

Guidelines for the Role and Function of Specialist Assessors

**Under the Intellectual Disability
(Compulsory Care and
Rehabilitation) Act 2003**

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Introduction

These guidelines are intended to provide specialist assessors designated under the Intellectual Disability (Care and Rehabilitation) Act 2003 (IDCCR Act) with information and guidance on the role of the specialist assessor.

Aim of guidelines

The aim of these guidelines is to establish a consistent national process for specialist assessment for people with an intellectual disability. Providing the assessor with a framework to assess risk and develop recommendations for intervention and rehabilitation to reduce the perceived risks. It is intended that the guidelines will reflect:

- the characteristics, cultural, moral, and legal imperatives of the people of New Zealand; in particular, acknowledging the importance of the Treaty of Waitangi
- the practices and values held important regarding the rights and dignity of people with an intellectual disability
- aspects of the current best practice in risk assessment as exemplified in the published literature in international journals of psychology and psychiatry.

The risk assessment process advocated in these guidelines is a functional approach to the assessment of offending behaviour. Under this approach the assessment focuses on why the person is behaving in a particular way, and on the identification of contingencies that maintain the offending behaviour.

Definition of key terms

Hazard	Anything that can cause harm. For example, violence, manual handling, infection, etc.
Risks	The likelihood of harm occurring.
Harm	Any undesirable outcome that gives rise to ill health, injury or damage (physical or emotional), permanent or otherwise, including damage to property, etc.
Risk assessment	The process of identifying potentially harmful hazards, determining their predisposing, precipitating and correlating factors.
Risk management	Development of strategies to reduce the likelihood of an adverse event occurring, minimise the impact of such an event or reduce the severity of an event in the least restrictive manner whilst maintaining an acceptable level of safety for others.
Risk	An informed, professional opinion of a complex composite of the likelihood, imminence, magnitude and severity of harm occurring.

Person	Throughout these guidelines the term ‘person’ will be used to refer to the person who is the subject of the assessment. Under the IDCCR Act this person is called a proposed care recipient .
Specialist assessor	Specialist assessors or assessor means an appropriately qualified health or disability professional who is for the time being designated by the Director-General of Health for the purposes of the IDCCR Act.
Care co-ordinator	A compulsory care co-ordinator is a person who is appointed by the Director-General of Health by a notice published in the NZ Gazette (section 140). Co-ordinators are nominated by Regional Intellectual Disability Care Agencies (RIDCAs) and appointed by the Director-General of Health. Co-ordinators should be health and disability professionals with no less than two years’ experience in working with people with disabilities.
Care manager	Care managers are health and disability professionals who have undergone training in, and are competent in, the assessment, care and rehabilitation of persons with intellectual disability. Care managers are designated by the care co-ordinator for each individual under the IDCCR Act. They are entrusted with the care and rehabilitation of individual care recipients and are responsible for developing and implementing a person’s care and rehabilitation plan and for ensuring regular clinical reviews of the person’s condition take place.

Assessment examination

The co-ordinator initiates the assessment process by designating under section 32(b), one or more specialist assessors who are to assess the person. Confirmation of this designation will be provided in writing by the co-ordinator.

The purpose of the assessment process is to determine:

- a. whether the proposed care recipient has an intellectual disability and is in need of compulsory care (section 37(1)(a); and
- b. if the person does have an intellectual disability to assess the level of care that is required to manage the risk that the proposed care recipient’s behaviour poses to the health and safety of the care recipient or of others (section 37(1)(b)).

Meaning of intellectual disability

Section 7 of the IDCCR Act

- (1) A person has an 'intellectual disability' if the person has a permanent impairment that –
 - a. results in significantly sub-average general intelligence; and
 - b. results in significant deficits of adaptive functioning, as measured by tests generally used by clinicians, in at least two of the skills listed in subsection (3); (4) and
 - c. became apparent during the developmental period of the person.
- (2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.
- (3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed –
 - a. as 70 or less; and
 - b. with a confidence level of not less than 95%.
- (4) The skills referred to in subsection (1)(b) are –
 - a. communication
 - b. self-care
 - c. home living
 - d. social skills
 - e. use of community services
 - f. self-direction
 - g. health and safety
 - h. reading, writing, and arithmetic
 - i. leisure and work.
- (5) For the purpose of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.
- (6) This section is subject to section 8.

Section 8: Persons who do not have an intellectual disability

- (1) A person does not have an intellectual disability simply because the person –
 - a. has a mental disorder, or
 - b. has a personality disorder, or
 - c. has an acquired brain injury or
 - d. does not feel shame or remorse about the harm that person causes to others.

(2) To avoid doubt, if –

- a. a person does not have an intellectual disability, the provisions of this Act relating to the compulsory care cannot apply to that person, whether or not the person has any other disability
- b. a person does have an intellectual disability, those provisions are not prevented from applying to the person simply because the person also has one or more of the characteristics described in subsection (1)(a) to (d).

The specialist assessor where possible should consult with the following people about the proposed care recipient's condition and background (section 37(2)):

- the proposed care recipient's principal caregiver
- any welfare guardian of the proposed care recipient
- if the proposed care recipient is a child or young person, each parent or guardian of the child or young person
- if the proposed care recipient is a child or young person who is not residing with any of his or her parents or guardians, any person –
 - with whom the care recipient is living
 - who has had the care of the care recipient for a period of not less than six months immediately before the application was made
- the care recipient's family or whānau.

Section 33: Assessment of child or young person

This section states that, whenever practicable, a specialist assessor who practises in the field of child and adolescent disability must be involved in the assessment of a child or young person.

Please note that the assessments must be carried out within **seven days** of the receipt of the application for assessment from the Director of Area Mental Health Services or the prison superintendent. It is the co-ordinator's responsibility to ensure that this happens.

Place of assessment

The co-ordinator has the power to notify the superintendent or Director of Area Mental Health Services who has requested an assessment for a person in their care, that the inmate or former special patient must stay in a specified facility while they are being assessed by a specialist assessor; while they are undergoing a needs assessment; or while an application for compulsory care is pending before the Family Court.

During this period an inmate to whom the notice relates ceases to be in the legal custody of the superintendent concerned and becomes the legal responsibility of the care manager designated for the inmate.

An inmate or special patient may also be assessed in a facility without formal notice from the care co-ordinator to a Director of Area Mental Health Services or a prison superintendent. In these circumstances the inmate or former special patient may not stay in the facility overnight, and in the case of an inmate, he or she will continue to be in the legal custody of the superintendent concerned and may not stay in the facility overnight.

Inmates and former special patients who are required to travel to and from facilities for assessment should be taken under the direction of the appropriate superintendent or Director Area Mental Health Services.

Assessment of intellectual disability

The following is a suggested assessment procedure to determine if the person has an intellectual disability. The procedure is based on current clinical practice within New Zealand where services carry out eligibility assessment (eligible for funding and services which have been specifically designed for people with an intellectual disability). The process consists of:

1. **developmental history:** a detailed developmental history should be obtained from family, whānau or people who know the person well. The history should include: family genetic history (ie, known genetic disorders such as Fragile-X syndrome, other family members with psychiatric disorders etc), details of pregnancy, birth, developmental milestones, school and employment achievements etc.
2. **cognitive assessment:** typically, this involves the use of standardised and well-recognised psychometric tests of cognitive ability (eg, the Wechsler Adult Intelligence Scale Peabody 3rd edition), but may need to use alternatives in exceptional circumstances (eg, Peabody Picture Vocabulary test etc).
3. **adaptive functioning:** a recognised test of adaptive functioning can be used to estimate the person's level of competence to live independently.

A clinical decision is reached based on the above sources of information, clinical judgement related to the person's functioning during the testing, and should take into account the psychometric properties of the tests, the person's strengths and deficits, and support needs.

Assessment of risk

1. To establish factual evidence for the level of harmful behaviour evidenced by the person:
 - to place the behaviours of concern in a chronological sequence, document details of the behaviour and its impact on the person and others
 - obtaining details of chronology, topography of the behaviour, frequency, harm, chains of behaviour, sequencing etc
 - to gather information about the context in which the behaviour occurred: that is, antecedent events, consequent events, and the circumstances in which the behaviour occurred, cultural specific factors influencing behaviour
 - to establish a historical pattern to the behaviour that would provide evidence of trends in the behaviour (ie, rising or falling patterns in frequency and seriousness, etc).
2. To establish the person's strengths, skills, weaknesses, and skills deficits:

- including the kinds of relationships that the person has with significant others (ie, family, whānau, peers, partner etc)
 - educational and employment history
 - offending history, criminal charges and convictions
 - health issues: where appropriate, it would be important to identify the health practices of the person's whānau and how they utilise Māori tikanga/ways of healing
 - mental health.
3. To establish the person's current supports and how adequately these support meet his or her needs.
 4. To determine if the person has opportunities to have a reasonably satisfying and happy life (Quality of Life).
 5. To formulate a set of hypotheses about the function/causation/pathologies that the behaviour fulfils for the person, ranking these hypotheses according to the factual evidence available.
 6. To establish conditions under which the behaviour is likely to be displayed in future.
 7. To use accepted actuarial tools (where appropriate) to estimate the probability of the person presenting dangerous behaviour. Note that currently there are no actuarial tools that have been validated for this population or for New Zealand conditions.
 8. To make qualified statements on the risk that the person is likely to present in future and link this with the circumstances/conditions/limitations under which these predictions are made.
 9. To suggest immediate and ongoing interventions that can reduce severity and the likelihood of risk behaviours.
 10. To make suggestions for ongoing functional assessment.

Information sources

The specialist assessor will need to gather information from a range of sources to ensure that the assessment process is based on the most accurate and reliable data. The assessor will need to identify key people and documentation necessary to ensure that adequate coverage of information is achieved. When it is not possible to access specific people or written material then this deficit should be noted in the report and the reasons for the omission should be stated.

Care should be taken to note the various sources from which information is gained. This will be important in the writing of the report, and in drawing conclusions about the reliability of the information. It is likely that there will be considerable variability in the quality and veracity of information gathered. There are likely to be situations when people will report statements that are suspicions and/or concerns that are not backed up with direct evidence. It is valid to include these concerns within the assessment, but this sort of information needs to be reported in a manner that makes clear the source of the information and the evidence that exists to support its reliability. The specialist assessor should, where possible, be checking the reliability of information gained from a number of sources. In the event of conflicting stories the assessor should state their view of the most credible source of information and the reasoning which supports the view.

The following potential sources of information should be considered:

1. Interviews with:
 - i. the subject of the assessment
 - ii. the person's family/whānau
 - iii. related professionals if appropriate (ie, psychiatrists, doctors, psychologists, etc)
 - iv. care providers (both current and in the past), teachers, social workers, prison staff, etc.
2. School reports, Group Special Education reports, Individual Education Plans (IEP).
3. Children and Young Persons Service (CYPS) reports and any reports from Family Group Conferences (FGC).
4. Hospital files/GP records:
 - i. medical information
 - ii. genetic testing.
5. Offending record.
6. Police files.
7. Psychiatric reports.
8. Psychologist reports.
9. Victim reports.
10. Cultural experts who may be asked to carry out a cultural assessment, and also to provide comment on the person and issues related to their behaviour in relationship to the person's particular cultural background.
11. Psychometrics: It is important to ensure that only the most up-to-date and valid form of psychometric instruments are used. Short forms of instruments are not appropriate. At the current time the use of actuarial psychometric instruments are problematic with this population: there is little or no empirical data supporting the use of actuarial tools with people who have an intellectual disability, nor is there data supporting their use with a New Zealand population. At best these tools may be used as a checklist to prompt areas of investigation.

Information gathering

1. Biographical information:

- date of birth
- family information
- living situation.

2. History:

- place of birth
- developmental milestones, features of developmental delay or autistic spectrum disorder etc
- educational history including highest academic achievements
- account of relationships with family/whānau, peers, significant others, children, etc (note that in Māori culture, whakapapa and tribal affiliations are a very personal treasure and if these are shared then great care should be made to protect and respect this information)
- contact with support agencies (CYPS, Child Development Centres, Group Special Education etc).

Points to consider:

- evidence of adequate family/whānau support
- promoting self-esteem and positive role modelling behaviour
- evidence of positive supportive peer group.

3. Offending history:

- age of first offence
- offending patterns
- diversity of offending
- specifics of the offending:
 - are there any clues or verbalisations from the person that give insight into his or her motivation?
 - does this behaviour always happen when he or she is angry or intoxicated, or both?
 - what are the characteristics of the victims with regard to gender, age, physical size, and ability to defend themselves?
 - are offences always sexual in nature? Are physical force and/or weapons employed?
 - where is the offending most likely to occur (eg, in a residential, community setting, with family/whānau etc)?
 - when is the behaviour most likely to occur (eg, particular time of year, time of day, etc)?

4. Relationship/sexual history

Points to consider:

- evidence of deviant sexual behaviour or a sexual orientation towards children, animals etc
- are opportunities or skills necessary to hold down a relationship, or at minimum have a consenting sexual relationship with an appropriate adult?

5. Medical history

Points to consider:

- is there adequate medical intervention available to ensure good health?
- outstanding unmet medical needs (eg, evidence for recent: dental care, eyesight, hearing checks, blood screens, full medical check-up etc)
- known disease processes in place that might contribute to harmful behaviour (eg, frontal lobe epilepsy, uncontrolled diabetes etc)
- the person's understanding of medical issues and ability to care for him or herself, level of support necessary to meet needs
- the cultural health practices of the person's whānau.

6. Mental health issues

Points to consider:

- orientation to place and time
- are there signs of mental health disturbance requiring a full psychiatric assessment (if assessor is not a psychiatrist)?
- the cultural context of how the person presents (symptoms), that is, how would the presenting issues be viewed by members of the person's cultural group?
- evidence of depression, anxiety, disordered thinking, delusions etc
- course of mental health issues
- how well controlled on medication
- what factors contribute to relapse?
- what are early warning signs?
- is the person able to demonstrate an understanding of mental illness and how to manage this? What kinds of supports have been offered in the past?
- frequency of admission to hospital
- world view
- goals and aspirations for the future
- insight into behaviour
- account of why the harmful behaviour has occurred.

7. Consultation with cultural experts (Maori or other):

- how well does this person's behaviour fit within the norms of his or her culture?
- what do others within the person's cultural group say about the person and their whānau?
- are there issues related to tapu violation or cultural matters that are likely to impact on the person and their whānau?
- what cultural practices/traditional healings could be used to help the person and their whānau/family?

8. Assessment of life stressors

- past stressful events: abuse, neglect, rape, financial poverty etc
- current life stressors: grief due to loss of family/whānau members, financial debts, trauma (ie, resulting from accidents, rape, assaults etc).

Clinical judgement

1. Evaluation of the quality of the person's life should be made; that is, are the person's current life circumstances those that would allow him or her to have a reasonably happy and satisfying life? Paying attention to opportunities for making choices, having valued roles, relationships with other people etc.
 - Is the current level of support provided for the person adequate to allow the person to have a reasonable life?
 - What level of understanding do other people have of the person's life/needs/limitations etc?
2. The clinician will need to identify skill deficits displayed by the person that may contribute to the behaviour of concern.
3. The Risk Factors Form may be used to assist the clinician to make judgements on the level of harm displayed by the person.
4. The clinician should develop hypotheses on the functional relationships between the person's behaviour, environment, needs, cultural needs, triggering events, skills deficits etc.
5. These hypotheses should be ranked from most to least likely to explain the person's behaviour (based on the available factual information uncovered and clinical impressions gained during the assessment).
6. If necessary, and within the time limits of the assessment, the clinician should attempt to gather further information to test these hypotheses.

Result of assessment (section 38)

On completion of the assessment of a proposed care recipient, the specialist assessor must set out in a report to the co-ordinator their assessment as to whether the person has an intellectual disability and in need of compulsory care, and the level of care required to manage the risk that the proposed care recipient's behaviour poses to the health and safety of proposed care recipient and others.

If the report states that the proposed care recipient does not have an intellectual disability then the co-ordinator must ensure that the person is immediately advised of the result and is returned to the custody of the appropriate superintendent or Director of Mental Health Services.

Report

The information gathered during the assessment and the subsequent synthesis should lead to a greater understanding of the person and the circumstances of his or her life. Based on these new understandings a number of summary documents (reports) will need to be written. Note that there are two main groups who will use this information: the courts and associated legal professionals, and the care co-ordinator, care manager, and service providers. The court will require a brief executive summary of the assessment, formulation/conclusions and recommendations. The more detailed formal psychological report summarising the assessment is to be included as an appendix in the documents provided to the court by the care co-ordinator. The care co-ordinator and care manager can use the detailed information provided in the report as a resource for establishing a plan for service provision.

Care should be taken to ensure that the intended audiences for the reports are able to utilise the information to best advantage. It should be noted that clinical professionals are not the intended audience, so the use of complex technical terms, psychological and psychiatric language are likely to be unhelpful. Similarly recommendations should be made in a manner that makes clear the intent of the issue but should not be so prescriptive in the detail that it makes the practical delivery of services difficult or impossible.

The formal report should summarise:

1. that the person does or does not have an intellectual disability
2. the historical circumstances of the person
3. the person's living situation at the time of the harmful behaviour and current circumstances
4. the topography and frequency and other characteristics of the harmful behaviour including, where possible, antecedent and consequencing relationships and the magnitude of the harm
5. a summary of the cultural factors that might be contributing to the current situation
6. the strengths and weaknesses displayed by the person
7. the levels of support currently in place and its adequacy to meet the person's needs
8. the results of the psychometric assessment, including, where appropriate, reporting and interpretation of the results of actuarial risk assessment

9. the outcomes of the cultural assessment and the judgements/conclusions placed on these outcomes by the kaumātua and whaea
10. a formulation of the person's behaviour that uses psychological principles to make links between the person's circumstances and their behaviour and the function that the behaviour might play in the person's life, including, where appropriate, cultural aspects of the person's circumstances
11. recommendations for management of the assessed risk which should include:
 - a. an estimate, if available, on the likelihood of the person committing a violent act
 - b. a qualified statement about the risk the person presents, and under what circumstances such risk is predicted (that is, the limitation of such predictions)
 - c. suggestions for immediate intervention that could reduce/manage the level of risk, this might involve specifying the level of security necessary for rehabilitation, the number of staff support necessary, environmental management, etc
 - d. the plans for the management of the potential risk should cover suggestions for maintaining safety under the most likely circumstance, best, and worst case scenarios; that is, based on the historical and current circumstances of the person the safety plans should make allowances for how the person's behaviour may present across a continuum: ranging from the potential for very harmful level of behaviour to little or no harm
 - e. culturally appropriate interventions to manage aspects of the person's behaviour that may arise from tapu violation, cultural estrangement etc
 - f. suggestions for ongoing assessment and management of risk behaviours
12. recommendation for rehabilitation/intervention which may include:
 - a. identification of skills deficits that might be targeted, therapy issues, and quality of life issues that might need to be put in place
 - b. ways of reconnecting the person to his or her cultural base and sense of self and history
 - c. suggestions for further assessment.

Executive summary for the court

Based on the indepth psychological report, the specialist assessor should prepare a brief (no more than two page) executive summary. The purpose of this summary document is to clarify the situation and to provide the key outcomes of the assessment in an easily accessible manner. This summary should provide a brief description of the behaviours of concern, relevant historical background information and a conclusion section that discusses the writer's formulation/synthesis of the assessment. The summary should conclude with the list of recommendations for managing the risks and suggestions for intervention.

Reviews undertaken by specialist assessors

Six months¹ after the care co-ordinator has approved a care recipient's initial care and rehabilitation plan they must present a report to the Family Court on the continued appropriateness of the plan and, if the care recipient is subject to a compulsory care order, the continued appropriateness of the order. The co-ordinator must arrange for a clinical review of the care recipient's condition to be carried out by a specialist assessor at least 14 days before the report is due.

The exception to the requirement to report to the court is where a care co-ordinator has applied, or is about to apply, to the court for cancellation of a care recipient's compulsory care order.

A review of a care recipient under section 77 must be conducted by one or more specialist assessors designated by the co-ordinator for the purpose.

When the co-ordinator designates two or more specialist assessors for the purpose of a review under section 77, the co-ordinator must nominate one of the assessors as the assessor who is principally responsible for the conduct of the review.

In reviewing a care recipient under section 77, the specialist assessor or specialist assessors must –

- a. examine the care recipient
- b. consult with other health or disability professionals involved in the care of the care recipient, and take their views into account when assessing the results of the review of the care recipient's condition.

Six-month review

Sections 72 and 77 mandate a regular six-monthly review for all care recipients. The approach to take here is one based on **clinically significant change**. That is, to ensure there have been real and useful changes in how the person lives his or her life, and there is, as a result, a substantial drop in the risk of harm the person presents. Clinically significant change is usually thought to have two components:

1. The magnitude of the change for an individual should be statistically significant; that is, the change is big enough that it could not be seen as the result of chance or measurement error.
2. Whether there have been changes in the individual or their circumstances to warrant a change of their orders or their status under the Act.

Note that not all special care recipients will be resident in a Regional Intellectual Disability Services (RIDSS) service; some special care recipients could have a lower level of security/supervision than some care recipients. Specialist Assessor's role is to define what the recipient requires, not base their assessment on what's available. It is the care co-ordinator's role to find the services to provide that care.

¹ Refer to section 72: If the care recipient's court order lasts less than six months then the report must be presented no later than two months after the order has been made.

The review process should focus on establishing whether it is necessary to maintain the person under the Act.

The review process should focus on looking for evidence the compulsory treatment and rehabilitation has created behaviour change for the care recipient that significantly reduces the likelihood that he or she will cause serious harm to him or herself or others in the community. Further, that the level of harm the person is thought likely to present should not be significantly different from that of the person's peer group. Peer group could be taken to mean other people with an intellectual disability.

Based on the assessment of risk and the functional assessment conducted, the care co-ordinator will establish a set of criteria for the review. The criteria will target specific behaviours, quality of life issues, skills deficits, etc related to the person's behaviour of concern at the time of the assessment. These criteria are not fixed, that is, the criteria may evolve as the person is cared for and a relationship established with the service provider. The new information may suggest that there are a variety of behaviours and skills that should be included or replace some of the criteria established during the initial assessment. If such changes become necessary they should be added to the review process.

The initial criteria may include the following:

1. Changes to scores on standardised tests such as the HCR-20 (predicting likelihood of further violent behaviour), depression and anxiety instruments, Quality of Life measures, etc. There should be evidence that there has been a reduction in the predicted levels of harm, and positive changes on other measures that may act as factors to reduce the level of harmful behaviours.
2. Changes to topologies (patterns), frequency, magnitude, etc of the potentially harmful behaviour. For example, for a person who committed assaults, that there has been a significant reduction in the number of assaults or attempts and/or the magnitude of assaults etc.
3. Changes in collateral behaviour: particularly in the case of behaviours that are of very low frequency or may have no opportunities to occur while the person is in a secure setting (ie, sexual assaults, fire setting etc) then changes in collateral behaviours should be monitored. That is, for example, data should be collected that monitored whether the person was making inappropriate sexual comments or showing other evidence in his or her thinking about committing a sexual offence, or had attempted to collect fire setting equipment etc.
4. Changes in skills and coping strategies: looking for evidence that the person has acquired new skills that might impact on his or her harmful behaviour and how well the person has generalised the use of the skill across settings and situation. For example, the person has learned to problem solve and communicate with others about situations that would have previously elicited angry outburst.
5. Changes in the relationship between the person and the support service provider. Specifically: does the person show evidence that he or she has developed a strong working relationship with the care provider that would allow for continued support of the person without requiring the need for compulsion? Is there strong evidence that the person is willing to accept support by a service provider and so can be kept safe, or does he or she

need to remain under the legislation to maintain safety? Is the person able to maintain the reductions in their behaviours with a gradual reduction of restrictive interventions i.e. the behaviour stays ok as the controls are relaxed.

6. It is important to make contact with family/whānau where possible to ensure that information is gained on changes and developments on the part of the person. If the person under review is Māori the specialist assessor may also need to check for signs of a developing cultural identity, that there has been work done on dealing with tapu violation, etc. This may require a cultural assessment or discussion with kaumātua and whaea who have been supporting the person and their whānau.

The criteria for the review will have been established within the care programme (section 26). Goals for behaviour change will have at this time been set after discussion with the care co-ordinator, the specialist assessor(s), and the care manager as the representative of the support service provider.

This process will have a significant impact on the care recipient: loss of freedom and choices, enforced treatment etc. It is essential that realistic goals be established and updated so that a decision to continue the compulsory care is based on clear evidence of a need to protect the person and the community, and balance this against the rights of the person.

On review (section 78(3)) the specialist assessor will need to liaise with the person, their family/whānau, the care co-ordinator, support service provider(s), and any other relevant people (ie, psychiatrists, significant others etc). Records and other information sources (daily diaries, client progress notes, etc) should, where appropriate, be considered as ways of monitoring the person's progress under the care order.

If the available information makes a good case for the continuation of the compulsory care order then a certificate (section 79) to this effect should be issued and forwarded to the care manager, care co-ordinator and in cases of special care recipients also to the Director-General (section 80). If it is assessed in consultation with the care manager and care co-ordinator as part of the review that a variation is required to the compulsory care order the co-ordinator may apply to the Family Court for a variation of the order (section 86). The care provider, due to their more established relationships and much longer assessment understandings with the person, may have noted behaviours that should be added to the review criteria and also should become the focus of intervention for the next period of care and rehabilitation.

Should the information indicate that the compulsory care order should not be continued then the accompanying recommendation to court should note the kinds of ongoing support that should be put into place to ensure that there is no deterioration of the person's circumstances. The person may, for example, have the care order lifted but still require a high level of support from a more mainstream service provider for people who have an intellectual disability.

Specialist assessor to issue certificate

Section 79 states that:

1. A review of a care recipient under section 77 is concluded by the issue of a certificate as to whether the status of the care recipient needs to be continued or needs to be changed.
2. The certificate required by subsection (1) must be given by the specialist assessor who is responsible or principally responsible for the conduct of the review.
3. The certificate required by subsection (1) must comply with whichever of the following provisions are relevant:
 - a. section 82 (which relates to a care recipient no longer subject to the criminal justice system and to special care recipients liable to detention under sentences) or
 - b. section 89 (which relates to a person who is a special care recipient because of an order made, under the Criminal Justice Act 1985, following a finding that the person is unfit to stand trial) or
 - c. section 92 (which relates to person who is a special care recipient because of an order made, under the CPMIP (Criminal Procedure Mentally Impaired Persons) Act 1985, following the acquittal of the person on account of insanity).

Section 82 goes on to specify the form of the clinical review certificate for care recipients who are no longer subject to criminal justice system and care recipients liable to detention under sentence.

When a specialist assessor completes a certificate, under section 79, in respect of a care recipient no longer subject to the criminal justice system or a special care recipient who is liable to detention under a sentence, the specialist assessor must state whether in his or her opinion –

- (a). the care recipient still needs to be cared for as a care recipient or
- (b). the care recipient no longer needs to be cared for as a care recipient.

Appendix: Specialist Assessor's Guidelines

Literature review

Background

The management of people with an intellectual disability who commit offences, presents considerable legal and ethical problems. For many people with an intellectual disability the justice system and legal procedures are difficult or impossible to understand. This seriously impacts on their ability to gain the best from the legal system. Once convicted, people with an intellectual disability cope poorly with the demands of prison and in their interactions with other prisoners. Often they are unable to integrate into rehabilitation programmes and so have few opportunities to learn new skills to reduce re-offending, or that skills would allow them to live successfully in the community.

International studies have shown that the percentage of people who have an intellectual disability who are prison inmates, may be as high as 19.1 percent (Noble and Conley 1992). As it is recognised that between 2–3 percent of the general population have an intellectual disability, this suggests that people with an intellectual disability are many times over-represented in prison. One study showed that men with an intellectual disability were three times more likely to offend, and five times more likely to commit a violent offence, than non-disabled men. Corresponding figures for women showed women with an intellectual disability were four times more likely to offend and 25 times more likely to commit a violent offence. Two possible explanations for this finding were offered (Mikkelsen and Stelk 2001). Firstly, the increased level of offending might be a reflection of a lack of impulse control. Secondly, people with an intellectual disability often live highly supervised and monitored lives compared with non-disabled people, and so their behaviour was more likely to be reported. A New Zealand study suggested a considerably lower number of people with an intellectual disability in prison, approximately 0.1 percent. However, there were methodological problems associated with this study that may have reduced the apparent numbers.

Much of the international literature is written from an adult perspective so little understanding of children and young people's presentation is known. In addition each of the studies is framed from the local legal jurisdiction that applies. The New Zealand experience may show more variation for this client population than that of the overseas studies.

The United Kingdom experience shows the most common type of offending for people with an intellectual disability are property offences. However, sexual offending and fire setting are the other types of offending associated with this group, with sexual offending being reported to be four to six times more likely among people with an intellectual disability than in the general population. The profile of a person with an intellectual disability who offends is most often male, with a mild to moderate level of disability, who commits crimes against person or property, and who has a secondary diagnosis of mental illness or substance abuse (Holland, et al 2002).

History

There is considerable variability in how people with an intellectual disability who offend are managed. For many service providers there is a desire to protect the people they support and so they minimised, hid, or glossed over offences (Holland et al 2002; Mikkelsen and Stelk 2001; Turner 2000). When behaviour does come to the attention of the police there is considerable discretion on whether to lay formal charges. Some members of the police made decisions not to prosecute, as they did not believe that a person with a disability would be able to manage the court system, or would be able to manage in prison. Others made the decision to prosecute based on the need to protect the public, or for other reasons. There is no systematic approach to this decision-making and some individuals with an intellectual disability are convicted for very minor offences and given long prison terms or incarcerated in mental health services, while others who had committed serious assaults are not charged. In a similar manner information on offending by people with an intellectual disability is often limited or deliberately left unrecorded (Johnston 2002). This has a serious impact on understanding the prevalence of this type of behaviour and subsequently on research and service provision.

Prior to 1992 people with an intellectual disability who were in need of care were included under the Mental Health Act 1969. However, when the Mental Health (Compulsory Assessment and Treatment Act (MH(CAT)) Act 1992 was developed it deliberately excluded people with an intellectual disability, as it was recognised that, while people with an intellectual disability had substantial limitations in their functioning, this was not the same as a mental illness. In consequence, individuals with an intellectual disability who were in need of care were not specifically provided for under the law and may have been inappropriately placed in prison, mental health services or discharged into the community.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) is designed to establish the limits that can be imposed on the freedoms of people who have an intellectual disability and who are in need of compulsory care. The Act provides new options for the courts in making decisions about how to provide treatment and care for these individuals. It should be noted that the IDCCR Act only covers individuals who have an intellectual disability and who commit a serious offence (eligible for a period of three months imprisonment or longer).

These guidelines have been prepared to provide direction for the work of specialist assessors as mandated under the IDCCR Act. Under the IDCCR Act there is a requirement for a designated clinical professional known as a specialist assessor. It is the responsibility of the specialist assessor to undertake an assessment to determine if the person being assessed has intellectual disability and poses a serious danger to him or herself or others and to make recommendations for intervention/rehabilitation to reduce the perceived risks. This process has been termed as a specialist assessment. It is from the information gained from the specialist assessment and from other sources (ie, cultural assessment, intensive needs assessment etc) that a programme of care will be developed. This programme will provide those supporting the person with strategies to reduce the risks the person poses and a planned approach to providing rehabilitation within the least restrictive environment. A further task of a specialist assessor will be to carry out a six-monthly review of the person once they are placed under compulsory care. This review process is designed to assess the continued need for the person to remain under the provisions of the Act.

Risk assessment

It is beyond the scope of these guidelines to provide an in-depth review of the field of risk assessment. Only a brief synopsis of this area will be presented. Risk assessment is the process of collecting information, interpreting the information and establishing a plan to manage the perceived risks (Maden 1996). There is a considerable body of research that has been devoted to understanding the process of risk assessment and to ensure the process is efficient and effective. A major outcome of this literature is that risk assessment is a highly complex and controversial issue.

The potential impact of risk assessment on the individual and for the community is high. If a clinician arrives at a decision that a person is highly likely to cause harm to others, then he or she may recommend the person be held for compulsory treatment or incarcerated in prison, limiting the person's freedom and human rights. A decision that the person is highly probable to cause harm being over-estimated could result in the person being unfairly held. On the other hand, if the clinician determines the person presents a low probability of causing harm then the recommendation would be to release the person from detention. The consequence for an incorrect decision in this case could place the community at risk. Research evidence suggests that clinicians are likely to make conservative judgements in these circumstances and as a result are more likely to make judgements that the person poses a high risk and requires care.

Early approaches to risk assessment were made on the bases of clinical judgement. That is, the clinician interviewed the person, and examined available information and made a prediction that a person might in future cause harm, based on the clinician's professional training and experience. This approach has been shown to have very poor predictive value. A leading researcher, John Monahan (1981) reviewing studies on prediction suggested that at best clinicians were accurate in no more than one out of three predictions of future violence.

At each stage of the risk assessment process there are opportunities for judgement errors, stereotypical biases and cognitive heuristics to influence the outcome (Ward and Eccleston 2000). The task of knowing what kind of information to gather, knowing which information to weigh and prioritise as important in making a decision, and then synthesising this to produce a reliable prediction of future behaviour is a very complex and poorly defined task. It has been demonstrated that clinicians will disagree in their predictions of risk when they are examining the same data (Ward and Eccleston 2000). It has also be suggested that assessments frequently occur in highly controlled setting such as hospitals or prisons where it is difficult for clinicians to adequately assess the impact of contextual factors that may trigger dangerous behaviour.

To compensate for the apparent deficits in clinical judgement there has been a movement towards developing a more systematic and reliable approach to risk assessment. This approach called actuarial risk assessment is based on statistical/regression analysis of large groups of people who have committed offences or violence (Litwick 2001). The research focuses on common factors (ie, type of offending, age of first offence etc) among the group that can be shown to be statistically significant in predicting/mediating future offending. From this analysis it is possible to identify specific risk factors that can be quantified and used to make predictions about the probability that a person will offend. Risk factors identified by actuarial methods fall within four domains:

1. dispositional factors such as psychopathy, cognitive variables, and demographic data
2. historical factors such as adverse developmental history, offending, mental health issues, and treatment compliance
3. contextual antecedents such as criminogenic needs (risk factors for criminal behaviour), deviant social networks, and lack of positive social support
4. clinical factors such as diagnosis, and substance abuse (Borum 1996).

A number of highly regarded psychometric instruments based on this approach are used in the forensic and mental health settings. For example, the HCR-20 is an instrument that uses 10 items that focus on historical variables, five items that reflect current clinical status and personality characteristics and five items that focus on future risk or violent behaviour. This instrument is used within New Zealand in correctional and forensic settings.

While there is growing evidence that actuarial predictions are superior to clinical judgment on a number of tasks, this is not the case for prediction of dangerousness. Critics of the actuarial approach note that there needs to be considerable work to improve the validity and usefulness of this methodology (Litwick 2001). It has been observed that, while statistical methods can compare across large groups of offenders to discover potentially important risk factors, this method attempts to predict an individual's behaviour based only on his or her comparison to an offender group. That is, the actuarial process tends to ignore the unique aspects of the offender's circumstances. It should also be noted that actuarial methods continue to ask users to make clinical judgements about the offender's characteristics based on presentation and file information. For example, the Psychopathology Check List Revised requires that the clinician make a judgement on whether the person being assessed demonstrates empathy.

Another serious criticism has been that the risk factors identified are historical, static factors that are not open to intervention or changes made on the part of the individual, though as noted above, newer actuarial tools, such as the HCR-20, make some attempt to include current and future factors in making predictions. It has also been suggested that actuarial methods are only useful when predicting behaviours that occur at a high rate (approximately 50 percent); for behaviours that are rare events then there is limited predictive value (Litwick 2001).

There has been a movement among clinicians to use a combination of actuarial methods, guided clinical interviewing, and assisted actuarial approaches in risk assessment. This combination allows the clinician to enhance the quality of clinical judgement with actuarial information and to take account of the unique circumstances of the individual to come to a final decision about the probability of future offending.

It is now recognised that it is not possible to be definitive about the probability that a particular person will or will not cause harm in future (Mikkelsen and Stelk 2001). There has been a move away from such a dichotomous approach to one that places emphasis on making qualified estimates of the probability that a particular behaviour will occur in future. Monahan and Steadman (1996) drew an analogy between how weather predictions are made and how risk assessments are communicated. He suggested that predictions of future offending/violence should be made with a given level of uncertainty, and that the time-frame for the prediction be specified. For short time periods (ie, 24 hours) it might be possible to make predications with a

high degree of certainty; however, the longer the time-frames the greater the degree of uncertainty (ie, over six months).

Risk assessment and intellectual disability

There has been little published work on risk assessment with people with an intellectual disability. There are no specific processes or instruments that have been validated for this population. Consequently risk assessment for people with an intellectual disability has predominately used a clinical judgement approach (Johnston 2002). While there have been suggestions that offenders with an intellectual disability would share many of the characteristics of offenders in the general population, this is considered controversial and has not been empirically demonstrated. Actuarial methodologies have not been normed for people with an intellectual disability. Data on actuarial methods have focused on offenders and people with mental illness. There would need to be significant research to make these approaches suitable for people with an intellectual disability and to meet the cultural needs of the people of New Zealand.

Turner (2000) described a number of risk factors that have been identified for offenders who have an intellectual disability. These include mental illness (particularly where treatment compliance has been poor), brain damage and epilepsy, and substance abuse. Unstable early childhood backgrounds (including loss of parents, placements in multiple homes etc) and very limited financial circumstances have also been associated with male offenders with an intellectual disability.

The risk assessment process advocated in these guidelines is a functional approach to the assessment of offending behaviour. Under this approach the assessment focuses on why the person is behaving in a particular way, and on the identification of contingencies that maintain the offending behaviour. This approach does not focus simply on the offending behaviour (Clare and Murphy 1998). The operation of this approach does not preclude the use of research-generated risk factors (actuarial risk factors) to help the clinician in the assessment and in determining probability of future offending. Such information can be used to inform the clinician about factors that are likely to be impacting on the person and their behaviour, and by gathering this information in conjunction with a holistic assessment of the person (eg, his or her skills base, adequacy of his or her support, relationships with family/whānau, cultural issues, etc) to build a comprehensive picture of the person and his or her circumstances. It is from this broad understanding that qualified statements of the probability of future offending may be predicted and intervention plans for rehabilitation crafted.

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