. Because of participant anonymity, it was not possible to obtain data on attendees who did not participate.

[4] In maintaining confidentiality, it was not possible to identify the health boards of each participant.

4.2. Distribution of study information and invitation to attend

A study information sheet (appendix 2.1) was sent to forensic mental health professionals across Scottish Health Boards. The information was sent via circular e-mail to all forensic mental health professionals in Glasgow and State Hospital Health Boards. It was then distributed throughout Scotland by the Forensic Network, a professional network of forensic mental health professionals in Scotland. Ten professionals agreed to participate in the study, and were forwarded materials. Seven sets of materials were returned.

4.3. Description of sample

Descriptive statistics in tables 1 and 2 provide an overview of the professional characteristics of the sample. Participants worked in adult forensic mental health and learning disabilities settings and consisted of Psychiatric Nurses (n=13), Clinical Psychologists (n=8) and Psychiatrists (n=7). Participants were qualified in their profession for a mean of eleven years and had a broad range of experience and familiarity in using the RSVP and other risk assessment tools. Almost half of the sample - eight Nurses, two Clinical Psychologist, and three Psychiatrists had no previous experience of using the RSVP.

This study did not require participants to make diagnoses of mental disorder (this information was provided in case vignettes). For this reason, all participants (including staff without expertise in diagnosis) met all of the RSVP user qualifications (outlined on page 49). Five Nurses reported contributing to multi-disciplinary risk assessments using the RSVP whilst the remaining Psychiatrists (n= 4) and Clinical Psychologists (n=6) had experience of taking a lead role in undertaking numerous risk assessments using the RSVP. All but one of the participants, a Psychiatrist with five years forensic experience, had received formal RSVP training.

	N	Proportion of Sample (%)
Profession		
Nursing	13	46%
Clinical Psychology	8	29%
Psychiatry	7	25%
Total	**28**	**100%**
Primary Clinical Setting(s)		
Community	7	25%
Inpatient - Low Secure	4	14%
Inpatient - Medium Security	9	32%
Inpatient - High Security	6	21%
Between Medium and Low Security	1	4%
Between Low Security and Community	1	4%
Total	**28**	**100%**
Primary Client Group		
Learning Disability	5	18%
Non-Learning Disability	23	82%
Total	**28**	**100%**
Number of Years Qualified		
0 - 4 years	7	25%
5 - 9 years	8	28%
10 - 14 years	3	11%
15 years +	10	36%
Total	**28**	**100%**
Number of Years in Forensic settings		
0 - 4 years	11	39%
5 - 9 years	10	36%
10 - 14 years	4	14%
15 years +	3	11%
Total	**28**	**100%**
Number of times RSVP used		
0 occasions	14	50%
1-10 occasions	9	32%
11-20 occasions	2	7%
20 - 35 occasions	3	11%
Total	28	100%
Days formal RSVP training		
0 days	1	4%
1-2 days	23	82%
2-4 days	4	14%
Total	**28**	**100%**

Table 1. Professional characteristics of samples.

	N	Min	Max	Mean	S.D
Length of time qualified in profession (years)	28	0.5	30	11	9.05
Length of time working in forensic settings (years)	28	0.17	25	7	6.40
Formal RSVP training received (days)	28	None	4	1.75	0.89
Number of occasions RSVP used	25*	None	25	4	7.38

Table 2. Length of time qualified in profession, forensic settings and experience of RSVP manual. * 3 clinicians not included due to missing data.

4.4. Ethical approval

Ethical approval was sought and granted by NHS Glasgow and Lothian Research Ethics Committees. Research & Development approval was granted by NHS Glasgow and NHS State Hospital Health boards. Documentation confirming Ethics and R&D approval is shown in appendix 2.2. All participants were given a detailed study information sheet (appendix 2.1) and gave informed consent to participate in the study (appendix 2.3).

5. Materials

Participants were given the following materials: 1) a complete published version of the RSVP manual (Hart et al, 2003); 2) six fictitious case vignettes (brief summaries in appendix 2.4); 3) six data-collection workbooks (appendix 2.5) and 4) a purpose-designed Professional Information Questionnaire (appendix 2.6).

5.1. Case vignettes

High quality case vignettes, loosely based on cases from the research team's clinical experience, were developed by the trainee. Details of any actual individuals were significantly altered and anonymised. Vignettes were designed to represent the broad range of clinical complexity, risk of sexual violence and offence characteristics that are encountered in NHS forensic mental health settings.

In order to enhance authenticity, cases were written in a standard clinical assessment format that provided both risk-relevant and contextual information. Vignettes were 2-4 pages long and were structured under the following headings: Sources of Information, Background History (including family, forensic, romantic/sexual, social, psychiatric, employment and education histories), Index Offence (including witness, victim, police and offender accounts) and Current Presentation (including reports of psychiatric, social, behavioural, and attitudinal presentation). Fictitious names, dates, and other details were specified throughout. Cases were as follows: 'Bill' (low risk / low-medium clinical complexity); 'Mathew' (low risk / medium-high clinical complexity); 'Simon' (medium risk / low-medium complexity); 'Mark' medium risk / medium-high clinical complexity; 'Donald' high risk / low-medium clinical complexity, and; 'Stuart' (high risk / medium-high clinical complexity.

5.2. Expert review of cases and development of 'gold-standard' judgements

Once completed, a panel of six highly experienced expert evaluators were asked to review the cases. This stage was included to provide 'gold-standard' item ratings, and to verify the quality and authenticity of the vignettes.

Expert evaluators were: Professor Stephen Hart (Professor in Forensic Clinical Psychology), Professor Randall Kropp (Professor in Forensic Clinical Psychology), Dr Caroline Logan (Consultant Forensic Clinical Psychologist and Honorary Research Fellow), Professor David Cooke (Consultant Forensic Clinical Psychologist and Professor in Forensic Clinical Psychology), Dr Ruth Stocks (Consultant Forensic Clinical Psychologist) and Dr Lorraine Johnstone (Consultant Forensic Clinical Psychologist). All of the experts are experienced assessors in the RSVP. All of the experts are trainers in structured clinical judgement tools, and three of the experts (SH, CL & RK) co-authored the RSVP manual.

Each case was randomly assigned to an expert rater. In order to minimise demands on the experts' time, each case was pre-evaluated beforehand by the trainee and field supervisor. Experts provided detailed evaluation of each case and confirmed their agreement with the majority of pre-ratings. All experts made several amendments to the suggested ratings and requested clarification in relation to some items. In each instance, further information was added to the vignette to facilitate unambiguous rating where possible. A further review of the final evaluations confirmed that the expert judgements adhered to the guidelines set out in the RSVP manual.

Experts also completed a feedback questionnaire (appendix 2.7) which asked about their perception on the authenticity, quality, risk and complexity of cases. In general, experts were highly approving of the case quality and authenticity. They agreed that cases were consistent with the level of risk and complexity that they were designed to portray. One of the raters raised concerns that many of the additional research items (stages four and five) were

forced-choice, and this did not reflect the complexity of judgments in clinical practice. This rater also expressed the view that scores of "present and partially" are both effectively scores of "yes", and might therefore be dichotomized in analysis. This method would have excluded data from analysis and would not have been amenable to statistical analysis using ICC. Therefore, the decision was made not to use this method.

5.3. Data collection workbook and Professional Information Questionnaire

For each case, a nine page data collection workbook collected forced-choice judgements to gather data on response variables (outlined on page 57). Tables 3 to 7 below provide brief descriptions of the data collection items used. At the end of each case, participants were also asked to provide an estimation of their overall *estimation of sexual violence risk* (responses: very low, low, moderate, high and very high).

STEPS 2-3: IDENTIFICATION OF RISK ITEM PRESENCE AND RELEVANCE Clinicians are required to rate the presence (past and recent) and relevance of each of these risk items (replicated verbatim from the RSVP).	
A. Sexual Violence History	
1. Chronicity of Sexual Violence	Persistence and frequency of sexual violence (e.g. early onset).
2. Diversity of Sexual Violence	Diversity in the nature of offending (e.g. offence and victim characteristics).
3. Escalation of Sexual Violence	Pattern of escalation in offending severity, frequency or diversity over time.
4. Physical Coercion in Sexual Violence	Actual, attempted or threatened physical harm during the course of sexual violence, or to further the commission of sexual violence.
5. Psychological Coercion in Sexual Violence	Acts committed involving either threatened loss or promised gain of status, privilege, favour or affection.
B. Psychological Adjustment	
6. Extreme Minimization or Denial of Sexual Violence	Failure to admit or accept responsibility for acts of sexual violence and consequences.
7. Attitudes that support or Condone Sexual Violence	Beliefs and values that either directly or indirectly encourage or excuse sexual violence.
8. Problems with Self-Awareness	Lack of self-appraisal of factors or processes that increase the risk of sexual violence.
9. Problems with Stress or Coping	Unstable psychosocial adjustment and susceptibility to external stressors.
10. Problems Resulting from Child Abuse	Serious problems in psychosocial adjustment that are the result of abuse experiences in childhood or adolescence and that are associated with increased risk of sexual violence.
C. Mental Disorder	
11. Sexual Deviance	Stable pattern of deviant sexual arousal.
12. Pychopathic Personality Dis.	As defined and assessed by the PCL-R Psychopathy Checklist-Revised (Hare, 1991, 2003).
13. Major Mental Illness	Substantial impairment in the person's cognition affect or behaviour.
14. Problems with Substance Use	Use of legal and illegal substances that cause significant psycho-social impairment.
15. Violent or Suicidal Ideation	Thoughts impulses and fantasies of harming ones self or others.
D. Social Adjustment	
16. Problems with Intimate Rels.	Failure to establish or maintain stable intimate relationships.
17. Problems with Non-Intimate Rels.	Failure to establish or maintain positive (pro-social) non intimate relationships. Refers to conflict, isolation and sexualisation of non-intimate relationships.
18. Problems with Employment	Failure to establish and maintain stable legal employment or education.
19. Non-Sexual Criminality	Serious non-sexual criminality.
E. Manageability	
20. Problems with Planning	Failure forming or implementing realistic pro-social life plans.
21. Problems with Treatment	Failure to benefit from rehabilitative services to address psychosocial difficulties.
22. Problems with Supervision	Failure to co-operate with supervision services.

Table 3: Brief descriptions of items from RSVP Steps 2 and 3: Presence and Relevance of Risk Factors.

STEP 6: SUMARY JUDGEMENTS Clinicians are required to make summary judgements in relation to the following:	
1.Case Prioritisation	The degree of effort or intervention that it will require to prevent the person from commiting sexual violence: *Low /Routine* (person is not considered in need of special intervention), *Moderate / Elevated* (person requires some management strategies), *High / Urgent* (there is an urgent need to develop a risk management plan for the person.
2.Risk of Serious Physical Harm	Severity and imminence of sexual violence that the person might commit: Low, Medium and High.
3.Immediate Action Required	Need for Immediate Action*: Yes, Possibly and No.*
4.Other Risks Indicated	Risk of non-sexual criminality: *Yes, Possibly and No.*

Table 4: Brief description of items from RSVP Step 6: Summary Judgements.

STEP 4: SCENARIO PLANNING: Clinicians were asked to identify plausible 'repeat' and 'escalation' offence scenarios. In order to quantify characteristics of scenarios, they were required to respond to the following forced choice items:	
Repeat Scenario	
1.Nature	The type of offence*: sexual breach of peace* (e.g. harassment), *indecent exposure, indecent assault, rape* (without serious violence), *rape* (with serious violence) *and sexual homicide.*
2.Victim	The likely victim of scenario: *prepubescent male, prepubescent male, adolescent female, adolescent male, adult female* or *adult male.*
3.Level of psychological harm	Level of psychological harm: *none/negligible, minor* (short term/mild emotional distress), *moderate* (medium term/moderate emotional distress) or *severe* (significant/long term distress and psychological disturbance incl. PTSD).
4.Level of physical harm	Level of physical harm: *none/negligible, minor* (e.g. grazing), *moderate* (e.g. cuts and bruises), *major* (e.g. serious cuts and bruises) or *fatal /near fatal.*
5.Imminence	Estimated imminence of scenario (from having the opportunity to offend): *1-4 weeks, 6 months, 12 months,* or *several years.*
6.Frequency	Estimated frequency of scenario: *unlikely/never, once/twice, several times* or *habitually/repeatedly.*
7.Likelihood	Estimated likelihood of scenario: *very low probability, low probability, moderate probability, high probability* and *very high probability.*
Escalation Scenario	
1.Nature	The type of offence*: sexual breach of peace* (e.g. harassment), *indecent exposure, indecent assault, rape* (without serious violence), *rape* (with serious violence) *and sexual homicide.*
2.Victim	The likely victim of scenario: *prepubescent male, prepubescent male, adolescent female, adolescent male, adult female* or *adult male.*
3.Level of psychological harm	Level of psychological harm: *none/negligible, minor* (short term/mild emotional distress), *moderate* (medium term/moderate emotional distress) or *severe* (significant/long term distress and psychological disturbance incl. PTSD).
4.Level of physical harm	Level of physical harm: *none/negligible, minor* (e.g. grazing), *moderate* (e.g. cuts and bruises), *major* (e.g. serious cuts and bruises) or *fatal /near fatal.*
5.Imminence	Estimated imminence of scenario (from having the opportunity to offend): *1-4 weeks, 6 months, 12 months,* or *several years.*
6.Frequency	Estimated frequency of scenario: *unlikely/never, once/twice, several times* or *habitually/repeatedly.*
7.Likelihood	Estimated likelihood of scenario: *very low probability, low probability, moderate probability, high probability* and *very high probability.*

Table 5: Additional research items designed to capture RSVP Step 4 (scenario planning).

STEP 5: CASE MANAGEMENT Clinicians were required to make forced choice recommendations about the most appropriate supervision and monitoring strategies.	
Recommended Level of Supervision	Level of supervision that should be implemented: *community outpatient (no supervision in place), community outpatient (supervision in place), inpatient (non-forensic), inpatient (low-secure), inpatient (forensic medium secure), inpatient (forensic high secure).*
Recommended Level of Monitoring	Level of monitoring that should be implemented*: regular professional contact* or *mid-appointment telephone calls with relevant professionals*.

Table 6: Additional research items designed to capture monitoring and supervision recommendations from RSVP Step 5 (case management).

PROFESSIONAL INFORMATION QUESTIONNAIRE The questionnaire required participants to provide self-report information in relation to the following:	
Profession	E.g. Clinical Psychology, Nursing, Psychiatry.
Work Setting (Current and Previous)	E.g. Community, Low Secure, Medium Secure, High Secure.
Client group (Current and Previous)	E.g. Adults, Children & Adolescents, Learning Disability.
Number of years qualified in profession	
Number of years working in forensic settings	
Number of Days Formal RSVP training received	Estimated risk of client being exploited by others.
Perceived level of confidence in accuracy of judgements	10 point visual analogue scale (very unconfident – very confident)
Perceived level of objectivity when using the RSVP	10 point visual analogue scale (very subjective – very objective)
Perceived level of adherence to RSVP manual	10 point visual analogue scale (manual not consulted at all – manual consulted at all stages)

Table 7: Brief description of Professional Information Questionnaire items.

5. Data analysis

Decisions about statistical test selection and analysis were guided by the statistical literature in this field and through consultation with independent statistics consultants from the University of Glasgow, Robertson Biostatistics Centre. Advice on the proposed data analysis and final results was sought from Dr Christine Michie (Statistician, Glasgow Caledonian University). Different methods were selected for the analyses relating to each research question. Statistical procedures were carried out using SPSS (Statistical Package for the Social Sciences) for Windows Version 14.

5.1. Primary research questions

Question 1: What level of inter-rater reliability does the RSVP achieve when used by multi-disciplinary forensic mental health clinicians?

Question 2: To what extent do clinicians using the RSVP agree with 'gold-standard' ratings developed in consultation with experts in forensic risk assessment?

Intra-Class Correlation Coefficients (ICCs) were used to ascertain the inter-rater reliability of individual RSVP items. Mean ICCs were provided for RSVP domains and steps overall. Percentage agreement was used to ascertain inter-rater agreement and agreement with 'gold-standard' judgements. Analyses were conducted separately for standard RSVP items (Steps 2, 3 and 6), and research items (items capturing Steps 4, 5 and overall *estimation of risk*).

5.1.1. Intra-class Correlation Coefficient (ICC)

ICC models are based on estimates of mean variability and can be conceptualised as the ratio of between-groups variance vs. total variance. ICCs provide a measure of 'chance-corrected agreement' by comparing the variability of different judges of the same test item to the total variation across all judges and items. It is the recommended statistic for measuring reliability when there are more than two raters and data are ordered categories (Uebersax, 2009). The weighted Kappa statistic is also applicable to this situation. However, the ICC was selected as it yields mathematically equivalent results to weighted Kappa (Cicchetti & Sparrow, 1981; Landis & Koch, 1977) and is more common in the field of clinical-forensic research, thus allowing comparability of results to other studies. There are several variations of the ICC statistic (McGraw & Wong, 1996) and each is suitable for different study designs. The Case 2 ICC (two-way random effects) is appropriate here because all judges rate all cases and both can be considered a random sample. ICCs were calculated for 'absolute agreement' and 'single measures'.

Following previous studies evaluating the inter-rater reliability of the RSVP, ICC interpretation guidelines are taken from Fleiss (1981). These are as follows: ICC <.39 = 'poor', ICC .4 to .59 = 'fair', ICC .6 to.74 = 'good' and ICC >.75 = 'excellent'.

5.1.2. ICC sample size justification

Walter et al (1998) provide an equation for calculating the number of raters and subjects required to use ICCs. PASS (Power and Sample Size for Windows; Hintze, 2008) includes this equation and was used to calculate the number of raters and subjects required for this study. Six cases and a minimum of 22 raters are required based on power being set at .8, a null hypothesis of ICC .3 ('fair' agreement), an alternative hypothesis of ICC .7 ('substantial' agreement), and significance level of .5. Null and alternative hypotheses of

'fair' and 'substantial' agreement were based on ICC interpretation guidelines by Landis and Koch (1977)[5]. A sensitivity analysis revealed that, whilst cases are at a premium, having more than 22 judges has a negligible impact on power.

5.1.3. Percentage Agreement

Despite often being neglected, percentage agreement provides essential information about raw agreement at a practical level (Uebersax, 2009). For the purposes of this study, three measures of percentage agreement were used: *agreement with 'gold-standard', agreement with item mode* and *agreement with item mean* (rounded to the nearest whole number/rating). Each agreement measure represents the proportion of observations that were in agreement with 'gold-standard', mode and mean respectively. Percentage agreement was calculated for each item and overall cases and raters. Calculations were adjusted to account for missing ratings.

In this study, the mode and mean reflect the outcomes of different, but equally plausible methods of multi-disciplinary decision making. Whilst the mode for each item represents the most popular rating, the mean might be regarded as the rating that would be reached through a process of negotiation and consensus.

[5] These interpretation guidelines were used in the research proposal and sample-size estimation. However, guidelines by Fleiss (1981) are used in the analysis to allow comparability with other studies (Hart, 2003; Watt et al, 2006 and Watt & Jackson, 2008).

5.1.4. Missing data

Of the RSVP standard items (Steps 2, 3 and 6) there were 267 missing observations (2.2% of total 11760 expected). Of the additional research items, there were 99 missing observations (2.5% of total 3864 expected). Visual inspection revealed that common causes of missing data appeared to be participant error e.g. a page of responses not completed or two responses given, and inconclusive scoring e.g. item not scored with comment from judge stating that they are unsure how to respond.

When computing ICCs, it was noted that a single missing observation resulted in the exclusion of the entire data series for that case. The least biased method of resolving this problem was to exclude judges with incomplete data on an item by item basis. As has been mentioned, the exclusion of judges has a negligible impact on power whereas the removal of case data substantially reduces power.

5.2. Secondary research questions

Question 3: Are self-reported clinician variables associated with average estimation of risk and level of agreement (amongst clinicians and with 'gold-standard')?

The following agreement indices were calculated for each individual participant:

(1) Average level of perceived risk of sexual violence (average of all cases).

(2) Average percentage agreement with mode (for standard items Steps 2, 3, and 6).

(3) Average percentage agreement with 'gold-standard' judgements (for standard items Steps 2, 3, and 6).

Spearman's Rho correlations were calculated for the associations between these indices and the continuous variables gathered in the Professional Information Questionnaire.

In order to identify further factors associated with inter-rater agreement, a secondary analysis of professional variables was conducted. To perform this analysis, participants were ranked in order of their average percentage agreement with mode. The ordering of participants therefore represented the extent to which their responses were in agreement with the majority of the other participants.

Participants were then divided into two equally sized groups using the middle rank (median average agreement with mode) as the dividing threshold. These groups are referred to as the 'upper reliability group' (n=14) and 'lower reliability group' (n=14) respectively. Mann Whitney U tests were then used to compare these groups on means of continuous professional variables (outlined above).

5.2.1. Testing assumptions of normality and homogeneity

For all professional variables, assumptions of normality and equal variance were tested. For the majority of variables, the Kolmogorov-Smirnov test indicated that the distribution of data significantly deviated from normal ($p < .01$). Levene's test of homogeneity of variance revealed that sample variances were not significantly different ($p > .1$). As data did not meet these assumptions, and a small number of cases were used, nonparametric statistics (Spearman's Rho and Mann-Whitney) were used to address Question 2.

Question 4: Are case-specific variables (*risk of sexual violence* and *clinical complexity*) associated with average estimation of risk and level of agreement (amongst clinicians and with 'gold-standard')?

The following agreement indices were calculated for each case:

(1) Average level of perceived risk of sexual violence (average across judges).

(2) Average percentage agreement with mode (for standard items Steps 2, 3, and 6).

(3) Average percentage agreement with 'gold-standard' judgements (for standard items Steps 2, 3, and 6).

Descriptive statistics will allow cases to be compared with respect to these variables.

6. Results

6.1. Standard RSVP items

Question 1: What level of inter-rater reliability does the RSVP achieve when used by multi-disciplinary forensic mental health clinicians?

The average percentage agreements across steps two, three and six were as follows: *agreement with mode*, 71% and *agreement with mean*, 65 %.

Figure 2 and Tables 8-13 show the range of percentage agreements and ICCs achieved for individual RSVP items and domains. Figure 2 ranks items in order of inter-rater reliability (highest to lowest), and shows the confidence intervals for each ICC. The number of clinicians excluded due to missing data is also provided in tables 8-13.

The average ICC2 was .51, a 'fair' level of reliability. This level of overall agreement was corroborated by an analysis of all items taken together, which revealed ICC2 = .53 (95% CI: .49 - .58). This supplementary analysis involved stacking all items as independent cases. Missing observations were replaced by the scale midpoint value. This method of replacing missing data may have introduced bias and therefore a sensitivity analysis applying random data imputation was performed. This method revealed an almost identical finding of 'fair' agreement and greater sensitivity, ICC2 = .53 (95%CI: .49 - .56).

As can be seen in figure 2, ICC's ranged from 'poor' (ICC2 = .05) to 'excellent' (ICC2 = .78) with these values correlating positively with values for percentage agreement with 'gold-standard', Spearman's Rho = .4 (P<.001). Summary Judgements had the highest inter-rater reliability (ICC2 = .6, 'good') whilst the *sexual violence history* domain had the lowest mean (ICC2 = .45, 'fair'). 4 % of items achieved 'excellent' reliability, 26% 'good', 47% 'fair' and 23% 'poor'.

As can be seen in results tables, risk items with 'good' inter-rater reliability (ICC2 ≥ .6 for past, recent and future) were *attitudes supportive of sexual offending, problems resulting from child abuse, major mental illness* and *problems with treatment*. Items achieving 'poor' reliability (ICC2 ≤ .39 for past, recent and future) were *psychological coercion, problems with stress or coping* and *problems with planning*.

Summary Judgements: *case prioritization, risk of serious physical harm* and *other risks indicated* achieved 'good' inter-rater reliability (ICC2 all ≥ .6). However, Summary Judgement: *immediate action required* achieved only 'fair' reliability (ICC2 = .43, 95% CI: .2-.82).

Question 2: To what extent do clinicians using the RSVP agree with 'gold-standard' ratings developed in consultation with experts in forensic risk assessment?

Tables 8-13 also show the range of percentage agreements with 'gold-standard' achieved for individual RSVP items and domains. The average level of agreement with 'gold-standard' was 64 % and ranged from 44% to 87.17%. As can be seen in tables 8-13, risk items achieving the highest levels of agreement (≥ 70% for past, recent and future) were *extreme minimisation/denial of sexual violence, problems resulting from child abuse, major mental illness, non-sexual criminality* and *problems with treatment*. Risk items achieving the least reliability (≤ 55% for past, recent and future) were *psychological coercion*, *violent/suicidal ideation* and *problems with planning.*

There was 67% agreement with 'gold-standard' on *case prioritization*. However, the other Summary Judgements had amongst the lowest agreement with 'gold-standard' (all <50%). Further exploration of data revealed that, in comparison to experts, participants had over rated *risk of serious physical harm*, under rated *immediate action required* and under-rated *other risks indicated.*

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
1.Chronicity									
Presence (Past)	60%	76%	62%	25	*3*	0.59	0.34	-	0.90
Presence (Recent)	60%	66%	60%	23	*5*	0.49	0.25	-	0.86
Relevance (Future)	72%	72%	68%	24	*4*	0.54	0.30	-	0.88
2.Diversity									
Presence (Past)	58%	74%	63%	23	*5*	0.49	0.25	-	0.86
Presence (Recent)	60%	69%	50%	22	*6*	0.53	0.29	-	0.88
Relevance (Future)	69%	69%	62%	23	*5*	0.58	0.33	-	0.89
3.Escalation									
Presence (Past)	54%	76%	67%	24	*4*	0.64	0.39	-	0.92
Presence (Recent)	44%	63%	48%	23	*5*	0.28	0.11	-	0.72
Relevance (Future)	58%	66%	59%	25	*3*	0.47	0.24	-	0.85
4.Physical Coercion									
Presence (Past)	80%	80%	80%	25	*3*	0.74	0.51	-	0.95
Presence (Recent)	54%	65%	48%	24	*4*	0.21	0.07	-	0.65
Relevance (Future)	57%	63%	50%	25	*3*	0.44	0.22	-	0.83
5.Psychological Coercion									
Presence (Past)	51%	59%	58%	23	*5*	0.39	0.18	-	0.81
Presence (Recent)	46%	58%	47%	24	*4*	0.09	0.01	-	0.45
Relevance (Future)	51%	58%	40%	24	*4*	0.21	0.07	-	0.65
Domain Average	58%	68%	58%	-	-	0.45	-		-

Table 8. ICC and % agreement statistics for RSVP Steps2-3, Domain A: Sexual Violence History.

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
6.Minimization / Denial									
Presence (Past)	77%	81%	71%	23	*5*	0.67	0.43	-	0.93
Presence (Recent)	79%	79%	75%	22	*6*	0.74	0.51	-	0.95
Relevance (Future)	71%	71%	71%	23	*5*	0.51	0.27	-	0.87
7.Attitudes									
Presence (Past)	68%	76%	73%	26	*2*	0.63	0.38	-	0.91
Presence (Recent)	68%	79%	79%	24	*4*	0.71	0.47	-	0.94
Relevance (Future)	67%	73%	56%	25	*3*	0.60	0.35	-	0.90
8.Self-Awareness									
Presence (Past)	64%	72%	62%	26	*2*	0.54	0.29	-	0.88
Presence (Recent)	66%	74%	65%	24	*4*	0.58	0.34	-	0.90
Relevance (Future)	65%	68%	62%	23	*5*	0.42	0.20	-	0.82
9.Stress or Coping									
Presence (Past)	58%	68%	57%	27	*1*	0.13	0.03	-	0.52
Presence (Recent)	60%	60%	47%	25	*3*	0.13	0.03	-	0.52
Relevance (Future)	76%	76%	68%	27	*1*	0.05	0.00	-	0.35
10.Child Abuse									
Presence (Past)	83%	83%	83%	27	*1*	0.76	0.54	-	0.95
Presence (Recent)	73%	80%	80%	26	*2*	0.70	0.46	-	0.93
Relevance (Future)	75%	78%	78%	27	*1*	0.69	0.45	-	0.93
Domain Average	70%	75%	68%	-	-	0.52	-		-

Table 9. ICC2 and % agreement statistics for Steps2-3, Domain B: Psychological Adjustment

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
11.Sexual Deviance									
Presence (Past)	56%	71%	67%	25	*3*	0.46	0.23	-	0.84
Presence (Recent)	50%	63%	58%	24	*4*	0.40	0.19	-	0.81
Relevance (Future)	69%	76%	65%	25	*3*	0.43	0.21	-	0.83
12.Psychopathy									
Presence (Past)	79%	79%	79%	25	*3*	0.53	0.29	-	0.88
Presence (Recent)	80%	80%	80%	26	*2*	0.51	0.26	-	0.87
Relevance (Future)	56%	68%	63%	25	*3*	0.56	0.31	-	0.89
13.Major Mental Illness									
Presence (Past)	70%	79%	79%	26	*2*	0.71	0.48	-	0.94
Presence (Recent)	80%	81%	80%	25	*3*	0.78	0.57	-	0.96
Relevance (Future)	71%	79%	75%	26	*2*	0.67	0.42	-	0.93
14.Substance Misuse									
Presence (Past)	74%	77%	74%	26	*2*	0.20	0.06	-	0.62
Presence (Recent)	66%	68%	57%	25	*3*	0.45	0.22	-	0.84
Relevance (Future)	77%	81%	81%	25	*3*	0.30	0.12	-	0.74
15.Violent/Suicidal Ideation									
Presence (Past)	47%	74%	67%	26	*2*	0.59	0.34	-	0.90
Presence (Recent)	52%	62%	52%	25	*3*	0.45	0.22	-	0.84
Relevance (Future)	45%	74%	70%	26	*2*	0.59	0.34	-	0.90
Domain Average	65%	74%	70%	-	-	0.51	-		-

Table 10. ICC2 and % agreement statistics for Steps2-3, Domain C. Mental Disorder.

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
16.Intimate Relationships									
Presence (Past)	70%	70%	67%	27	*1*	0.15	0.04	-	0.55
Presence (Recent)	60%	71%	54%	25	*3*	0.58	0.00	-	0.33
Relevance (Future)	87%	87%	84%	25	*3*	0.20	0.06	-	0.63
17.Non-Intimate Relationships									
Presence (Past)	65%	74%	72%	27	*1*	0.67	0.43	-	0.93
Presence (Recent)	58%	66%	55%	24	*4*	0.57	0.32	-	0.89
Relevance (Future)	62%	70%	69%	26	*2*	0.55	0.31	-	0.89
18.Employment									
Presence (Past)	71%	71%	69%	27	*1*	0.57	0.32	-	0.89
Presence (Recent)	64%	64%	64%	25	*3*	0.43	0.21	-	0.83
Relevance (Future)	66%	71%	62%	27	*1*	0.55	0.30	-	0.88
19.Non-Sexual Criminality									
Presence (Past)	81%	85%	81%	28	*0*	0.77	0.56	-	0.96
Presence (Recent)	80%	82%	68%	23	*5*	0.43	0.21	-	0.83
Relevance (Future)	73%	81%	81%	25	*3*	0.73	0.50	-	0.94
Domain Average	70%	74%	68%	-	-	0.52	-		-

Table 11. ICC2 and % agreement statistics for Steps 2-3, Domain D: Social Adjustment.

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
20.Planning									
Presence (Past)	49%	60%	49%	27	*1*	0.32	0.14	-	0.75
Presence (Recent)	49%	56%	51%	26	*2*	0.34	0.15	-	0.77
Relevance (Future)	51%	64%	59%	27	*1*	0.35	0.15	-	0.77
21.Treatment									
Presence (Past)	74%	74%	68%	26	*2*	0.65	0.41	-	0.92
Presence (Recent)	71%	73%	73%	26	*2*	0.69	0.45	-	0.93
Relevance (Future)	74%	77%	75%	27	*1*	0.59	0.34	-	0.90
22.Supervision									
Presence (Past)	63%	68%	58%	26	*2*	0.52	0.28	-	0.87
Presence (Recent)	66%	66%	55%	26	*2*	0.46	0.23	-	0.84
Relevance (Future)	65%	68%	61%	27	*1*	0.43	0.21	-	0.83
Domain Average	63%	67%	61%	-	-	0.48	-		-

Table 12. ICC2 and % agreement statistics for Steps2-3, Domain E: Manageability.

	Percentage Agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
1. Case Prioritisation	67%	67%	65%	24	*4*	0.62	0.37	-	0.91
2. Risk of Serious Physical Harm	49%	68%	68%	24	*4*	0.69	0.45		0.93
3. Immediate Action Required	44%	55%	52%	24	*4*	0.43	0.20	-	0.82
4. Other Risks Indicated	45%	74%	73%	24	*4*	0.66	0.41	-	0.92
Domain Average	51%	66%	65%	-	-	0.60	-		-

Table 13. ICC2 and % agreement statistics for Step 6: Summary Judgements.

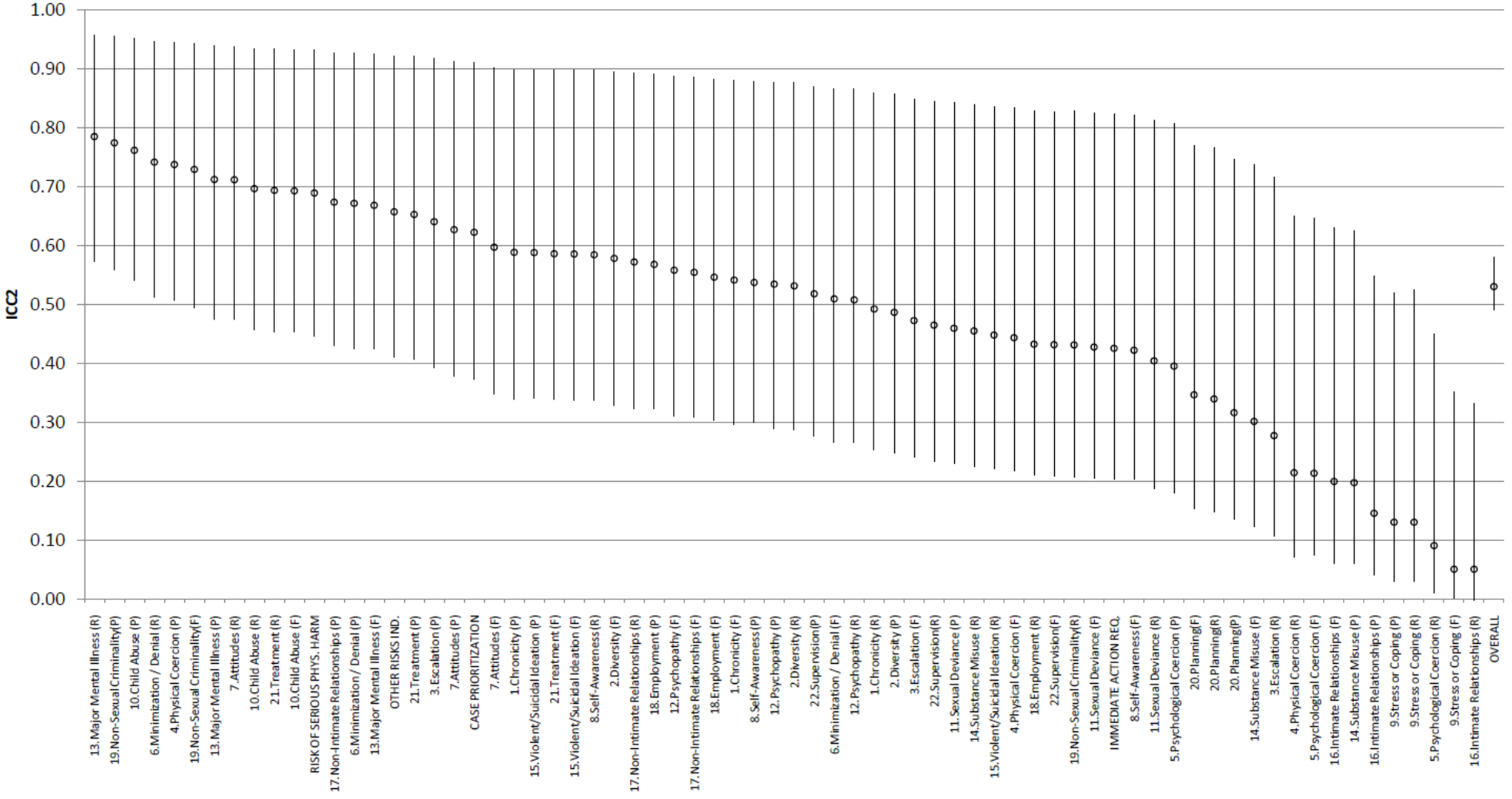

Figure 2: Case 2 ICC's and confidence intervals for standard items for RSVP Stages 2, 3 and 6.

6.2. Research items

Question 1: What level of inter-rater reliability does the RSVP achieve when used by multi-disciplinary forensic mental health clinicians?

The average percentage agreements across research items were as follows: *agreement with mode*, 62% and *agreement with mean*, 50%. The average ICC2 was .62, a 'good' level of agreement. Figure 3, table 14 and table 15 show the range of percentage agreements and ICCs achieved for individual RSVP items and domains. The number of clinicians excluded due to missing data is also shown.

As can be seen in figure 3, ICCs ranged from 'poor' (ICC2 = .25) to 'excellent' (ICC2 = .87). 13% of items achieved 'excellent' reliability, 7% 'good', 60% 'fair' and 20% 'poor'. There was poorer agreement on characteristics of escalation scenarios (mean ICC2 = .46) compared to characteristics of repeat scenarios (mean ICC2 = .59). Items achieving 'good' or 'excellent' inter-rater reliability (ICC2 ≥ .6,) were *nature of scenario* (repeat), *victim in scenario* (repeat and escalation) and *recommended level of supervision.* There appeared to be excellent percentage agreement with mean and mode in relation to *monitoring recommendations* (see table 15). However, there was insufficient variance in order to calculate an ICC for this item. Items achieving 'poor' reliability were *level of psychological harm* (escalation), *estimated imminence of scenario* (escalation), and *estimated frequency of scenario* (escalation).

Question 2: To what extent do clinicians using the RSVP agree with 'gold-standard' ratings developed in consultation with experts in forensic risk assessment?

The average level of agreement with 'gold-standard' was 49% and ranged from 27% to 81%. As can be seen in tables 14 and 15, items achieving the highest agreement with 'gold-standard' (≥ 70%) were *victim in scenario* (repeat) and *recommendations for supervision*. Items achieving the least agreement with 'gold-standard' (≥ 30%) were *likelihood of repeat scenario, level of physical harm* (escalation) and *imminence of scenario* (escalation). Further exploration of data revealed that, in comparison to experts, participants had on average; under-rated *likelihood of scenario* (escalation), over rated *level of physical harm* (escalation scenario) and under-rated *imminence of scenario* (escalation scenario).

	Percentage agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
Repeat Scenario									
Nature of scenario	63%	72%	66%	25	3	0.67	0.42	-	0.93
Victim in scenario	81%	81%	46%	25	3	0.85	0.67	-	0.97
Level of psychological harm	61%	65%	65%	25	3	0.56	0.31	-	0.89
Level of physical harm	48%	59%	38%	25	3	0.58	0.33	-	0.90
Estimated imminence of scenario	41%	55%	30%	21	7	0.46	0.22	-	0.84
Estimated frequency of scenario	46%	61%	61%	25	3	0.49	0.26	-	0.86
Likelihood	30%	44%	44%	25	3	0.52	0.28	-	0.87
Domain Average	53%	62%	49%	-	-	0.59	-		-
Escalation Scenario									
Nature of scenario	36%	60%	48%	25	3	0.57	0.32	-	0.89
Victim in scenario	68%	69%	51%	25	3	0.78	0.57	-	0.96
Level of psychological harm	54%	76%	74%	25	3	0.25	0.10	-	0.69
Level of physical harm	27%	53%	45%	25	3	0.53	0.29	-	0.88
Estimated imminence of scenario	28%	57%	17%	22	6	0.32	0.13	-	0.75
Estimated frequency of scenario	32%	47%	37%	25	3	0.29	0.12	-	0.72
Likelihood	36%	43%	38%	25	3	0.48	0.24	-	0.85
Domain Average	40%	58%	45%	-	-	0.46	-		-

Table 14. ICC2 and % agreement statistics for additional items for Step 4: Scenario Planning.

	Percentage agreement								
	Gold Std.	Mode	Mean	n	Excl. n	ICC2	ICC2 95% CI		
Recommended Level of Supervision	71%	71%	71%	24	4	0.87	0.71	-	0.98
Recommended Level of Monitoring	67%	89%	89%	25	3	-	-		-
Domain Average	68%	80%	80%	-	-	-	-		-

Table 15. ICC2 and % agreement statistics for additional items for Step 5: Case Management.

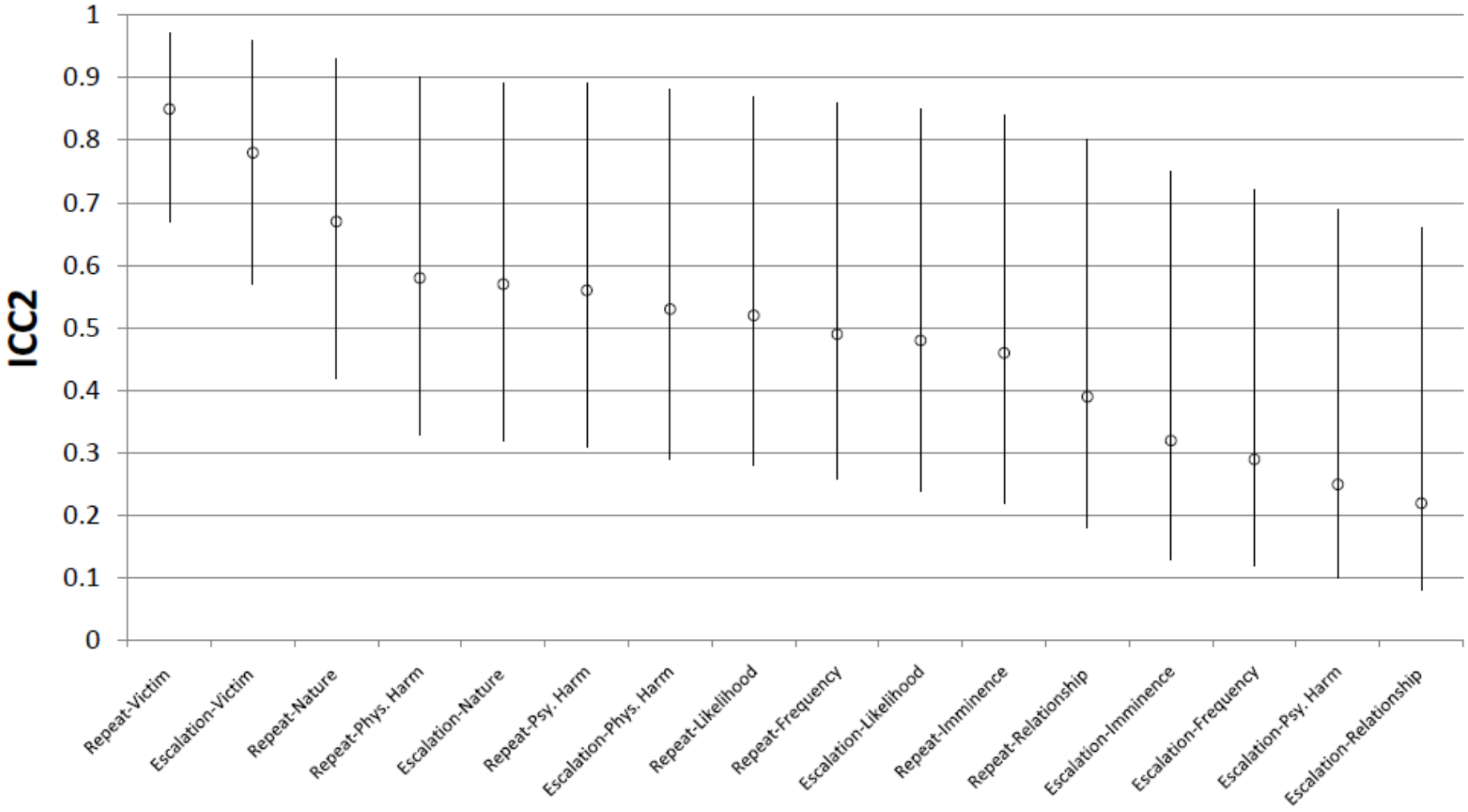

Figure 3: Case 2 ICC's and confidence intervals for research items capturing RSVP Stage 4.

Question 3: Are self-reported clinician-specific variables associated with clinician judgement of risk and average agreement (with other professionals and 'gold-standard')?

Spearman's Rho correlation coefficients were calculated between continuous professional variables and: *average agreement with 'gold-standard'*; *average agreement with mode*, and mean *estimation of sexual violence risk*. Correlations were calculated from the data of all judges (n=28) and are presented in table 16 below.

This analysis revealed only three significant correlations, each involving *number of formal RSVP training days attended*. There were significant positive correlations between *number of days formal RSVP training received* and: average agreement with 'gold-standard' ($p<.01$) and average agreement with mode ($p<.05$). There was also a significant negative correlation ($p<.01$) between *number of days formal RSVP training received* and mean *estimation of sexual violence risk* (see table 16).

Mann-Whitney U tests were used to make comparisons between the 'upper reliability group' and 'lower reliability group' on means of continuous professional variables (described above). None of these comparisons reached statistical significance, although two comparisons appeared to be approaching significance ($p<.1$). Compared to the lower reliability group, the upper reliability group had received, on average, .75 days more formal training ($z = -1.94$, $p = .053$) and reported being less objective in their assessment of cases ($z = -1.68$, $p = .093$). The upper reliability group contained 75 % (n=6) of Clinical Psychologists, 57% (n=4) of Psychiatrists and 31% (n=4) Psychiatric Nurses.

	Mean Percentage Agreement		Mean Judgement of Sexual Violence Risk
	Gold Standard	Mode	
Number of years qualified in profession	-0.23	0.03	-0.16
Number of years in forensic setting	-0.30	0.10	-0.13
Number of days RSVP training received	0.50**	0.46*	-0.56**
Self reported adherence to manual	-0.03	0.24	-0.33
Self-reported confidence in judgement accuracy	0.18	-0.23	-0.28
Self-reported objectivity of judgement process	-0.23	-0.25	0.43

Table 16: Spearman's Rho Correlation Coefficients (2-tailed): Associations between professional variables and average agreement (with gold-standard and mode) and overall estimation of sexual violence risk. ** denotes a correlation that is significant at the 0.01 level.
* denotes a correlation that is significant at the 0.05 level.

Question 4: Are case-specific variables (*risk of sexual violence* and *clinical complexity*) associated with average inter-rater agreement and clinician judgement of risk?

Table 17 below compares the average percentage agreements ('gold-standard', mean and mode) across cases for key Summary Judgements (*case prioritisation, risk of serious physical harm* and *immediate action required*).

As can be seen, for each of the key summary judgements, the highest average percentage agreements with mode and mean were for the cases at either extreme of the risk/complexity spectrum (Bill and Stuart). Bill was the lowest risk / lowest clinical complexity case whilst Stuart was the highest risk / highest clinical complexity. For *case prioritisation*, the case achieving the lowest average agreement with mode, mean and 'gold-standard' was Donald. It may be relevant that Donald was unique in the important aspect that he denied his sexual offences.

For risk of serious physical harm, Simon and Mark achieved the lowest level of agreement with mean and mode. Both of the high risk cases had very low level of percentage agreement with 'gold-standard' judgement. In both instances, experts had estimated a moderate risk of serious physical harm, whilst the vast majority of judges had estimated this as high.

	BILL	MATHEW	SIMON	MARK	DONALD	STUART
Risk	Low	Low	Med.	Med.	High	High
Clinical Complexity	Low - Med.	Med. - High	Low - Med.	Med. - High	Low - Med.	Med. - High
Summary Judgement 1: Case Prioritisation						
% agreement Gold Standard	81%	61%	61%	57%	56%	88%
% agreement Mode	81%	61%	61%	57%	56%	88%
% agreement Mean	81%	61%	61%	57%	41%	88%
Summary Judgement 2: Risk of Serious Physical Harm						
% agreement Gold Standard	81%	79%	46%	46%	22%	20%
% agreement Mode	81%	79%	46%	46%	78%	80%
% agreement Mean	81%	79%	46%	46%	78%	80%
Summary Judgement 3: Immediate Action Required						
% agreement Gold Standard	37%	57%	11%	46%	44%	68%
% agreement Mode	59%	57%	54%	46%	48%	68%
% agreement Mean	59%	57%	36%	46%	48%	68%

Table 17: Average percentage agreement ('gold-standard', mode and mean) for key summary judgements across case vignettes.

7. Discussion

This is the first study to fully evaluate the inter-rater reliability of the RSVP. Clinicians with varying professions, levels of experience and training, used the instrument to evaluate six case vignettes with varying offence characteristics, clinical-complexity and risk. An important element of this study is that it evaluated clinician agreement with 'gold-standard' judgments that were developed in consultation with experts in forensic risk-assessment. The study also explored possible case and clinician specific reasons for variance in agreement. Forced-choice items were used to capture judgements from Scenario Planning and Case Management steps of the RSVP. This allowed important items from these steps to be analysed using inter-rater reliability statistical methods. Below, results are discussed in relation to research aims. Methodological strengths, weaknesses, and recommendations for further study are then discussed.

7.1. Primary research aims

Inter-rater reliability was 'fair' overall with ICC values for standard and additional items ranging from 'poor' to 'excellent'. 30% of standard items achieved 'good' or 'excellent inter-rater reliability, and 47% achieved 'fair' inter-rater reliability. Importantly, there was a 'good' level of inter-rater reliability on Summary Judgements and Supervision Recommendations. These key judgements often have important implications for case-management, and it is therefore very encouraging that they achieved amongst the highest levels of inter-rater reliability in this study.

For RSVP standard and additional items, superior inter-rater reliability ('good' or 'excellent') was found for judgements relating to *attitudes supportive of sexual offending*, *problems resulting from child abuse, major mental illness* and *problems with treatment*.

Items achieving poor reliability were *psychological coercion*, *problems with stress or coping* and *problems with planning*. There does not appear to be any specific reason why these items achieved greater inter-rater reliability than did other items. This may be attributable to aspects of case vignettes, formal training or clinician expertise which enhanced agreement in these items. It is noteworthy that the above items did not achieve superior inter-rater reliability in a previous study by Watt et al (2006)[6].

Analyses of forced-choice research items found that participants achieved 'good' inter-rater reliability in their estimation of the nature and victim in offence Scenario Planning. There was 'poor' inter-rater reliability for particular judgements about the estimated imminence, frequency and psychological harm associated with escalation scenarios. Participants were considerably more reliable in their judgements about repeat scenarios compared to escalation scenarios. This is understandable given that clinicians can refer to previous behaviour in making judgements about repeat scenarios as opposed to scenarios that have not been previously observed. It highlights the difficulty and subjectivity involved in speculating about possible future offence scenarios.

The study also examined the degree to which participants agreed with 'gold-standard' judgements. Across standard and additional judgements, level of agreement with 'gold-standard' varied from 27% to 87%. Participants agreed with experts in 64% of standard RSVP items. Items having over 70% agreement with 'gold-standard' were *extreme minimisation/denial of sexual violence, problems resulting from child abuse, major mental illness, non-sexual criminality, problems with treatment, victim in repeat scenario* and *recommendations for supervision.*

[6] Previous studies investigating the inter-rater reliability of the RSVP were all unpublished. Watt and colleagues kindly forwarded the results of their conference posters but the other studies (Hart, 2003 and Watt & Jackson, 2008) were not available at this time.

With the exception of *case prioritisation*, Summary Judgements had amongst the lowest levels of agreement with 'gold-standard' (all <50%). Other items achieving low agreement with 'gold-standard' *were psychological coercion in sexual violence, violent/suicidal ideation, psychological coercion, problems with planning, likelihood of repeat scenario, level of physical harm in escalation scenario* and *imminence of escalation scenario*. Although experts and clinicians disagreed on these items, the direction of rating (high /low) was not consistent. I.e. on some-items, clinicians appeared to overestimate risk in comparison to experts, whilst on others they appeared to underestimate risk. Differences between experts and clinicians' ratings may be attributable to a number of factors associated with expertise in risk assessment. However, the present study design does not allow parameters to be attributed to the variability in responses between the two groups.

7.2. Secondary research aims

The study also explored associations between a small number of case and clinician specific variables and three outcomes: average estimation of sexual violence risk, average agreement with mode (most popular) judgement, and; average agreement with 'gold-standard'.

There was a positive relationship between the amount of formal RSVP training received and clinician agreement with mode and 'gold-standard'. This association was partially supported by further Mann-Whitney comparisons of upper and lower reliability groups. This analysis found that number of days training was a notable (although not quite significant) discriminator between these groups. These results may suggest that formal RSVP training has an important positive influence on improving inter-rater reliability and concordance with expert 'gold-standard' opinion. However, this finding may be indicative of other important factors such as professional background, qualifications and other specialist training.

It is essential to recognise that only the more experienced Clinical Psychologists and Psychiatrist had received more than one and a half days training. And, the vast majority of Clinical Psychologists and slight majority of Psychiatrists were represented in the upper reliability group. In comparison to Nurses, these professionals will have received more extensive training in relation to RSVP user-competencies in: individual assessment, mental disorder and sexual violence.

Perhaps surprisingly, this study did not find that other professional variables such as years clinical/forensic experience, or self-reported confidence and adherence using the RSVP manual to be significant correlates of agreement indices. These relationships have been confounded by the effect of professional group on reliability. However, due to insufficient participant numbers and ethical considerations, this study did not compare professional groups with respect to inter-rater reliability.

A negative correlation was found between number of days training received and average estimation of sexual violence risk. In addition to being less reliable, this suggests that evaluators who have had less training were also more likely to over-estimate risk. It is possible that this relationship might be mediated by the effect of evaluators with less training being more cautious in their decision making regarding risk.

Due to the small number of case vignettes, it was not possible to investigate relationships between case-specific factors and inter-rater reliability using inferential statistics. Instead, descriptive statistics were used to compare cases with respect to average percentage agreements for key Summary Judgements (*case prioritization, risk of serious physical harm,* and *immediate action required*). Notably higher levels of agreement were achieved for the case with minimum clinical complexity and risk, and conversely the case with the maximum clinical complexity and risk. This is an important finding and indicates that it is more

difficult to achieve adequate inter-rater reliability on cases where there is middling levels of case-complexity and risk. It is understandable that there may be greater ambiguity and confusion in relation to the middle 'grey area' cases.

7.3.Methodological strengths and limitations

This study used a very different method to the three previous (unpublished) evaluations of the RSVP's inter-rater reliability (Hart, 2003; Watt et al, 2006 and Watt & Jackson, 2008). These previous studies used two highly experienced professionals and rated 50 to 90 cases from casenote data. This study used six case-vignettes and 28 raters who varied in their level of experience and training in using the RSVP.

A strength of this study is the recruitment of medium sample of clinicians, representing the breadth of skills, training and experience found in forensic mental health services. The diversity of this sample enhances the 'ecological validity' of the study and has allowed for the further exploration of clinician variables that might predict the reliability of individual clinicians. However, this variability may explain why this study achieved lower levels of inter-rater reliability than did previous studies. This explanation has also been given by authors of studies evaluating the inter-rater reliability of the SVR-20 (Sjostedt & Langstrom; 2003) and SARN (Webster et al, 2006). These two studies also used many raters of varying expertise and similarly found lower levels of inter-rater reliability than would have been predicted by studies using fewer highly experienced raters.

It might also be argued that use of a large proportion of Psychiatric Nurses is not adequately representative of current clinical practice. At present, in the NHS Scottish context, Psychiatric Nurses would be expected to contribute to aspects of the risk assessment process, with Clinical Psychologists and Psychiatrists taking overall responsibility and carrying out

risk assessments more frequently. Therefore, this study would have been more representative had it included a larger proportion of Clinical Psychologists and Psychiatrists. The results of this study also suggests that the inclusion of a greater number of Clinical Psychologists and Psychiatrists would have enhanced the inter-rater reliability of the tool.

In response to these potential criticisms, it is important to recognise that all of the study participants met the RSVP user requirements and except for one experienced Psychiatrist had received formal accredited training in using the RSVP. Clinicians participated in this study because they either currently used, or were increasingly being required to use the RSVP in their clinical work.

This study used comprehensive, authentic and high quality case-vignettes that were developed in collaboration with experts in the field of forensic mental-health and risk assessment. Whilst these vignettes provided sufficient information for the purposes of completing the RSVP, the validity of this study would have been strengthened by the use of complete case-files, perhaps accompanied by audio or video recordings of clinical interviews. If the participant time and resources were available to re-conduct this study using such materials, a greater level of participant familiarisation with cases, and thus reliability in judgements might be expected. Alternatively, more information might have led to greater difficulty and inconsistency in judgments.

Whilst 28 participants is more than a sufficient clinician sample size for this study, the use of six case vignettes achieves only the minimum level of statistical power that is adequate. By using a process of expert review, this study has attempted to maximise the validity and authenticity of the cases used. Nevertheless, a greater number of cases would have improved the representativeness and statistical power of this study.

This study used additional items to capture key participant judgements in relation to RSVP Step 4 (Scenario Planning) and 5 (Case Management). Whilst being an improvement over previous studies that did not evaluate these RSVP steps at all, the forced-choice method has some limitations. It is not a valid reflection of the published RSVP manual and it yields data that are limited in comparison to the qualitative feedback normally given for these steps. For these reasons, the research items are analysed and discussed separately from the standard RSVP items.

7.4. Recommendations for further research

Future research into the psychometric properties of the RSVP and other structured professional judgement approaches should seek to address the methodological issues described above. Firstly, studies will be strengthened by use of medium-large samples of clinicians who are fully qualified to use the RSVP and are clinically representative of clinicians using the tool in clinical practice. Secondly, cases of varying offence characteristics, risk and complexity should be used. This study has found that case and clinician factors influence inter-rater reliability. It is therefore not meaningful to evaluate inter-rater reliability solely on data from one subset of offenders or clinicians. Thirdly, it is desirable to use authentic case information (including file review and audio-visual recordings). Fourthly, it may be valuable for future studies to use qualitative research methodologies to more comprehensively evaluate qualitative judgements of the RSVP. Finally, it will be important to further investigate clinician and case-specific associations with inter-rater agreement. Such studies may help to identify targets for the improvement of risk assessment training programmes and ongoing supervision. Some of these recommendations have also been outlined by Hart & Boer (2009).

7.5. Clinical implications

These findings have some important implications for clinical practice using the RSVP. Whilst shown to have 'fair' reliability overall, the RSVP had a broad range of agreement across cases, items and clinicians. Results suggest that caution should be exercised when using the RSVP, especially when used by less qualified assessors, in particular items, and in cases of middling complexity and risk.

Levels of professional qualification and further training appear to have an important role in enhancing inter-rater reliability or risk assessment judgements. Results show that there are items of the RSVP that are particularly likely to reveal disagreement (outlined in 7.1). These findings are relevant to those who are involved in providing RSVP training and those who use this instrument in clinical practice. For instance, trainers in the RSVP may wish to pay particular attention to these items and practitioners may wish to seek consultation when making these judgments. There is also a need to provide supervision and further support to professionals who have limited background training and competency in risk assessment.

Throughout the course of this study, several participants have commented on the value of using these case-vignettes as an adjunct to training. Whilst case vignettes are used in formal training, submission of further mock risk assessments as 'homework' could be a pre-requisite of training certification or accreditation to use the tool. Online/electronic surveys may hold cost-effective ways of gathering and analysing this data. Similarly, mock risk assessments could be used to audit existing risk assessment practice and to provide individual feedback on agreement with colleagues and experts. Other instrument training programmes have used such feedback to monitor and calibrate user rating standards (Reichelt at al, 2003; Muller & Wetzel, 1998).

8. Conclusion

This study finds that the RSVP can be used to attain adequate levels of inter-rater reliability. However, this is dependant on the training and expertise of professionals who use the tool. Importantly, the RSVP achieved a good level of inter-rater reliability on Summary Judgements and Supervision Recommendations. Results showed that lower levels of agreement were found in relation to specific items and in cases with middling levels of complexity and risk. There is a need to provide supervision and training to clinicians who are less competent in risk assessment. This need is particularly evident when one considers that professionals with lower levels of specialist training agreed less with their colleagues and experts, and also over-estimated sexual violence risk. This study has clinical relevance and has revealed important findings for the development of training, practice and future research.

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CHAPTER THREE: ADVANCED CLINICAL PRACTICE I - REFLECTIVE CRITICAL ACCOUNT

(ABSTRACT ONLY)

Third year reflections on a morning in the Sheriff Court

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Abstract

As part of my placement induction, I visited the Sheriff Court. Over the course of a morning, I worked with a Mental Health Nurse (named here as "Maureen") and shadowed her assessing three clients in the court cells. I have used this reflective account to try to understand and learn from what was a personally challenging and extremely significant day in my clinical training. I have written a reflection that focuses on my experience of the court, the court cells and the assessment of two clients. This is followed by a discussion of some of the key issues that arose when writing this piece.

CHAPTER FOUR: ADVANCED CLINICAL PRACTICE II - REFLECTIVE CRITICAL ACCOUNT

(ABSTRACT ONLY)

The causes of offending and working in a forensic setting

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Abstract

I have centred this reflection on a fundamental question in forensic-clinical psychology: *what causes offending?* Then I have discussed how this question is addressed within the broader roles of a clinical psychologist. I have tried to pay specific attention to implications for research and evaluation, training others, consultancy and management. This reflective account is influenced by: notes from ongoing reflective practice on clinical placement, the forensic clinical-psychology literature (particularly literature on the aetiology of offending by Phil Rich and Liam Marshall), course teaching on reflective practice, and broader literature of personal interest (e.g. reflective writing and compassionate mind approaches).

APPENDIX 1: SYSTEMATIC LITERATURE REVIEW

Appendix 1.1 Quality Rating Tool.			
SECTION 1: INTERNAL VALIDITY			
1.1	**The study addresses an appropriate and clearly focused question (or questions).** The study clearly outlines its question, either in the introduction or during the methodology section.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
SELECTION OF SUBJECTS:			
1.2	**The two (or more) groups being studied are selected from comparable populations.** E.g. Groups are matched for demographic and socio-economic factors.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.3	**For each of the groups being studied, the study indicates how many of the people who were asked to take part in the study did.** If the participation rate is low, or there is a large difference between the two groups, the study should be downgraded, and rejected if the differences are very large.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.4	**The study indicates how individuals were selected/assigned to each group.** A reliable indicator of offender status is used (criminal conviction is regarded as more reliable than allegation information or self report).	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.5	**The same exclusion criteria are used for all groups.**	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.6	**Comparison is made between participants and non participants to establish their similarities and differences.** A well conducted study will look at samples of the non-participants among the source population to ensure that the participants are a truly representative sample.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.7	**Recruitment to groups has attempted to screen for and exclude participants who do not belong to that group.** E.g. It has been established that violent offender and controls groups do not have a history of sex offending. Similary, child sex offender groups do not contain offenders against adults etc. ***If the methods of group selection are not described, the study should be rejected.***	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.8	**If applicable, the study reports the percentage of individuals recruited into each group who dropped out before the study was completed.** A 20% drop out rate is regarded as acceptable. What is this percentage?	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.9	**If applicable, comparison is made between full participants and those lost to follow–up, group or attachment status.** A well conducted study will attempt to identify any such differences between full and partial participants across groups. Any indication of differences,	Well covered Adequately addressed	Not addressed Not reported

	should lead to the results being treated with caution.	Poorly addressed	Not applicable
ASSESSMENT			
2.0	**Assessment of attachment and other variables is clearly defined and measured in a standard, reliable and valid way.** Attachment should be measured using a standard narrative or self report tool, and not using non-validated instruments. ***If the measures used are not stated, or the study bases its conclusions on non-validated measures, the study should be rejected.***	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
2.1	Assessment of attachment and other variables is made blind to group or diagnostic status.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
2.2	**Where blinding was not possible, there is some recognition that knowledge of diagnostic or group status could have influenced the assessment of attachment or other variables.** This might include comparison of process measures e.g. frequency of observations, who carried out the observations, the degree of detail and completeness of observations. If process measures are comparable between the groups, the results may be regarded with more confidence.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
2.3	**Evidence from other sources is used to demonstrate that the method of assessing attachment is valid and reliable.** The authors explain why a particular assessment measure has been selected and offer references to support their choice.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
CONFOUNDING			
2.4	**The main potential confounders are identified and taken into account in the design and analysis.** The report of the study should indicate which potential confounders have been considered, and how they have been assessed or allowed for in the analysis. Clinical judgement should be applied to consider whether all likely confounders have been considered. The study should be downgraded or rejected, depending on how serious the risk of confounding is considered to be.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
STATISTICAL ANALYSIS			
2.5	**Have confidence intervals been provided?**	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable

SECTION 2: OVERALL ASSESSMENT OF THE STUDY		
2.6a	How well was the study done to minimise the risk of bias or confounding, and to answer Question 1?	
2.6b	Taking into account clinical considerations, your evaluation of the methodology used and the statistical power of the study, are you certain that the study provides evidence of an association between insecure attachment and sex offending?	
2.7a	How well was the study done to minimise the risk of bias or confounding, and to answer Question 2?	
2.7b	Taking into account clinical considerations, your evaluation of the methodology used, and the statistical power of the study, are you certain that the study provides evidence of an association between attachment style and type of sex offending?	
Summarise the author's conclusions. Add any comments on your own assessment of the study, and the extent to which it answers the question.		

This section relates to the overall assessment of the paper. The code allocated here, coupled with the study type, will decide the **level of evidence** that this study provides.

++ **A**	**All or most** of the criteria have been fulfilled. Where they have not been fulfilled the conclusions of the study or review are thought *very unlikely* to alter.
+ **B**	**Some** of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought *unlikely* to alter the conclusions.
- **C**	**Few or no** criteria fulfilled The conclusions of the study are thought *likely or very likely* to alter.

Appendix 1.2. Table 1- Overview of Reviewed Studies

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Miner et al (2010)	Adjudicated adolescent sex offenders (ages 13-18)with child victims (n=107), peer/adult victims (n=49), and non sex offending delinquents (n =122). Participants were recruited from residential and outpatient sex offending treatment programmes, juvenile probation departments, and juvenile detention centres. They were assigned to group based on commitment crimes and 'available histories'.	*INTERVIEW:* Blind independent raters provided scores on two continuous attachment dimensions (Anxiety and Avoidance) using a measure derived from the History of Attachments Interview (Bartholomew & Horowitz, 1991).	Questions 1 & 2. ANOVA revealed that child sex offenders had a significantly higher score for attachment anxiety than did other groups (d=4.1, p<0.001). Sex offenders with peer/adult victims had greater levels of attachment avoidance although this finding was non-significant. Non sex-offending delinquents had the lowest levels of anxiety and avoidance. Logistic regression modelling suggested an indirect association between attachment style and sex offending. Anxious attachment in adolescence was related to expectation of rejection from peers, and feelings of interpersonal inadequacy. These factors in turn, differentiated offenders against children from offenders against peers/adults. Evidence is provided indicating that results are independent of age and race.	**A**	20% of peer/adult offenders had a child victim by history yet these crossover cases were not excluded in analysis. Risk of confounding due to recruitment of voluntary sample, without participants being compared or matched to non-participants. Only a limited range of possible confounders is considered.
Wood & Riggs (2008)	Adjudicated, paroled child molesters (n=61) vs. community controls (n=51). Offenders were recruited from community sex offender treatment programmes and assigned to groups based on their felonies. Controls were recruited through businesses, neighbourhoods and churches.	*SELF-REPORT:* Continuous anxiety and avoidance scores derived from the Experiences in Close Relationship Inventory (Brennan, Clark and Shaver, 1998). Participants also completed the Marlowe Crown Social Desirability Scale (Crowne & Marlowe, 1960).	Question 1. Logistic regression modelling revealed that attachment anxiety was most significant predictor of child molester status. Increasing levels of attachment anxiety raised the odds of sex offender status by 56%. Evidence is provided indicating that results are independent of social desirability in responding, race, age, sample crossover, marital status and income.	**A**	Self report assessment method only. Risk of confounding due to recruitment of voluntary sample, without participants being compared or matched to non-participants. Only a limited range of possible confounders is considered.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Simons et al (2008)	Adjudicated rapists (n=137) and child molesters (n=132). Participants were volunteers from a prison (medium and high security) treatment programme and assigned to groups based on review of official records.	*SELF REPORT:* Three categories (Secure, Anxious & Avoidant) and measure of maternal and paternal attachment derived from modified items from the Childhood Attachment Questionnaire (Hazen & Shaver, 1987). Participants also completed the Balanced Inventory of Desirable Reporting (Paulus, 1988).	Question 2. Child sex abusers reported were significantly more likely to report anxious attachment bonds in comparison to rapists (62% vs. 20%, p<0.005). Rapists were significantly more likely to be avoidant (76% vs. 27%, p<005). Amongst child sex offenders there was no significant difference between paternal and maternal bonding scores. Rapists reported significantly poorer attachment bonds to paternal figures in comparison to maternal figures (p<0.05). Evidence is provided indicating that results are independent of social desirability in responding, sample crossover, race, age, marital status and income.	A	Self report assessment method only. Substantial number of participants (46%) had some offence crossover (defined as a minimum of 80% of offending). Insufficient description of how the CAQ was modified. Risk of confounding due to recruitment of voluntary sample, without participants being compared or matched to non-participants. Only a limited range of possible confounders is considered.
Stirpe et al (2006)	Adjudicated extra-familial child molesters (n=22), intra-familial child molesters (n=19), rapists (n=20), non-violent offenders (n=21), violent offenders (n= 19) and AAI normative sample. Participants were recruited from prisons and assigned to groups based on conviction histories.	*INTERVIEW: Attachment state of mind classifications (Dismissing, Preoccupied and Secure) derived from the Adult Attachment Interview (George et al, 1996).*	Questions 1 and 2. Compared to normative attachment data, all sex offenders were less likely to be securely attached (9.8% vs. 45-55%). There was no difference between groups across five attachment domains, and therefore a three factor model of attachment was used. Compared to other groups, extra-familial child molesters were significantly more likely to be preoccupied, $\chi 2 = 26.59$, p<0.001. Rapists, violent offenders, and to a lesser degree incest offenders were more likely to be dismissing. Non-violent offenders were comparatively more secure. Evidence is provided indicating that results are independent of sample crossover and level of education.	A	Small sample size. Risk of confounding due to recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Only a limited range of possible confounders is considered.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Abracen et al (2006)	Adjudicated rapists (n=48), child molesters (n=43) and violent non-sexual offenders (n=21). Participants were recruited from a prison treatment programme and assigned to groups based on review of police records.	*SELF-REPORT:* Four attachment categories (secure, preoccupied, fearful and dismissing) derived from a shortened form of the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994).	Question 1 and 2. ANOVA revealed that sex offenders (rapists and child molesters combined) were significantly more pre-occupied than violent non-sex offenders ($F= 4.18$, $p<0.05$). There was no difference between combined sex offenders and non-sex offenders who were securely / insecurely attached. Post-hoc analysis (using Scheffe method) found that child molesters were significantly more pre-occupied than rapists and violent non-sexual offenders (mean difference = 1.94, $p <0.05$). Evidence is provided indicating that results are independent of sample crossover, age and PCL-R score.	B	Self report assessment method only with no measurement of social desirability in responding. Risk of confounding due to recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Insufficient description of how the RSQ was shortened. Only a limited range of possible confounders is considered.
Baker & Beech (2004)	Adjudicated sex offenders (n=20), non-sexual offenders (n=15), and community sample (n=21). Offenders were recruited from prison and assigned to groups based on review of prison records.	*SELF-REPORT:* Continuous anxiety and avoidance scores derived from Relationship Scales Questionnaire (Griffin & Bartholomew, 1994). Participants also completed the Paulhus Deception Scales (Paulhus, 1998)	Question 1. ANOVA revealed no significant differences between groups in either anxiety or avoidance sub-scales. Sex offenders did not show greater variability over time on self reported attachment dimensions. Results are considered unsupportive of a relationship between sex offending and disorganised attachment style. Evidence is provided indicating that results are independent of sample crossover, ethnicity, occupational classification and social desirability in responding.	B	Small sample size. Recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Only a limited range of possible confounders is considered.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Lyn & Burton (2005)	Adjudicated sex offenders (n=144) and non-sexual offenders (n=34). Participants were recruited from a low security prison, and assigned to groups based on self-report data.	*SELF-REPORT:* Four attachment dimensions (secure, preoccupied, fearful and dismissive) derived from a modified version of the Experiences in Close Relationship Inventory (Brennan, Clark and Shaver, 1998).	Question 1. Insecurely attached participants were 5.53 ($p<0.05$) times more likely than securely attached individuals to be in the sex offender group. When the insecure attachment category was divided into fearful, preoccupied and dismissing categories, fearful status was significantly associated with having a sex offence history, $\chi 2. = 11.22$, $p<0.001$. After collapsing sex offenders into victim characteristics: 90% of offenders who had ever abused children (n = 103, crossover cases included) reported an insecure attachment, whereas 63.6% of the adult only victimisers (n = 11) reported insecure attachment ($\chi 2= 5.74$, $p<0.5$. Similar results were found when crossover cases were excluded. With respect to characteristics of the victim, there was no significant relationship between attachment designation and acquaintance to victim (known to offender vs. not known to offender), $\chi 2 = 2.31$, $p= 0.13$. Similarly, there was no significant relationship between attachment designation and penetration (anal or vaginal), or modus operandi (physical force vs. emotional coercion). Evidence is provided indicating that results are independent of age and high-school completion.	B	Self report assessment method only with no measurement of social desirability in responding. Insufficient description of recruitment and screening procedures. Crossover cases included in some analyses. Group assignment determined by self-reports alone. Risk of confounding due to recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Only a limited range of possible confounders is considered.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Marsa et al. (2004)	Adjudicated child sex offenders (n=29), violent non-sex offenders (n=30), non-violent non-sex offenders (n=30) and community controls (n=30). Offenders recruited from prison treatment programme and assigned to groups based on conviction history. Community controls were recruited from a training centre, university and business.	*SELF REPORT:* Two attachment dimensions (anxiety and avoidance), and four attachment categories (secure, fearful dismissive and preoccupied) were derived from the Experiences in Close Relationship Inventory (Brennan, Clark and Shaver, 1998). Parental caring and over-protectiveness scales were derived from the Parental Bonding Instrument (Parker et al, 1979). Participants also completed the Personal Reaction Inventory (Beckett et al, 1994), a measure of social desirability in responding.	Question 1. Compared to non-violent offenders, violent offenders, and community controls, the child sex offender group contained a significantly lower proportion of cases with a secure attachment style ($\chi 2. = 20.05$, $p<0.5$). 93% of Sex Offenders revealed as being insecurely attached. Three comparison groups contained in excess of four times more securely attached cases than the child sex-offender group. Within the child sex offender group, the proportion of cases with a fearful attachment style was significantly greater than the other three attachment styles (more than 8 times more likely than secure attachment). Compared to the comparison groups, child sex offenders, reported lower maternal ($t=6.39$, $p<0.01$) and paternal ($t=2.85$, $p<0.05$) care, and higher maternal ($t=3.68$, $p<0.01$) and paternal ($t=8.39$, $p<0.01$) over-protection. Evidence is provided indicating that results are independent of age, socio-economic status, social desirability in responding and sample crossover.	B	Small sample size. Recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Only a limited range of possible confounders is considered.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Smallbone & Dadds (1998)	Adjudicated rapists (n=16), intra-familial child molesters (n=16) and extra-familial child molesters (n=16), property offenders (n=16) and correctional officers (n=16). Offenders were recruited from prisons and assigned to groups based on offence histories.	*SELF-REPORT:* Three attachment categories (secure, anxious/ambivalent & avoidant) were derived from modified version of the Childhood Attachment Questionnaire (Hazen & Shaver, 1987) and the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994).	Questions 1 and 2. ANOVA's revealed that: combined sex offenders (n=48) were significantly less secure in their maternal childhood attachment than were correctional officers, F= 22.14, p<0.001. Combined sex offenders were also found to report less secure attachment to their fathers than were correctional officers, F = 11.77, p<0.001. Combined sex offenders were less secure in their orientation to adult intimate relationships than were correctional officers, F = 6.49, p = 0.001. After controlling for age, ANCOVAs revealed that combined sex offenders were significantly less secure in their childhood attachments than property offenders, F = 3.08, p = 0.42. Q2. There were no significant differences between specific groups with respect to continuous measures of maternal anxious, paternal anxious, and adult anxious attachment. Evidence is provided indicating that results are independent of sample crossover, age and socioeconomic status.	B	Small sample sizes. Extremely selective comparison groups (correctional officers and property offenders). Self report assessment method only with no measurement of social desirability in responding. Recruitment of voluntary sample, with no comparison or matching of participants to non-participants.

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Marshall et all (2000)	Adjudicated child molesters (n=30), non-sexual offenders (n=24) and non-offenders (n=29). Offenders were recruited from prison. Controls were recruited through a government employment agency.	*SELF-REPORT*: Three maternal and maternal dimensions (secure, anxious/ambivalent and avoidant) derived from the Childhood Attachment Questionnaire (Hazan & Shaver, 1987). Participants also completed the Marlowe Crown Social Desirability Scale (Crowne & Marlowe, 1960).	Question 1. MANOVA's did not reveal significant differences between groups with respect to paternal and maternal attachment scores. Child molesters report higher mean anxious/ambivalent attachment to father and mother, yet these results are not significant. Evidence is provided indicating that results are independent of age, education, occupation, socio-economic status, sample crossover and social desirability in responding.	B	Small sample size. Recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Insufficient detail on recruitment, screening ands assignment to groups. No inclusion or exclusion criteria applied.
Ward et al (1996)	Adjudicated child molesters (n=55), rapists (n=30), violent offenders (32) and non-violent offenders (30). Child molesters were recruited via a prison treatment programme. Other offenders were recruited via the same prison (but not in treatment). Offenders were assigned to groups based on offence histories.	*SELF-REPORT*: Four attachment categories and continuous ratings (secure, fearful preoccupied, and dismissing) derived from the Relationship Questionnaire and Relationship Scales Questionnaires (Griffin & Bartholomew, 1994).	Questions 1 and 2. The majority of all groups insecurely attached with significant differences between groups $\chi 2 = 19.68$, $p<0.02$. 97% of violent offenders, 82% of child molesters, 70% of rapists and 67% of non-violent offenders were insecurely attached. Child molesters were more likely to have a preoccupied or fearful attachment style than rapists and to be less dismissive. Both rapists and violent non-sex offenders were similarly likely to be dismissive.	B	Recruitment of voluntary sample, with no comparison or matching of participants to non-participants. Self report assessment method only with no measurement of social desirability in responding. Authors acknowledge that self-report measures may not have been valid (only 77% agreement between judges and participants with respect to attachment style).

Study	Participants	Measure of Attachment	Questions Addressed & Relevant Findings	Rating	Main Methodological Issues
Sawle and Kear-Colwell (2001)	Adjudicated paedophiles (n=25), non-offending victims of sexual abuse (n=22) and student controls (n=23). Offenders were recruited from custodial and community based treatment programmes. Victims were recruited from community based treatment programmes. Controls were recruited from a university.	*SELF-REPORT:* Five attachment domains (Secure, Preoccupied with Relationships, Need for Approval, Discomfort with Closeness and Relationships as Secondary) derived from Attachment Styles Questionnaire (Feeney et al, 1994).	Question 1. Controls and victims had significantly higher scores on the confidence (secure attachment) scale than paedophiles, $F = 29.49$, $p<0.01$. Paedophiles scored significantly higher than controls and victims with respect to relationships as secondary (form of avoidant attachment) $F = 13.02$, $p <0.001$.	**C**	Small sample size. Self report assessment method only with no measurement of social desirability in responding. Recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Risk of sample crossover insufficiently addressed.

Jamieson & Marshall (2000)	Incest Offenders (n=20), non-familial child molesters (n=20) vs. non-sex offenders (n=20). Vs. Community controls (n=21) Offenders were recruited from prisons.	*SELF-REPORT: Four attachment categories (secure, preoccupied, fearful-avoidant and dismissive avoidant) derived from the Relationship Questionnaire (Griffin & Bartholomew, 1994).* *Participants also completed the Marlowe Crown Social Desirability Scale (Crowne & Marlowe, 1960).*	Question 1 and 2. A comparison of the attachment styles of the pooled group of child molesters and the community males did reveal a differential pattern of attachment $\chi 2$ (2) = 6.09, $p<0.05$. The non-familial child molesters differed from the community group $\chi 2$ (2) = 7.12, $p <0.5$, but incest offenders did not. Non-familial child molesters were 4.85 times more likely (95% CI = 1.2 to 1 - 21 to report a fearful avoidant relationship style than a secure style compared to the community group. There were no significant differences in attachment representations of sex offenders compared to property offenders, with the exception of childhood maternal attachments. ANOVA revealed that there was no significant difference between individual groups with respect to ratings on the attachment domains, other that the fearful avoidant rating, where non-familial child molesters rated themselves significantly higher than incest offenders or community controls, $F (3,74) = 3.27$, $p<0.3$. Evidence is provided indicating that results are independent of age, education and social desirability in responding.	C	Small sample size. Insufficient description of recruitment, screening and group-assignment procedures. Recruitment of voluntary sample, with limited attempt to compare or match participants to non-participants. Participants not compared or matched to non-participants. Risk of sample crossover insufficiently addressed.

Appendix 1.3 – Notes for Contributors (Journal of Forensic Psychiatry and Psychology).

Taylor & Francis Style No. 1	
Running heads	*(verso) J. Smith and P. Jones* or *J. Smith* et al. if 3 or more authors. If J.B. Smith then initials are closed up *(recto) Journal Title* position left and right of pages
Article type (when needed)	**RESEARCH ARTICLE** bold caps, ranged left
Title	**Bold, first word and proper nouns cap only** ranged left
Authors	An Author and Another Author (initials closed up if J.B. Smith) ranged left
Affiliation	[a]*Department, University, City, Country;* [b]*Department, University, City, Country* ranged left
Received dates	(*Received 20 July 2005; final version received 17 August 2006*) After affiliation, ranged left
Abstract	Text smaller, indented both sides ranged left
Keywords	**Keywords:** word; another word; lower case except names Position aligned with abstract, same size as abstract
Correspondence details	Given as footnote on page 1* *Corresponding author. Email: xxxxxxx ranged left, no indent. Postal address not needed. If there is only one author, use *Email: xxxxxxx
Headings	A. **Bold initial cap only** B. ***Bold italic initial cap only*** C. *Italic initial cap only* D. *Italic initial cap only.* Text runs on All ranged left, numbers to be included if supplied, no indent below.
Paragraphs	Indented
Tables	(Table 1) in text. Table 1. Title initial cap only. (ranged left above table) Note: This is a note. (ranged left under table)
Figures	(Figure 1) in text. Figure 1. Caption initial cap only. (ranged left under figure) Note: This is a note. (ranged left under figure)
Displayed quotations	Indented left and right, smaller font (over 40 words, or when appropriate)
Lists	(1) for numbered lists Bullets if wanted
Equations	Equation (1) in text Centred
Acknowledgements	A heading. Goes before notes, bio notes and refs

	Text smaller
Notes	**Notes (A heading)** 1. This is a note. 2. This is another note. Text smaller
Notes on contributors Not all journals require this – please see the relevant instructions for authors page	**Notes on contributors (A heading)** First author details. Line space Second author details. Goes after Acknowledgements, before refs Text smaller
Appendix	**Appendix 1. Title if given (A heading)** Goes after refs

APPENDIX 2: MAJOR RESEARCH PROJECT

Appendix 2.1. Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Sexual Violence Risk Assessment:
An investigation into the inter-rater reliability of the RSVP in Scotland.

1. **What is this study about?**
   We invite you to take part in our study which aims to ascertain the level of inter-rater reliability of the RSVP in Scotland. Inter-rater reliability is the extent to which a tool can be used in the same way by different assessors independently. The RSVP is used widely by trained professionals to make important judgements about patient risk, and to inform decision making about supervision and intervention. We have predicted that there will be a high level of consistency amongst Scottish clinicians who use this tool. To test this hypothesis, we need a number of qualified clinicians who are familiar with the RSVP to briefly assess six fictitious case vignettes using a shortened form of the RSVP data collection proforma. This data will enable us to explore the inter-rater reliability of the RSVP within a Scottish setting. We are also interested in the extent to which raters agree with expert consensus judgements and the effect of different professional variables (e.g. years experience, work setting, type of training) on inter-rater reliability.

2. **What will happen if I agree to take part?**

   We would like you to complete a short risk assessment for six fictitious case vignettes as well as a short questionnaire gathering professional information. With the materials and information given, it should take around thirty minutes to rate each case. In total, it should take approximately three hours for you to complete this study. If you agree to participate, we will either (1) send you the study materials and a freepost envelope for returning them. If you need a copy of the RSVP manual, the authors have given us permission to provide this to you on the condition that you return this with your materials, or (2) provide the materials to you following a training event on the RSVP.

3. **Will my participation be anonymous?**
   Yes, throughout this study, your data will be identified by a randomly assigned number. All the information you provide will be stored anonymously in a locked filing cabinet at the Section of Psychological Medicine, Gartnavel Royal Hospital. All electronic information will be stored on secure NHS or University network hard-drives. After a period of five years, the data will be destroyed.

4. **What happens if I change my mind?**
   You are free to withdraw from this study at any time.

5. **What are the possible disadvantages of taking part?**
   Participating in this study requires a commitment of time and effort. We greatly appreciate this commitment and understand that participating in this study would be a significant addition to your workload. It is possible that case vignettes might contain details that are disturbing. However, all participants will already be employed in mental health settings and familiar with such material.

6. **What are the possible advantages of taking part?**
   Participation will contribute to the development of your experience and skills in using the RSVP. However, there are no immediate personal benefits to participating in this study. However, we believe this to be a much needed research project with potential implications for all those who use the RSVP tool. This study has been identified as a priority by the RMA (Risk Management Authority) and may have particular implications for the training and use of the RSVP in future.

7. **What will happen to the results of the research study?**
   Once the study has been completed, we will produce a report that will describe our findings. We will of course, provide you with a summary of this report. You will not be identified in any report or publication.

8. **Will I receive payment or expenses?**
   No. Unfortunately, we are unable to offer any expenses or other forms of payment. However, some training courses in RSVP are being provided as part of this study and this contributes to vast savings to organisations.

9. **How do I complain?**
   If you have concerns about the study, please first contact Alan Sutherland on the phone number or e-mail address shown below. Alternatively, you can contact other members of the research team: Dr Lorraine Johnstone (Tel: 01555 840293 / e.mail: lorraine.johnstone@tsh.scot.nhs.uk) or Professor Kate Davidson (Tel: 0141 211 3900 / e.mail: k.davidson@clinmed.gla.ac.uk). If you still have concerns and wish to complain formally, you can do this through the NHS Complaints Procedure.

10. **Who is funding the research**
    The study is funded by NHS Greater Glasgow and Clyde, and the University of Glasgow.

11. **Who has reviewed the study?**
    This study has been reviewed and approved by the Greater Glasgow and Clyde Research Ethics Committee in order to protect your safety, rights, wellbeing and dignity. The study has also been approved by the State Hospital Research Committee and the University of Glasgow Doctorate of Clinical Psychology, Major Research Project submissions process.

12. What do I do now?

If you would like to participate in this study, please contact Alan Sutherland:

by phone on: **0141 211 8000** or **07989 979 110**

or by e-mail: **alansutherland@nhs.net**

We will then send you a research pack containing the study materials and RSVP manual (if required). Please do not hesitate to contact any other member of the research team if you have any questions about this study or would like to take part. If you would like to speak to an independent person about this project, then please contact Dr Emma Drysdale on 0141 211 8000.

THANK YOU FOR READING THIS INFORMATION SHEET.

Principal Investigator:

Alan Sutherland
Trainee Clinical Psychologist

Project Supervised by:

Dr Lorraine Johnstone
Consultant Clinical Forensic Psychologist & Honorary Research Fellow

Professor Kate Davidson
Consultant Clinical Psychologist & Honorary Professor of Clinical Psychology

Appendix 2.2. Documentation confirming Ethics and R&D Approval.

NHS
Greater Glasg
and Clyde

Coordinator/administrator: Darren Gibson/Elaine O'Donnell
Telephone Number: 0141 211 6208
Fax Number: 0141 211 2811
E-Mail: Darren.Gibson@ggc.scot.nhs.uk

R&D Management Office
Western Infirmary
Tennent Institute
1st Floor, 38 Church Stre
Glasgow, G11 6NT

04 March 2010

Mr Alan Sutherland
Trainee Clinical Psychologist
Dept of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G 12 0XH

R&D Management Approval

Dear Mr Sutherland,

Project Title: An investigation into the inter-rater reliability of the RSVP(Risk of Sexual Violence) in Scotland.
Chief Investigator: Mr Alan Sutherland
R&D Reference: GN09CP559
Protocol: Version 1, 20 Oct 2009

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Management Appro** for the above study.

As a condition of this approval the following information is required during the lifespan of the project:

1. SAES/SUSARS – If the study is a **Clinical Trial** as defined by the Medicines for Human Use Clini Trial Regulations, 2004 (CTIMP only)
2. Recruitment Numbers on a quarterly basis (not required for commercial trials)
3. Any change of Staff working on the project named on the ethics form
4. Change of CI
5. Amendments – Protocol/CRF etc
6. Notification of when the Trial / study has ended
7. Final Report
8. Copies of Publications & Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Yours sincerely

Dr Darren Gibson
Research Co-ordinator

West of Scotland Research Ethics Service
West of Scotland REC 3
Ground Floor, The Tennent Institute
Western Infirmary
38 Church Street
Glasgow G11 6NT

Telephone: 0141 211 2123
Facsimile: 0141 211 1847
21 January 2010

Mr Alan Sutherland
Trainee Clinical Psychologist
Dept of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Dear Mr Sutherland

Study Title:	**Sexual Violence Risk Assessment: An investigation into the inter-rater reliability of the RSVP (Risk of Sexual Violence) in Scotland.**
REC reference number:	**09/S0701/100**
Protocol number:	**Version 1**

Thank you for your letter of 05 January 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by a sub-committee of the REC at a meeting held on 21st January 2010. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		20 October 2009
REC application		20 October 2009
Protocol	Version 1	20 October 2009
Investigator CV		20 October 2009
Participant Information Sheet	Version 1	20 October 2009
Participant Consent Form	Version 1	20 October 2009
Letter from Research Director		21 September 2009
Email from Stephen Hart		16 October 2009
Email from Chris Weir		14 August 2009
Participant Data Collection Forms		
Supervisor's CV - Professor K Davidson		
CV - Dr Lorraine Johnstone		
Vignette - Case 1		
Vignette - Case 2		
Vignette - Case 3		
Vignette - Case 4		
Vignette - Case 5		
Response to Request for Further Information		05 January 2010
Vignette - Case 6		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/S0701/100	**Please quote this number on all correspondence**

Yours sincerely

Liz Jamieson
Committee Co-ordinator on behalf of Dr Robert McNeill, Acting Vice Chair
Chair

Email: Liz.Jamieson@ggc.scot.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting
"After ethical review – guidance for researchers"

Copy to: Darren Gibson, NHSGGC Research & Development

Alan Sutherland
Trainee Clinical Psychologist
Dept of Psychological Medicine
University of Glasgow

Friday the 30th of October 2009

Dear Alan

Re: Sexual Violence Risk Assessment: An Investigation into the inter-rater reliability of the RSVP in Scotland.

Many thanks for your research proposal that was reviewed by the TSH Research Committee on 29th of October 2009. The committee found the proposal to be an interesting piece of work, and are happy to approve the study. However we do have a few questions that we would appreciate you addressing.

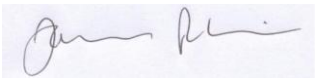
- The vignettes will almost inevitably be developed with specific triggers for RSVP related assessment included within the information provided. How will the study avoid becoming just an exercise in recognising these triggers that are also likely to have been identified within RSVP assessor training?
- How many of your assessor sample will come from TSH, and which disciplines will they come from as the impact of requiring 3 hrs to complete the study will have greater impact on ward based nursing staff than Psychologists and this could conceivably lead to a biased sample as these members of staff may not be able to find the time required to participate?

This letter will be copied to the Associate Medical Director along with evidence of your ethical approval, and will subsequently provide final management approval for the study to take place within TSH.

One condition of the research committees' approval is that you provide the committee with regular 6-monthly progress reports. This is an important mechanism by which the committee track progress, and is also a key component of our research governance processes.

If you require any further assistance then please do not hesitate to contact me.

Yours sincerely



JAMIE PITCAIRN
Research & Development Manager
The State Hospital

E-mail from Jamie Pitcairn to Alan Sutherland on the 15th of March 2010

Dear Alan,

The committee would like to record their thanks for your progress report on the research study **"Sexual Violence Risk Assessment: An Investigation into the inter-rater reliability of the RSVP in Scotland."** The update that you provided covered all of the points needed and the committee welcomed the progress reported. The committee asked that you provide a further update 6 months from now for the September committee. This would mean submitting an update in the same format by the 20th of September 2010. Let me know if there is any problem with this and we could arrange an alternative date, and don't hesitate to get in touch if there is anything I can do to support your taking the study forward here at TSH.

Many Thanks

Jamie

Jamie Pitcairn
R&D Manager
The State Hospital
01555 840293 Ext: 4355

Appendix 2.3 – Participant Consent Form

PARTICIPANT CONSENT FORM

Sexual Violence Risk Assessment:
An investigation into the inter-rater reliability of the RSVP in Scotland.

Participant Unique ID: _____

Please initial box

1. I confirm that I have read and understood the information sheet dated …… for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason. ☐
3. I understand that the information I give will be confidential. ☐
4. I agree to any qualitative comments I include in the study questionnaire being included in a written report or publication anonymously. ☐
5. I agree to take part in the above study. ☐

Name of Participant: _____ **Date:** _____ **Signature:** _____

Name of Principal Investigator: _____ **Date:** _____ **Signature:** _____

When completed: 1 copy to be retained by the participant and 1 to be returned to research team with study materials.

Appendix 2.4 Brief overview of cases

Case 1 ('Bill'): *Low Risk / Low-Medium Clinical Complexity*

Bill is a middle age heterosexual man referred to the community forensic mental health service by the court following conviction of sexual assault against his niece (forceful kissing and sexual touching). Bill has no recorded history of previous sexual offending or mental health problems. The offence occurred in the context of alcohol misuse and marital problems. Bill appears to display numerous protective factors such as self-awareness, remorse, victim empathy, full-time employment, supportive relationships and motivation to use support and psychosocial interventions.

Case 2 ('Mathew'): *Low Risk / Medium-High Clinical Complexity*

Mathew was a middle age homosexual man referred to the community forensic mental health service by his General Practitioner. He has longstanding problems with anxiety, depression and features of Borderline Personality Disorder. He has recently disclosed committing a sexual offence against a 6 year old boy when he was 14 years old and reports having longstanding fantasies of sexually abusing children. Since being made redundant from his work, he states that these fantasies have escalated and he is concerned that he might act on them. Due to inconsistent attitudes towards offending and mental health problems, it is difficult to gauge Mathew's attitudes towards offending and level of motivation.

Case 3 ('Simon'): *Medium Risk / Low-Medium Complexity*

Simon is a 26 year old homosexual man who was referred to the Community Forensic Mental Heath Team by his local Community Mental Health Team. He has a diagnosis of bipolar affective disorder and there are concerns about his risk of sexual violence during episodes of mania. During these episodes, Simon experiences violent sexual fantasies (involving adolescent boys) and has engaged in an escalating pattern of sexual offending: stalking (adolescent boys), public exposure, stealing items of clothing for sexual purposes, and coercing a vulnerable hospital patient to perform oral sex on him. When his mental health is stable, he displays protective factors including self-awareness, remorse, victim empathy, employment, supportive relationships and motivation to use support and psychosocial interventions.

Case 4 ('Mark'): *Medium Risk / Medium-High Clinical Complexity*

Mark is a 35 year old man who is currently cared for in a locked psychiatric setting. He has an extensive history of substance misuse and has a diagnosis of Schizophrenia with significant affective component. He has resided in secure hospitals for ten years and has experienced has considerable childhood adversity (incl. physical and sexual abuse) and transition (incl. residence in children's homes and prison). He has numerous prior criminal convictions for assault, burglary, shoplifting and drugs offences. For the last 10 years, his psychotic symptoms have been in constant (sometimes daily) fluctuation between episodes of florid psychosis and relative stability. During psychotic states, Mark often becomes obsessed with sex and experiences command hallucinations directing him to sexually offend against females (all ages). This has led to numerous incidents of inappropriate sexual behaviour and offending including: public masturbation, exposure of genitals, demanding sex from females, offering payment for sex, and inappropriately touching the breasts and buttocks of staff.

Case 5 ('Donald'): *High Risk / Low-Medium Clinical Complexity*

Donald is a 46 year old man who was recently released from prison following a 7 year prison sentence for violently raping a 14 year old girl and being in possession of child pornography. As a condition of his early release he was referred to the community forensic mental health team for a sex offending treatment programme. Donald has a history of depression, parasuicide and substance misuse. He has several previous allegations of sexually assaulting children, but despite considerable evidence of his offending, he completely denies this. He has derogatory and vengeful attitudes towards his victim and presents in a hostile, evasive and non-disclosing manner. He has no social contacts and spends much of his time alone in the community.

Case 6 ('Stuart'): *High Risk / Medium –High Clinical Complexity*

Stuart is a 30 year old heterosexual man who has a diagnosis of Paranoid Schizophrenia. He was admitted to high security hospital two years ago, after being charged with the rape of two women and the indecent assault of three others. Over the duration of two years previous to the offence, in parallel with decline in his mental state and increased substance misuse, Stuart had escalated the physical forcefulness and predatory nature of his sexual advances towards women. Stuart has many personality features consistent with the construct of Psychopathy (incl. superficial charm and apparent lack of empathy or conscience). He has an extensive history of substance misuse and has criminal convictions for theft and allegations of rape and serious assault. Since his hospital admission, he has inappropriately touched and propositioned female nursing staff.

Appendix 2.5 Example of data collection workbook

STEP 1: CASE INFORMATION (Step 1 - information gathering has been completed for you).	
Name of person being evaluated:	CASE 6: BILL
Space for assessor notes:	

STEPS 2 & 3: Presence and relevance of Risk Factors:

A. Sexual violence history	Coding
1. Chronicity of sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
2. Diversity of sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
3. Escalation of sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
4. Physical Coercion in sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
5. Psychological Coercion in sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No

B: *Psychological Adjustment*	Coding
6. Extreme Minimization or Denial of sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
7. Attitudes That Support or Condone sexual violence	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
8. Problems With Self-Awareness	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
9. Problems With Stress or Coping	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
10. Problems Resulting From Child Abuse	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No

C. Mental Disorder	Coding
11. Sexual Deviance ☐ *Definite* ☐ *Provisional*	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
12. Psychopathic Personality Disorder ☐ *Definite* ☐ *Provisional*	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No

13. Major Mental Illness ☐ *Definite* ☐ *Provisional*		*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**
14. Problems With Substance Use ☐ *Definite* ☐ *Provisional*		*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**
15. Violent or Suicidal Ideation ☐ *Definite* ☐ *Provisional*		*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**

D. Social Adjustment	**Coding**
16. Problems With Intimate Relationships	*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**
17. Problems With Non- Intimate Relationships	*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**
18. Problems with Employment	*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**
19. Non- Sexual Criminality	*Presence Past:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Presence Recent:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No** *Relevance Future:* ☐ **Yes** ☐ **Possibly/Partially** ☐ **No**

E. Manageability	*Coding*
20. Problems With Planning	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
21. Problems With Treatment	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No
22. Problems With Supervision	*Presence Past:* ☐ Yes ☐ Possibly/Partially ☐ No *Presence Recent:* ☐ Yes ☐ Possibly/Partially ☐ No *Relevance Future:* ☐ Yes ☐ Possibly/Partially ☐ No

STEP 4: RISK SCENARIOS (please consider the most plausible scenarios for a repeat offence and an escalation offence. Please indicate the offence nature, likelihood, severity, imminence and frequency for each scenario that you have in mind).

	'REPEAT' SCENARIO	***'ESCALATION' SCENARIO***
1. NATURE: **What kind of sexual violence is the perpetrator likely to commit?** *(Please tick only one and briefly specify details)*	☐ Breach of the peace (e.g. harassment) ☐ Indecent exposure ☐ Indecent assault ☐ Rape (without serious physical violence) ☐ Rape (with serious physical violence) ☐ Sexual homicide *Please give brief details:*	☐ Breach of the peace (e.g. harassment) ☐ Indecent exposure ☐ Indecent assault ☐ Rape (without serious physical violence) ☐ Rape (with serious physical violence) ☐ Sexual homicide *Please give brief details:*
2. VICTIMS: **Who is the likely victim?** *(Please tick only one)*	☐ Prepubescent male ☐ Prepubescent female ☐ Adolescent male ☐ Adolescent female ☐ Adult male ☐ Adult female	☐ Prepubescent male ☐ Prepubescent female ☐ Adolescent male ☐ Adolescent female ☐ Adult male ☐ Adult female
3. RELATIONSHIP: **What will the relationship status between victim and offender most likely be?** *(Please tick only one)*	☐ Intimate partner ☐ Immediate family member ☐ Other relative ☐ Acquaintance ☐ Stranger ☐ Work colleague ☐ Staff member ☐ Hospital patient ☐ *Other, please specify:*	☐ Intimate partner ☐ Immediate family member ☐ Other relative ☐ Acquaintance ☐ Stranger ☐ Work colleague ☐ Staff member ☐ Hospital patient ☐ *Other, please specify:*
4. *MOTIVATION:* What is the likely motivation? *(Please tick all that apply)*	☐ Sexual gratification ☐ Symptoms of major mental illness ☐ Intimacy seeking ☐ Anger / Control ☐ *Other, please specify:*	☐ Sexual gratification ☐ Symptoms of major mental illness ☐ Intimacy seeking ☐ Anger / Control ☐ *Other, please specify:*

5. *PSYCHOLOGICAL HARM:* What would be the psychological harm to the victims? *(Please tick only one)*	☐ None / Negligible ☐ Minor (short term / mild emotional distress) ☐ Moderate (medium terms /moderate emotional distress) ☐ Severe (significant / long term distress and psychological disturbance incl. PTSD)	☐ None / Negligible ☐ Minor (short term / mild emotional distress) ☐ Moderate (medium terms /moderate emotional distress) ☐ Severe (significant / long term distress and psychological disturbance incl. PTSD)
6. *PHYSICAL HARM:* What would be the physical harm to the victims? *(Please tick only one)*	☐ None / Negligible ☐ Minor (e.g. grazing) ☐ Moderate (e.g. cuts and bruises) ☐ Major (e.g. serious cuts and bruises / broken bones, requiring hospitalisation) ☐ Fatal / Near Fatal Injuries	☐ None / Negligible ☐ Minor (e.g. grazing) ☐ Moderate (e.g. cuts and bruises) ☐ Major (e.g. serious cuts and bruises / broken bones, requiring hospitalisation) ☐ Fatal / Near Fatal Injuries
8. *IMMINENCE:* How soon might the offender engage in sexual violence? *(Please tick only one)*	☐ Within **1 to 4** weeks of having opportunity to offend ☐ Within **6 months** of having the opportunity to offend ☐ Within **12 months** of having the opportunity to offend ☐ In the much longer term such as a period of **several years**	☐ Within **1 to 4** weeks of having opportunity to offend ☐ Within **6 months** of having the opportunity to offend ☐ Within **12 months** of having the opportunity to offend ☐ In the much longer term such as a period of **several years**
9. *WARNING SIGNS:* What are the warning signs that might signal that the risk is increasing or imminent? *(Please tick all that apply)*	☐ Relationship problems (Intimate) ☐ Relationship problems (Non-Intimate) ☐ Increased alcohol use ☐ Increased substance use ☐ Poor mental state ☐ Exposure to situational risks (e.g. visiting areas where there are potential victims) ☐ Poor compliance with treatment or supervision ☐ Change in setting ☐ Stress ☐ *Other, please specify:*	
10. *FREQUENCY:* How often might the sexual violence occur? *(Please tick only one)*	☐ Unlikely / Never ☐ Once / Twice ☐ Several Times ☐ Habitually /Repeatedly	☐ Unlikely / Never ☐ Once / Twice ☐ Several Times ☐ Habitually /Repeatedly
Is this risk Chronic or Acute (i.e. time limited?) *(Please tick only one)*	☐ Chronic Risk ☐ Acute Risk	☐ Chronic Risk ☐ Acute Risk
11. *LIKELIHOOD:* Based on the perpetrators history, how likely is it that this type of sexual violence will occur? *(Please tick only one)*	☐ Very Low Probability ☐ Low Probability ☐ Moderate Probability ☐ High Probability ☐ Very High Probability	☐ Very Low Probability ☐ Low Probability ☐ Moderate Probability ☐ High Probability ☐ Very High Probability

STEP 5: CASE MANAGEMENT (Recommend strategies for managing sexual violence risk).	
SUPERVISION: **Level of Supervision (What level of supervision should be implemented with this individual?)** *(Please tick only one)*	☐ Community Outpatient – No supervision in place ☐ Community Outpatient – Supervision in place ☐ Inpatient - Non-Forensic ☐ Inpatient - Forensic Low Secure ☐ Inpatient - Forensic Medium Secure ☐ Inpatient - Forensic High Secure
MONITORING: **What is the best way to monitor warning signs that the risks posed by the perpetrator may be increasing?** *(Please tick only one)*	☐ Regular appointments by professional (e.g. mental health, criminal justice or police). ☐ Mid-appointment telephone calls with relevant professional
What events, occurrences or circumstances should trigger a re-assessment of risk? *(Please tick all that apply)*	**Psychosocial issues, tick all that apply:** ☐ Worsening mental state ☐ *Other, please specify:* ☐ Relationship breakdown ☐ Job loss ☐ Bereavement **Indicators of sexual preoccupation, tick all that apply:** ☐ Sexually explicit language ☐ *Other, please specify:* ☐ Using pornography ☐ Masturbating frequently ☐ Propositioning others
TREATMENT: **What treatment or rehabilitation strategies should be implemented to manage the risks posed by the perpetrator?** *(Please tick all that apply)*	☐ Sex offender treatment programme ☐ Anger management ☐ Individual / Group Psychotherapy ☐ Family Therapy ☐ Vocational / occupational training ☐ Relationship Counselling ☐ Substance use /alcohol use programme ☐ Social skills training ☐ Psychiatric Medication *Other, please specify:*

STEP 6: SUMMARY JUDGEMENTS (Document Judgements regarding overall risk)

1. *CASE PRIORITISATION* (What level of effort or intervention will be required to prevent the person from committing acts of sexual violence?) *(Please tick only one)*	☐ High / Urgent ☐ Moderate / Elevated ☐ Low
2. *SERIOUS PHYSICAL HARM* (What is the risk that any future sexual violence will involve serious or life threatening physical harm?) *(Please tick only one)*	☐ High ☐ Moderate ☐ Low
3. *IMMEDIATE ACTION REQUIRED* (Does the person pose any imminent risks?) *(Please tick only one)*	☐ Yes ☐ Possibly ☐ No
4a. *OTHER RISKS INDICATED* (Is there evidence that the person poses a substantial risk of other, non-sexual violence or criminality?) *(Please tick only one)*	☐ Yes ☐ Possibly ☐ No

4b. Please estimate the likelihood of other risks below:

Risk of Suicide *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High
Risk of Non Sexual Violence *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High
Risk of Self-neglect *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High
Risk of Exploitation by Others *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High
Risk of Absconding *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High
Risk of Spousal Assault *(Please tick only one)*	☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very High

Appendix 2.6 Professional Information Questionnaire

UNIVERSITY of GLASGOW

Risk Of Sexual Violence Protocol (RSVP)
Inter-rater reliability study:
Professional Information Questionnaire
Participant No. _____

NHS Greater Glasgow and Clyde

Q1. To which professional group do you belong (e.g. Psychiatry, Clinical Psychology, Nursing)?

_____

Q2. Approximately how many years have you been fully qualified in that profession?

_____

Q3. If applicable, how many years have you been working in a forensic mental health setting?

_____

Q4. What type of clinical setting do you currently work in (e.g. Forensic community outpatient, medium secure inpatient, LD Psychology)?

_____

Q5. What clinical setting(s) do you have previous experience of working in (e.g. Forensic community outpatient, medium secure inpatient, LD Psychology)?

_____

Q6. Have you been given formal training in using the RSVP? Yes / No

If yes, **Q6a.** Who provided the training?

_____

Q6b. When was the last time you received formal training in using the RSVP?

_____

Q6c. Approximately how many days training in total have you had in using the RSVP? (e.g. 2.5 days)

_____

Q6d. How many times have you attended formal RSVP training events?

_____

Q7. Approximately how many times have you used the RSVP in your clinical work? (e.g. 5, 40-50)

_____

Q8. What other risk assessment tools have you used? (e.g. HCR-20, STATIC-99, SAM, PCL-R)

_____

_____

Q9. Have you been formally trained in using the PCL-R? Yes / No

Q10. To what extent did you consult the RSVP manual during rating these cases? (please mark an 'x' on the scale below to indicate your response)

Manual not consulted at all — *Manual consulted at all stages*

Q11. How confident were you overall in the accuracy of your clinical judgements in this study? (please mark an 'x' on thescale below to indicate your response)

Very Unconfident — *Very Confident*

Q12. To what extent do you feel that assessment was guided by your subjective feelings towards these cases? (please mark an 'x' on the scale below to indicate your response)

Very Objective / Personally Detached — *Very Subjective / Instinctive*

Q13. Did you have any specific difficulties interpreting or completing any item of the RSVP or this study? If so, please identify the item and describe the difficulty.

Q14. Please provide any comments or suggestions you have about your experience of using the RSVP or in participating in this study.

THANK YOU FOR YOUR PARTICIPATION.

Appendix 2.7. Expert reviewer feedback questionnaire

RSVP (RISK OF SEXUAL VILENCE PROTOCOL) INTER-RATER RELIABILITY STUDY
EXPERT PANEL REVIEW

NAME OF CASE BEING REVIEWED: _____

Many thanks for participating in the expert review process for this study. Participants in our study will be asked to assess six fictitious case vignettes using a shortened form of the RSVP. As you are aware, it is not possible to adequately represent the entire range of forensic mental health cases using only six cases. We aim to maximise the validity of our cases by including your expert judgement in our methodology. Your opinion is greatly appreciated and will allow us to verify the authenticity of our cases, and to include expert judgement in our analysis.

We have sought to develop cases that vary in their level of clinical complexity and risk of sexual violence. Risk of sexual violence is defined by in the RSVP manual (Hart et al, 2003). Clinical complexity relates to severity and co-morbidity of clinical problems.

The cases are intended to be distributed as follows:

	Low Risk	*Medium Risk*	*High Risk*
High Clinical Complexity	Matthew	Mark	Stuart
Low Clinical Complexity	Bill	Simon	Donald

Preliminary scores and rationale for scoring decisions (steps 2-3) has been provided in order to reduce the amount of time that is required of you in this task.

1. **On the data collection forms, please mark in pen where you disagree with any of the suggested ratings for this case.**

2. **In your opinion, does this case accurately represent the level of a) risk and b) clinical complexity that it is intended to?**

☐ **Yes** ☐ **No**

If not, please suggest what information should be included, removed or modified to ensure that the case is representative of it's intended level of clinical complexity and risk.

2. (*continued*)

3. Does the case 'feel' authentic?

☐ **Yes** ☐ **No**

If not, please suggest what information should be included, removed or modified to ensure that the case does feel authentic?

4. **Are there any other improvements or suggestions that you would make about the case vignette or data collection forms.**