THE IDENTIFICATION OF RECIDIVISM INDICATORS IN INTELLECTUALLY DISABLED VIOLENT INDIVIDUALS

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JO COURTNEY

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Abstract.

The Assessment of Risk and Manageability in Intellectually Disabled IndividuaLs who Offend (ARMIDILO) was developed to address the need for assessment tests specifically designed for intellectually disabled (ID) individuals who offend. This is the first study focusing on the application of the ARMIDILO by using comparative current risk assessment tests to evaluate the ARMIDILO as an effective risk assessment tool. In this research 16 ID people who have recorded sexual and or violent behaviour offences were evaluated using the Violent Offender Risk Assessment Scale (VORAS), Static-99 and ARMIDILO risk assessment tests. The ARMIDILO, VORAS and Static-99 assessments were completed using individual history files kept within the Regional Forensic Psychiatric Service. The VORAS and Static-99 were adapted to incorporate reported, but not charged or otherwise litigated offences and convictions. The adapted tests were then compared against the ARMIDILO as a risk assessment tool.

Analysis of the ARMIDILO showed strong validity in assessing ID people who offend. The main strength of the ARMIDILO is in identifying the risk needs of the ID person who offends and may be an effective management test when used in assessing individual needs and program implementation. Risk assessment through the ARMIDILO showed similar results to Static-99 but compared only moderately with the VORAS in measuring the risk of re-offending. Future research with a larger population may further validate the reliability of the ARMIDILO as an assessment tool. Adaptation of the current score sheet for use by non-clinical and correctional staff may prove cost effective.

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Chapter 1: Introduction.

The aim of this research is to evaluate risk assessment tools that focuses on intellectually disabled (ID) people who offend. In the last two decades, New Zealand and much of the developed world has seen the prison population increase (Harpham, 2008). Craig, Browne, Stringe and Hogue (2008) reported that following an international survey involving over 23,000 inmates, people with mental disorders were disproportionably over-represented compared to the non-offending population. These findings were confirmed by an additional 62 surveys that estimated 20 per cent of prisoner's required mental health care (Fazel & Danesh, 2002: Weinstein, Burns & Newkirk, 2000). More recently a report by the United States Department of Justice indicated that up to 50 per cent of inmates required mental health care (James & Glaze, 2006). Estimates by Beggs and Grace (2008) estimated ID people who offended as being "four times as likely to have been reconvicted of a sexual offence and more than twice as likely to have been reconvicted of a violent or general offence compared to any other group" (2008, p.11). Craig and Hutchinson (2005) found over a two year period, ID sex offenders were 6.8 times more likely to re-offend than non- ID offenders. There is overwhelming evidence that ID people who offend are high risk and are significantly present within correctional facilities yet there is no "reliable static actuarial measure specifically for the population of people with learning disabilities" (Craig, Browne, Stringer & Hogue, 2008, p.289).

Currently there are no tests which predict recidivism in recorded offenders who are (ID). The Assessment of Risk and Manageability for Intellectually Disabled Individuals who Offend (ARMIDILO), as shown in Appendix 1, is a test designed to address this issue (Boer, Haaven, Lambrick, Lindsay, McVilly, Salkdalan & Smith, 2008). Effective management programs based on a test that is relevant to ID people who offend may help the ID person achieve a safer and fuller life (Claire, 1993; Day, 1994; Lambrick & Glaser, 2004). The offending ID person's behaviour frequently interferes with, restricts or prevents access to everyday routines, settings, activities and relationships (Begley, 2007). Their behaviour poses a significant challenge to residential staff, caregivers and families / whānau (Eddy, Reid & Fetrow, 2000). Improved risk management and dedicated programmes may reduce cases of anger, violence and or inappropriate behaviour and sexual deviancy (Taylor, Novaco, Gillmer, Robertson & Thorne, 2005). Stakeholders and care-provider wellbeing, safety and working environment could also be improved by the detection of recidivist indicators (risk factors) (Inderbitzin, 2006).

This research will investigate if the ARMIDILO is an effective risk assessment tool when used to test people who are ID and have recorded offending behaviour. This research may also provide information that could be considered for program management planning. Additional findings from this research may include:

The measure of an individual's risk.

Some measure of the need for a risk management program.

A specification of treatment and supervision.

An assessment of the ability the ID person has to manage their overall current dynamic risk factors.

Whether the ARMIDILO can be adjusted to meet individual structured clinical risk assessment needs.

Whether the numerical scoring of the ARMIDILO can provide an actuarial risk baseline.

1.1 Background.

Studies in Australasia have been conducted to reduce recidivism in offenders by assessing the extent of risk (Ward & Dockerill, 1999; Ward & Stewart, 2003; Ogloff & Davis, 2004). The introduction of risk management assessments in the custodial system and programmes addressing the needs of offenders, specifically those who have committed serious offences, has seen a reduction in recidivism (Andrews & Bonta, 1998; Hans & Thornton, 2000; Shlonsky & Wagner, 2005). The public may see prisoners treated favourably whilst victims are marginalised (Evans, 2007). This perception may have prevented the development and progression of risk assessment and specialised training programs (Chadee, Austen & Ditton, 2006).

Public opinion does not make decisions on how offenders are treated but the public has "the power to influence the politics that hold the purse strings" (Huspek, 2007, p.824). Political party manifestos avoid the sensitive issues of

shorter, treatment-based sentences (Gottschalk, 2007; Spillane, 2007). The short term benefits of longer sentencing are more to the voting public's liking (Spillane, 2007) and policies such as 'Restorative Justice' may be seen as a lenient approach to perpetrators of crime (Braithwaite, 2007; Rodriguez, 2007).

The prison system in many developed countries is struggling in this environment and the ID offender may not be considered a high priority (Craig & Hutchinson, 2005). The ID person may be marginalised and overlooked in current offender management (Flynn, 2006; McDonagh, 2007).

1.2 Environment.

Environment is a key factor in assessing risk for an ID person. The ID person may have limited control over their environment and may be unsettled by change (Flynn, 2006). Often an ID person is cared for within their family home until they reach adulthood or become too difficult for their primary carer-giver to handle (Harris, 2003). In recent years, within developed countries, the large institutionalised hospitals that catered for some ID people have been closed and small supported residential care homes established (Harris, 2003).

The ID person convicted of an offence may find the prison system has limited suitable resources and the ID offender may be subjected to aggression and exploitation by other prisoners (Monahan, Steadman, Silver, Appelbaum, Robbins, Mulvey, Loren, Thomas & Banks, 2001). Within the prison system, ID people can be vulnerable and subjected to violence and abuse (Bonta & Hanson, 1996). This may result in the ID person being moved to low risk areas with non-

violent sexual offenders who may exploit, as well as influence, the ID person and encourage inappropriate behaviour (Dempster & Hart, 2002).

The ID person in residential care may also be at risk (Monahan, *et al*, 2001). Although largely successful in terms of everyday care, this environment may not address the risk needs of the ID person (Claire, 1993). ID people may be moved repeatedly depending on finance and their own behaviour (Cockram, 2005). To provide the most suitable and consistent treatment, the ID person requires a stable, needs based, environment (Calcraft, 2007). Security in residential care is varied (Wills, Ritchie & Wilson, 2008). This is particularly an issue for ID people who display difficult behaviour, where an open home would not be appropriate for their care or, in some cases, for the safety of the public (Worling, 2001). In addition, individual needs may be overlooked (Zebehazy, Hartman & Durando, 2006). ID people may have language disability, impaired reasoning, poor social skills and psychological illnesses which could make them vulnerable (Claire, 1993; Zebehazy, *et al*, 2006). Their inability to defend themselves physically and mentally makes them open to exploitation (Claire, 1993; Hogue, 2002). The ID person could easily be manipulated and coerced into inappropriate behaviour, including the misuse of alcohol and drugs, leading to offences against property and or others (Paradise & Cauce, 2002).

Due to difficulties in processing and testing within this population group, many ID people who offend are sent directly to prison (Underwood, *et al*, 2005). Poor screening and inadequate management of ID offenders have highlighted numerous concerns, resulting in attempts to provide better screening and

alternative care and treatment (Boer, et al, 2008). Appropriate assessment is imperative if the high risk of recidivism in offending ID people is to be reduced.

1.3 Risk Needs.

One model that has been suggested to combat recidivism amongst all offenders is the 'Risk, Needs, Responsivity Model' (RNRM) (Ward & Stewart, 2004; Ogloff & Davis, 2004). This model attempts to match the treatment to a person's ability and learning style (Andrews & Bonta, 1998; Ward & Stewart, 2004; Ogloff & Davis, 2004). The RNRM ensures that treatment is fully understood by the offender and therefore there is minimal disruption that could impede the effectiveness of therapy (Ward & Stewart, 2004; Ogloff & Davis, 2004).

The RNRM acknowledges offenders have limited abilities to secure goods, limited capabilities and multiple conflicts (Ward & Stewart, 2003; Ogloff & Davis, 2004). The emphasis is not on improving the quality of the offender's life, although this is incidental, but identifying the 'Big Four' risk factors; antisocial attitudes, history, antisocial peers and personality (Andrews & Bonta, 1998). The focus on rehabilitation of criminogenic need and dynamic risk factors is driven by risk assessment (Andrews & Bonta, 1998). The ID person who offends could benefit from RNRM assessment. The bridging causes of re-offending and treatment strategies are linked by addressing relapse prevention and taking into account assumptions of re-offending, namely that identifying, reducing or eliminating dynamic risk factors will decrease recidivism (Andrews & Bonta,

1998; Ward & Stewart, 2004; Ogloff & Davis, 2004). The RNRM targets the criminal and non-criminal requirements of the offender.

1.4 Characteristics of Intellectually Disabled Offenders.

Identifying ID people within the prison system is difficult as most prison services do not assess an offender's intellectual functioning (i.e. intelligence quotient or IQ) routinely (Hayes, 2005). The population within this research will be identified as ID on the basis of an IQ of 70 and below or other adaptive deficits (Sadock & Sadock, 2004). Many ID people have 'physical, cognitive and sensory disabilities' (Claire, 1993, p.168; Zebehazy*, et al*, 2006, p.598) and are inclined to be more at risk of infections or infectious disease, which can affect IQ testing reliability. Failure to take into account "variation in IQ testing" (Lambrick & Glasser, 2004, p.382) has resulted in offenders receiving custodial sentences which may be inappropriate to their needs. An example of this is the case in the United States of a convicted rapist receiving residential care which was later revoked when IQ testing was disputed (Martin, 2004).

1.5 Care Giver.

As the ARMIDILO incorporates a care giver component, the care giver and their interaction with the ID person is relevant to this research. People with ID have usually been institutionalised at some point in their lives (Flynn, 2006). There may be a high staff turnover within these institutions. Staff in the health care sector are often underpaid and under trained (Flynn, 2006; Calcraft, 2007). Although the issues of a poorly paid workforce need to be addressed, the safety of

the clientele is of paramount importance (Flynn, 2006; Calcraft, 2007). Training can address some of the issues and at the same time allow management the opportunity to assess their staff more thoroughly. The training of staff is an important consideration, yet people within the care service often feel that they lack adequate training (Chaplin, 2004). Care givers may be unaware how best to deal with clients and subsequently increase the ID offender's risk factors (Flynn, 2006; Calcraft, 2007; McDonagh, 2007). Douglas (2008) established that in a psychiatric residency program one-quarter of trainees expressed some concerns as to their capabilities. Lack of expertise, resources and special attention directed toward the ID population may lead to suboptimal health care (Nehama, Dakar, Stawski & Szor, 2006).

1.6 The Research Objective.

Studies have shown that statistical analysis was more accurate in predicting recidivism than clinical assessment (Levenson & Morin, 2006). Grove, Zald, Leblow, Snitz, and Nelson's research reported that there was an eight per cent accuracy prediction rate of recidivism by violent offenders when assessed by clinical professionals and strongly recommended the actuarial instrument (2000). Comparative investigation into the effectiveness of clinical judgement or actuarial instruments suggests that current assessment tests are more accurate than clinical judgement (Hanson & Morton-Bourgon, 2004). Lindsay, Todd, Hogue, Taylor, Steptoe, Mooney, O'Brien, Johnson and Smith (2008) noted that the "mean correlation coefficient for prediction of recidivism using actuarial methods was .22 whereas for clinical methods .08 was recorded" (p. 98). Assessment tools that

were accurate, cost effective and had the facility for non- professional or residential staff personnel to administer were needed. Considerable evidence was amassed confirming the accuracy of statistical techniques over clinical judgement risk assessment (Grove, *et al*, 2000; Monahan & Steadman, 2001).

Quantitative tests have been subjected to "strict actuarial methods based on formulae derived empirically from one or more samples" (Douglas, Yeomans & Boer, 2005, p.479). Analysis of comparative current risk assessment tests will be conducted and used to validate results obtained from the ARMIDILO test in this research. Comparing one test against another is a well established research practice in developed countries (Barbaree, Seto, Langton & Peacock, 2001; Bartash, Garby, Lewis & Grey, 2003; Craig, Beech & Browne, 2006; Lindsay, *et al*, 2008). Using comparisons is not without criticism particularly where there are differences in variables being assessed (Hanson & Bussiere, 1996; Dempster & Hart, 2002). Risk assessment tests utilised in this research will be the Violent Offender Risk Assessment Scale (VORAS; Howells, Watt, Hall & Baldwin, 1997) and the Static-99 (Hanson, 1999-2002) which is a combination of Rapid Risk Assessment for Sex Offence Recidivism (RRASOR;Hanson, 1997) and the Structured Anchored Clinical Judgement (SACJ; Grubin, 1998).

The VORAS was adapted to incorporate care giver reports (i.e., Staff-reported, but not legally charged) of sexual and or violent behaviour incidents and or convictions as shown in Appendix 4.1 and 4.2. The Static-99 (Hanson & Thornton, 1999), presented in Appendix 3.1 and 3.2, was also adjusted to include such staff reported offences for this research. The quantitative nature of these assessment tests ensures they can be completed by non-professional

administrators such as prison officers and or care staff, which is not only cost effective but efficient (Hanson 1997, Hanson & Thornton, 2000). Various studies into the predictive effectiveness of the Static- 99 and VORAS show that there are no significant differences and they appear to be consistent in their ability to predict recidivism effectively (Hanson, 2004).

Using empirical measurement tools as opposed to unguided clinical judgement is now considered to be an effective and reliable source for determining recidivism in high risk offenders. The Static- 99 has been found to be significantly predictive of recidivism in violent and sexual crimes with ID offenders (Lindsay, *et al*, 2008). In their recent compartive study of risk assesment testing Lindsay *et al* (2008, p.106), found that the Static- 99 'achieved a significantly predictive value area under the curve (AUC = .71, p = .000) and emerged as having consistent predictive accuracy'. The Static-99 contains ten risk factors for predicting the recidivism of a person in committing additional sexual offences. These ten factors can be divided into four subcategories which include anti-sociality behaviours, persistent sexual offending, range of potential victims and sexual deviance (Craig, *et al,* 2006). The test can be completed by a non-clinical staff member, for example a prison officer. The person completing the test records the age at which the offender first received a conviction, if they lived with a lover over a two year period, non-sexual violent convictions, sexual convictions, gender of the victim and if the victim was related to the offender. The scoring of the Static-99 indicates whether the individual is of low, low to medium, medium to high or is high risk of sexual-offending and may also indicate other non-sexual violent recidivism (Lindsay *et al*, 2008). Scoring is completed using guidelines advised by Harris, Phenix, Hanson and Thornton, (2003; the revised scoring rules)

which replaced those of Hansen and Thornton (2000), the former, shown in Appendix 3.1 and 3.2.

The VORAS was initiated primarily as a test that could be employed for ascertaining recidivism likelihood in convicted violent offenders (Howells & Day, 2006). As with the Static-99, the VORAS can be completed by non-clinical staff using the records of the offender. The VORAS has shown a reasonable predictive capacity (area under the receiver operating characteristic curve = .762 in a correctional sample (Polaschek, Hudson, Ward & Siegert, 2001). The VORAS uses a logical step by step procedure to determine if an offender has the probability of violent re-offending. The VORAS records the age the offender was when first convicted and takes into consideration drug and alcohol convictions and current use. The VORAS is divided into two sections; part one tests the level of harm and part two the probability of violent re-offending. When the two scores are added, the score indicates whether the individual is of low, medium or high risk. For this research reported instances will be added to questions two, three and four, this can be seen in Appendix 4.1 and 4.2.

The ARMIDILO is a structured risk and management instrument developed for assessment of developmental, intellectual or learning-disabled people (Boer, et al, 2008). The ARMIDILO is divided into four classifications; Stable dynamic items (environmental), Acute dynamic items (environmental), Stable dynamic items (client) and Acute dynamic items (client). Environmental items, both stable and acute, are directed at the client's level of care. Questions are answered by a main care giver, an element which has not previously been used in assessment risk analysis. The questions cover the length of service, training and

client knowledge, as well as reporting methods and client management. The second part of the questionnaire covers the stable and acute dynamic items and is answered by the ID offender. This part of the questionnaire focuses on any changes in the ID offenders living arrangements or relationships as well as their violent and sexual tendencies. Scoring of the ARMIDILO uses a positive and negative algorithm to obtain a final score. Positive scoring occurs if there is a 'definite' or 'possible protective factor' and a negative score indicates there 'may be a problem' or there 'is a problem' (Boer, et al, 2008). Since the present research into the validity of the ARMIDILO is the first to date, the strength of the test is conjectural but also informed by the empirical literature in the area.

To test the hypothesis that the ARMIDILO can be used as a risk assessment tool for offending ID individuals, a population of 24 male and two female subjects over 18 years of age under the care of the Regional Forensic Psychiatric Service (RFPS) was reviewed. These 24 individuals consist of all ID people who offend, under RFPS care within the Hamilton district in the last twelve months (2007-2008).

1.7 Summary.

The lack of validated assessment tools for ID offenders within the correctional system would suggest that the ID offender is not properly screened and therefore their risk can not be effectively treated. Currently there are no accurate assessment tools which focus on their needs and treatment. The major objective of this research is to test the effectiveness of the ARMIDILO in assessing the risk management of offenders with ID. An analysis of comparative

tools to validate the results obtained from the ARMIDILO consists of the VORAS and the Static- 99. The hypothesis for this research is that the ARMIDILO will show significant differences between sexually violent and non-sexually violent individuals and indications of program needs.

Chapter two presents the methods used in this research, including the subjects, apparatus and software. Chapter three reports the results obtained from the ARMIDILO, Static – 99 and VORAS. Chapter four discusses results and suggests further investigation. The final chapter addresses the hypothesis of whether the ARMIDILO results show significant differences in offending ID people and if treatment development could be initiated from the information given within the test. Conclusions will then be drawn from the research.

Chapter 2: Method.

2.1 Subjects.

Ethical approval for this study was obtained from the Psychology Department, University of Waikato ethics committee. Ethical approval was also obtained from the Waikato District Health Board to access the client files.

The RFPS at Waikato Hospital, Hamilton identified 26 clients for inclusion in this project. All individuals were assessed using Static - 99 and VORAS. Ten subjects were excluded due to incomplete file information. The ARMIDILO assessment was completed on the remaining 16 individuals. See Table 1 for demographic information regarding the subjects.

Table 1: Client list showing number of subjects with their randomised identification numbers under Ref, age in years, gender (MG = male gender, FG = female gender, ethnicity (E = European descent, M = Māori descent), sexual or violent offences/instances (S = Sexual, V = violent).

Number	Ref.	D.O.B.	Age	M/F	Ethnicity	Sexual/Violent
1	718	05/01/1982	25	MG	E	S
2	697	02/05/1964	43	MG	M	V
3	206	23/09/1979	28	MG	M	S
4	927	24/01/1979	28	MG	M	V
5	327	10/10/1964	43	MG	M	V
6	762	25/10/1989	18	MG	M	V
7	566	18/07/1989	18	MG	M	V
8	597	16/06/1975	32	MG	E	S
9	19	30/12/1976	31	MG	M	S
10	953	06/12/1969	38	MG	M	S
11	165	15/10/1969	38	MG	E	S
12	168	03/11/1977	30	MG	M	V
13	49	20/12/1965	42	MG	E	V
14	141	14/09/1952	55	MG	M	V
15	299	01/07/1972	35	MG	M	V
16	546	18/03/1988	19	FG	M	V

The 16 research subjects, 15 male and one female, consisted of six sexual offenders (mean age: 32 years, SD: 9.68, range: 25 to 38 years), and 10 non sexual violent offenders (mean age: 33.1 years, SD: 12.4, range: 18 to 55 years). Table 1 shows age, gender and ethnicity and offences committed.

Table 2: Care provider list showing number of subjects with their randomised identification numbers under Ref, position held, age in years, gender (M = male gender, F = female gender, ethnicity (E = European descent, M = Mãori descent), length of service in years.

Ref.	Position	Age	Gender	Eth.	Care(Years)
718	Carer	58	FG	M	5
697	Carer	58	FG	M	5
2 06	Carer	58	FG	M	5
927	Supervisor	64	MG	E	20
327	Carer	34	MG	M	4
762	Supervisor	64	MG	M	20
566	Carer	58	FG	M	5
597	Carer	39	MG	E	2
19	Supervisor	64	MG	M	20
953	Supervisor	35	MG	M	16
165	Parent	65	MG	E	32
168	Supervisor	64	MG	M	20
49	RFPS	42	MG	E	15
141	Carer	46	FG	M	28
299	Supervisor	36	FG	M	20
546	Supervisor	36	FG	M	20

Caregivers who answered the environmental questions of the ARMIDILO assessment included: one parent, one RFPS staff member, seven supervisors and seven care support staff. A total of 16 client carers participated (mean age: 51.3 years, *SD: 12.9*, range: 34 to 65 years), their length of service spent with the individual client varied (mean time: 14.8 years, *SD: 39.4*, range: 2 to 32 years). Subject age and ethnicity characteristics are displayed in Table 2 along with length of care with the client.

2.2 Apparatus.

The apparatus used in this research included the SPSS 15.0 (Statistical Package for the Social Sciences, version 15) to analyse data from the test results. Microsoft Excel 2002 and Microsoft Word 2002 were used to store data and the completed tests. An Excel spreadsheet randomising function allocated a random number to each client file. All stored files and data were password protected. The three tests used were the Static-99, the VORAS and the ARMIDILO. The design and structure of each is discussed below.

2.2.1 Static-99 Design

The Static-99 is a risk assessment tool used to evaluate the risk of recidivism in people who have committed sexual offences. The tool was designed for non-clinical personnel such as corrections officers to administer based solely on offender history. The Static-99 is divided into ten questions; the risk factors from one to ten include how old the person was at the time of their first offence, had they ever lived with anybody, prior sex offences, non contact sex offences and any male victims. In this study, non-adjudicated offences were included to see if the inclusion of non- reported offences would increase the sensitivity of the risk assessment instrument. Therefore, in sections three, five and seven any reported offences that had not resulted in convictions have been included. Within this category of risk factors, scores are weighted for multiple offending. The maximum score a person can obtain is twelve, although anything over six is

considered within the high risk category. Risk rating is obtained by the sum of the values from all questions. The risk rating is divided into four equal sections; 0-1 low risk, 2-3 medium-low risk, 4 -5 medium - high and 6+ high.

2.2.2 VORAS Design.

The VORAS, like the Static-99, can also be completed by non-clinical personnel. The VORAS is designed to evaluate the level of violent offences of a convicted person. This research has adapted the VORAS to include reports of instances, irrespective of conviction. The VORAS is divided into two sections; the first section (A) covers the level of harm, including current violent offences and any previous serious offences, while Section B assesses the probability of recidivism. Section B analyses previous violent offences or instances, previous non-violent offences or instances, age at first offence, use of alcohol and other drug misuse. Section A has a maximum score of nine and section B has a maximum score of 21. Section A indicates the level of harm, 1-4 demonstrates a low to medium level and 5-9 indicates a medium to high level. Section B indicates the probability of violent re-offending, 1-10 demonstrates a low to medium level of risk and 11-21 indicates a medium to high level of risk (Hanson & Thornton, 1999-2002).

2.2.3 ARMIDILO Design.

The ARMIDILO questionnaire is divided into four sections:

Stable Dynamic Items (Environmental and Staff SDIES)

Acute Dynamic Items (Environmental and Staff ADIES)

Stable Dynamic Items (Client; SDIC)

Acute Dynamic Items (Client; and ADIC)

The ARMIDILO uses vocabulary that may be more acceptable to North American ID people who offend. When used in a New Zealand setting, some of the language may need to be adapted, for instance; the use of the word 'Mom' would need to be replaced by 'Mum'. The first two sections are answered by the client's main caregiver and cover stable dynamic items and acute dynamic items. The stable dynamic items are long-term variables, for instance, place of residence and length of caregiver/support staff service. Acute dynamic items focus more on immediate changes, particularly within the last six months and include factors such as the client's primary support worker or environment. The remaining two sections are answered by the client and explore their stable dynamic items and acute dynamic items. The score sheet summarises the questionnaire responses into 12 graded scores in the caregiver section and 18 graded scores within the client section using a five point scale from -2 to 0 to +2.

SDIES includes questions such as: Do you like this work? How long have you been doing this work? Tell me about your client? Do any of your clients present special challenges for you? These questions are directed at staff, care givers and or parents to ascertain their level of attitude towards the ID person. It has been reported that the people who have close contact with the ID person can influence them and their attitude is a critical variable (Berry, shah, Cook, Greater, Barrowclough & Weardon, 2008; LaSala, Connors, Taylor, Pedro & Phipps,

2007; Kusel, Laughaarne, Perrington, McKendrick, Stephenson, Stockton-Henderson, Barley, McGaul & Burns, 2007).

ADIES includes questions such as: Are there any recent social, family, or anything else that has happened that we haven't discussed, and which may affect your client's ability to manage his/her behaviour effectively? Has your client any changes in his/her living arrangements that he/she is having problems with? What do you think your client thinks about the new place? Do you think they miss their old place? Research into people with ID frequently reports their difficulty in coping with change (Lucas, 2007: Davies & Girauld-Saunders, 2006).

The questions covering changes to a client's environment also include: who has your client spent time with lately? Does he/she spend time with new residents in a manner that suggests he/she is grooming them or becoming abusive? These questions are specifically directed at the changes the client may have to victim access (Levinson & Morin, 2006). Changes in the use or access to intoxicants are covered by questions such as; Do you have any concerns about your client in terms of him/her trying to use alcohol or drugs?

SDIC is the longest part of the questionnaire and covers 12 main points. The first point is the client's attitude toward and compliance with supervision. Some of the questions in this category are: Do you know why you have to live here? What do you think about the rules? Do you think you need the rules? Research has shown that a lack of compliance by the client may result in re-offending (Boer, *et al*, 1997; Hanson & Harris, 2000; Quinsey, *et al*, 2006). The attitudes and compliance with treatment is evaluated through questions such as: Who are the people trying to help you keep safe? How are they trying to help

you? Do you think it (treatment, medication, training programmes) is helping you? What have you learnt in the programme? How will you know when you're ready to stop taking treatment? The client's attitude, insight and compliance with treatment can affect their self management and ability to cope with their own behaviour (Quinsey, *et al*, 2006).

ADIC incorporates sexual deviance, sexual preoccupation, victim selection and acquisition or grooming categories. Many ID people have limited access to intimate relationships and are often victims of abuse, which may distort their views of acceptable sexual practices (Lindsay, 2002; Craig & Hutchinson, 2005). The questions in these categories include: Have you ever had sex with someone? Describe it for me. Did you like it, or did someone force you do to something sexual with them? Have you ever got in trouble because of doing something sexual? What happened? When is sex good or OK? When is it not OK? Are you allowed to have sex with other guys in the residence (or prison, etc)? Have you been able to have sex even if it's not allowed? How did you manage that?

SDIC also covers the emotional coping ability of the client. The client was asked questions such as: What sorts of things make you angry? (Ask the client about his visitors [or staff members] and try to find out how he/she reacted last time someone didn't show up when they were supposed to; or, how he/she reacted when a bus or ride or teacher [or anyone] didn't show up as scheduled). For example, "how did you feel when your Mom didn't show up to visit yesterday? Or, "what would you do if the bus was late?" The answers to these questions gave an indication of self governance and whether the client was aware and able to

control themselves in stressful situations. A follow on to self governance was self-efficacy. Many people with ID are treated the same way as adults treat small children. This leads to the ID person having feelings of powerlessness, low self esteem and a poor assertiveness (Boer, et al, 2008). The questions in this category cover: Do you like living in this place? Where would you like to live someday? What would you like to do some day for a living? Do you have plans for the future? What are they? What is the biggest problem you have at the moment? How can you solve that?

ID people often have difficulty in communicating their feelings and may have poor role models within their environment. Not only sexual relationships but also peer relationships can be difficult for the ID person due to their inability to form normal, healthy relationships. Questions covering the clients' relationship skills with sexual and non-sexual relationships include: How easy is it for you to make friends? Tell me about your best friend. Have you ever had a girlfriend/boyfriend? Tell me about the relationship. How about now? What is special about a girlfriend (or boyfriend)?

Misuse of drugs and alcohol has been found to affect the recidivism of the ID person to a greater degree than a non-ID person (Boer, et al, 2008). Within this section, the client was further asked: do you drink alcohol? (If yes: how much do you drink at a time?); do you smoke dope or use drugs? (If yes: how often/much?); have drugs or drinking caused any problems for you? These questions ascertain whether or not the client is aware of their behaviour under the influence of drugs and or alcohol and also gives an indication of their ability to

cope with substance misuse (Lanza-Kaduce, Bishop & Winner, 1997: Dembo, Wareham & Schmeidler, 2007; Khan, Falshaw & Friendship, 2004).

This section also covers the clients' impulsivity; this relates to both sexual and violent offending. Some of the indications of problems with impulsivity are increases in behavioural outbursts and mood fluctuations. The questions relating to this topic are: Do you sometimes act before thinking? Can you give me an example? Do you get bored easily? What do you do when you get bored? What's the silliest thing you've ever done on the spur-of-the-moment?

The next sections deal with threats of violence to self or others, mental health issues and other unique considerations. Often, a person with ID resorts to aggressive, violent behaviour towards others and, in some cases, themselves. Self harming can be an indication of the risk of violent offending (Boer *et al*, 2007). Examples of these questions are: Have you ever been so upset that you wanted to hurt yourself? Have you ever been so upset you wanted to hurt someone else? What is the worst you've ever hurt someone? How about yourself? Often, people with ID exhibit manifest forms of behaviour such as poor speech, poor eating habits, poor hygiene, lack of empathy, inappropriate behaviours and inappropriate social skills. These may be contributing factors to additional mental illnesses that the ID person can suffer from. It is likely the ID person may also suffer from other psychological and or psychiatric illnesses, such as bi-polar, autism and schizophrenia. The ID person's ability to recognise and or be treated effectively for these illnesses can have an impact on their violent or deviant behaviour. The ARMIDILO focuses on these issues with questions such as: Have you ever seen a doctor for any mental health problems? Like what? Do you take any medications

for your moods or anything like that? How does it help? How do you know if you are getting unwell? What do you do when that happens?

ADIC covers any changes that the client has experienced over the past year. Items one to six look at the changes in the client's attitude or behaviour towards supervision or treatment, sexual preoccupation, victim related behaviour, emotional state, coping strategies, mental health status and any other unique considerations. Due to the variety of themes investigated, the questions range from how have you been feeling lately? (If up and down, or mostly down, why?)' to 'have you been using alcohol or drugs in the last 3 months? How much?' The impact of change beyond the ID person's control may act as a catalyst for deviant behaviour as a client may feel the only recourse they have is to act violently to the situation.

A key aspect of the ARMIDILO design is the score sheet. The score sheet is also divided into four sections. In part one and two the scores from the caregivers' answers are recorded and in parts three and four, the scores from the clients' answers are recorded. The scores range from -2 to +2, which are risk management ratings. A score of -2 is defined as a definite protective factor, -1 is a possible protective factor, 0 indicates no problem (or the item is neutral or irrelevant) and 1 that there may be a problem and 2 there is a problem. Each section is summed then divided by the number of subsections, which calculates the mean for each section. The score from each section is then added and divided by four, giving a total score for the ARMIDILO questionnaire, as shown in the ARMIDILO scoring sheet, Appendix 2.

Chapter 3: Results.

The Static-99, VORAS and the ARMIDILO are analysed in this chapter. The Static-99 and the VORAS adapted and un-adapted scores were analysed and differences noted. Content and criterion validity of the three tests was investigated using current psychological assessment theory. The Static-99 and VORAS were then compared against the ARMIDILO with final analysis of the ARMIDILO as a risk assessment test and measurement effectiveness.

Data from the tests were analysed using the statistics software SPSS version 15.

3.1 Summary Data.

Descriptive statistics, such as the individual test scores, the VORAS and the ARMIDILO sub-sections cores and the total scores of all three tests, were calculated (see Table 6). The samples Mean and Standard Deviation (sd) of Static-99 and VORAS scores including sub-scores, were calculated (see Table 3). The Mean score for Static-99 and VORAS was 7.75 (sd = 4.31) and 12.68 (sd=3.36), respectively. The VORAS subscale scores were lower than those obtained for the Static-99 subscales, which was skewed toward the positive end of the range of scores as the skewness coefficient was greater than zero.

Table 3: Mean and Standard Deviation of Static-99 and VORAS scores

.

	ARMIDILLO	Static-99 Total	VORAS Part A	VORAS Part B	VORAS Total
Mean	.64	7.75	2.37	10.31	12.68
Standard Deviation	.52	4.31	1.45	2.30	3.36

A chi-square analysis was used to determine the statistical significant difference between the adapted and un-adapted VORAS and Static-99 (see Table 3 and 6 with Figures 5-36 page 170-178). The results are shown in Tables 4,5,7 and 8 with figures 1-4). The ARMIDILO was also compared against the VORAS and Static-99 respectively using partial correlation coefficient to quantify the similarity between the ARMIDILO and VORAS and the ARMIDILO and Static-99 scales. An analysis of the internal consistency of the ARMIDILO was performed using Cronbach's alpha (see Figures 38, 39 and 40). Finally, the ARMIDILO was analysed using multiple regression to determine the probability of the dependent variable (risk management) occurring when the independent (questions) variables are present or absent.

3.2 Content Validity.

The ARMIDILO was constructed by academic and clinical professionals with peer-assessed expertise in the field of risk assessment of re-offending for people with intellectual disabilities (ID). It is noted that experience of the authors with the risk assessment tools is vital to content validity (Groth-Marnat, 2003). The seven contributors to the ARMIDILO are Douglas Boer, James Haaven**,** Frank Lambrick, William Lindsay, Keith R. McVilly, Joseph Sakdalan and Melanie Smith. Further details of their published work and current fields of expertise are given in appendix 5.

3.3 Criterion Validity

Criterion validity is a measure of how well one variable or set of variables predicts an outcome based on information from other variables (Groth-Marnat, 2003). By examining known measures for risk, in this case the Static-99 and VORAS with the ARMIDILO it was possible to determine criterion validity. The ARMIDILO includes items on violent, violent sexual and deviant sexual behaviours and so has a theoretical relationship to the Static-99 and VORAS scales. The ARMIDILO includes items also questions the clients past and present environment as these factors are relevant to a persons risk management (Boer et al, 2007).

3.3.1 Staic-99, VORAS and ARMIDILO Criterion Validity.

The Static-99, VORAS and the ARMIDILO tests were administered over five weeks. This fell within the three month criteria advised in test completion when conducting test comparisons (Groth-Marnat, 2003). Groth-Marnat recommends this time limit as a means of preventing client fluctuation which may occur over a longer time span and could make comparisons of tests invalid as the subject's natural growth and development continues. The Static-99 and VORAS were completed using the adapted and un-adapted versions. Data were obtained from each client's historical records (see Tables 3 and 6 and Figures 5 to 37). To establish criterion validity with regards to client risk level, Static-99 and VORAS results were compared against the ARMIDILO results. The ARMIDILO demonstrated capability as a stand alone assessment based upon predictive

elements within the framework as shown in Table 14 where Staic-99 showed a strong partial correlation of 1.00 and VORAS a weaker correlation of 0.20.

3.4 Static-99 Criterion Validity.

The combination of the assessments SACJ-Min and RRASOR resulted in the Static-99 (Hanson & Thornton, 2000). Criterion validity for the Static- 99 has been established by extensive research (Leam, Beech & Browne, 2006; Sjöstedt & Långström, 2000; Thornton & Beech, 2002; Friendship, Mann & Beech, 2003). Consisting of ten items, the Static-99 addresses the probability of recidivism and reconviction in sexual offending.

An area under the curve (AUC) equal to 0.5 indicates that risk prediction is purely random, whereas an AUC equal to 1 indicates perfect accuracy. For example, if a test has AUC = 0.8, it is said to have a very good predictive accuracy in whatever it is proposed to measure (Thornton & Beech, 2002). Static-99 (AUC = 0.71, $r = 0.33$) was more accurate than the RRASOR (AUC = 0.68, $r = 0.28$) or SACJ-Min (AUC = 0.67, $r = 0.23$) in predicting sexual recidivism and showed moderate predictive accuracy for violent, including sexual, offence recidivism (AUC = 0.69, $r = 0.32$) (Thornton & Beech, 2002). Further study of the predictive validity of the Static-99 shows an AUC of 0 .70 and $r = 0.69$ in predicting sexual offence recidivism (Nunes, Firestone, Bradford, Greenberg & Broom, 2002). A two year longitudinal study of Static-99 reported an AUC = 0.57 and indicated that the Static-99 may be better at "predicting violent reconviction than sexual conviction in sexual and combined sexual and/or violent samples" (Leam, *et al*, 2006, p. 622).

The total scores for the 16 participants in this research using the adapted and unadapted Static-99 test are shown in Table 4, There were no distinct anomalies in the dataset, indicating that subjects in the higher scoring range are considered high risk in both versions of the Static-99.

Table 4: Static-99 results for the 16 subjects with the adapted test results and the un-adapted (highlighted in grey) test results.

Q.	718	718	697	697	206	206	927	927	327	327	762	762	566	566	597	597
	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U
1	1	1	0	0	1	1	0	0	0	0	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	0	1	1	1	1	0	1	0	1	0	1	1
4	1	1	1	1	1	1	1	1	0	0	1	0	1	0	1	1
5	3	0	1	1	3	0	1	0	3	2	1	0	0	0	3	1
6	1	1	0	0	0	0	0	1	1	1	0	0	0	0	0	0
7	1	0	1	1	0	0	0	1	1	0	1	0	1	0	1	1
8	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	0
9	1	1	1	1	1	1	1	1	0	0	0	0	0	0	1	1
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q.	19	19	165	165	168	168	49	49	141	141	299	299	546	546	953	953
	A	U	A	U	A	U	A	U	A	U	A	U	A	U	A	U
1	1	1	0	0	1	1	0	0	0	0	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3	0	0	1	0	1	0	1	1	1	1	1	1	1	0	1	1
4	0	0	1	0	1	0	1	1	1	1	0	0	1	0	1	1
5	3	3	2	0	0	0	0	0	0	0	1	1	0	0	1	0
6	1	1	0	0	0	0	1	1	1	1	0	0	1	0	0	0
7	1	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0
8	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
9	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1

The first row gives the subjects's allocated reference number and the second row indicates whether the test was adapted (A) or unadapted (U). Subsequent rows show obtained test scores for each test question as indicated by

the question number (Q.) in the first column. In adapted and unadapted tests, questions 2, 8, 9 and 10 were the same. Questions 3 to 7 inclusive were adapted, adaptions included reported instances and are shown as grey highlight.

Additional analysis of the adapted and un-adapted Static-99 was conducted using Chi-square. Comparison of the observed to the expected frequencies of the four categories, showed some differences between the adapted and un-adapted results. At the lower end of the risk ratings (Low and Low-Moderate)($\chi^2 = 0.036733$, $p \leq 0.99$ 0). The adapted data are not significant at $\chi^2 = 0.000134$, $p \leq 1$, see appendix 8. Figures 1 and 2 show the adapted and unadapted results.

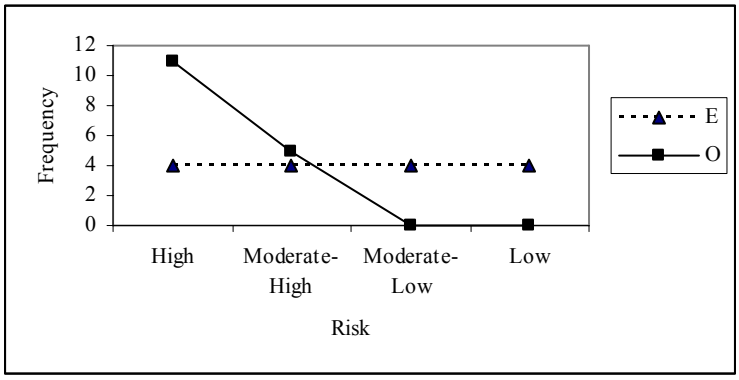

Figure 1: Chi-squared values for expected and observed frequencies for the Static-99 adapted results.

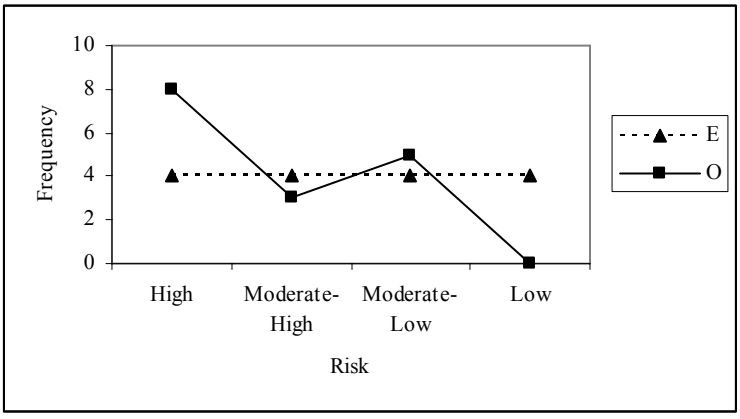

Figure 2: Chi-squared values for expected and observed frequencies for the Static-99 un-adapted results.

3.5 VORAS Criterion Validity

Ward and Dockerill (1999) tested the validity of the VORAS using the Violent Offender Treatment Program Risk Assessment Scale (VOTP-RAS) measure over a 34 month, 60 month and 84 month time period. They found the predictive accuracy for the time-at-risk intervals was "73 per cent, 74 per cent and 72 per cent, respectively" (1999, p.127). This finding demonstrates that the measure highly correlated with previous violence and future offence severity and indicated that the test was valid for assessing risk in prisoners. Douglas, Yeomans and Boer (2005) evaluated predictions made using actuarial (VRAG, VORAS) and risk assessment measures (HCR-20). In bivariate correlation and ROC analysis, strong support for the VRAG and HCR-20 was observed, including the structured final risk judgment intended for use in practice (Douglas, *et al*, 2005).

Table 5: VORAS results for the 16 subjects with the adapted test results and the un-adapted test results.

Q.	718 A	718 U	697 A	697 U	206 A	206 U	927 A	927 U	327 A	327 U	762 A	762 U	566 A	566 U	597 A	597 U
1	1	1	1	1	0	0	0	0	1	1	0	0	1	1	0	0
2	2	0	2	1	2	1	2	2	1	1	1	0	1	1	2	2
3	6	0	6	4	6	0	4	2	6	4	2	0	4	4	6	1
4	3	0	1	1	2	0	1	1	3	3	2	2	3	3	3	2
5	4	4	2	2	2	2	1	1	4	4	4	4	4	4	4	4
6	0	0	0	0	2	2	0	0	0	0	0	0	0	0	0	0
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Q.	19 A	19 U	165 A	165 U	168 A	168 U	49 A	49 U	141 A	141 U	299 A	299 U	546 A	546 U	953 A	953 U
1	0	0	2	2	0	0	2	2	1	1	0	0	3	3	0	0
2	0	0	2	0	2	2	3	3	2	2	0	0	2	2	2	2
3	0	0	6	0	4	4	6	6	6	6	4	4	6	2	4	4

4	2	2	3	0	1	1	3	2	2	2	3	3	2	0	2	2
5	2	2	2	2	3	3	3	3	3	3	3	3	2	2	3	3
6	1	1	0	0	0	0	0	0	0	0	0	0	4	4	0	0
7	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 5 shows the score of each subject on the adapted and un-adapted VORAS tests. The first row gives the subjects's allocated reference number and the second row indicates whether the test was adapted (A) or un-adapted (U). Subsequent rows show obtained test scores for each test question as indicated by the question number (Q.) in the first column. In adapted and unadapted tests, questions 1, 5, 6 and 7 were the same. Questions 2 to 4 inclusive were adapted; adaptions included reported instances and are shown as highlighted.

Appendix 6, figures 25-40, pages 168-175, show a few distinct anomalies in the dataset. Subjects 718 and 165 obtained a score of 6 (high risk) on the adapted VORAS assessment and zero on the un-adapted VORAS, indicating no risk. No subjects obtained low point scores on the adapted VORAS and a higher score on the un-adapted VORAS. The graph illustrates that subjects in the higher scoring range are considered high risk in both tests.

Chi-Square analysis of the adapted and un-adapted VORAS showed differences between the adapted and un-adapted tests (see Figure 3 and 4) particularly in the higher end of the risk ratings (Moderate-High) on the adapted test ($\chi^2 = 0.133614$, $p \leq 1$). Details of the analysis are shown in appendix 9 page 184.

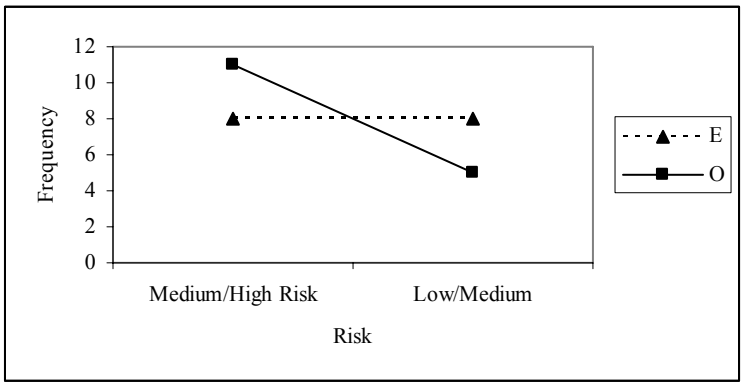

Figure 3: Chi-squared frequencies for the VORAS adapted results.

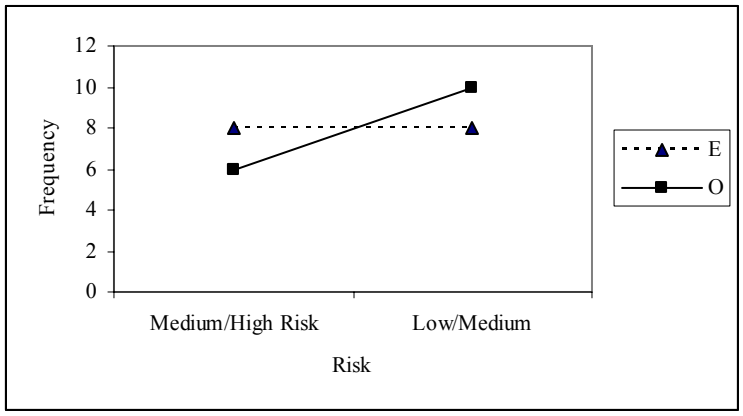

Figure 4: Chi-squared frequencies for the VORAS un-adapted results.

The level of harm, section one of the VORAS show no significant differences. The probability of harm, section two of the VORAS, suggests statistical differences in the adapted and un-adapted results at $\chi^2 = 0.317311$, see Appendix 9.

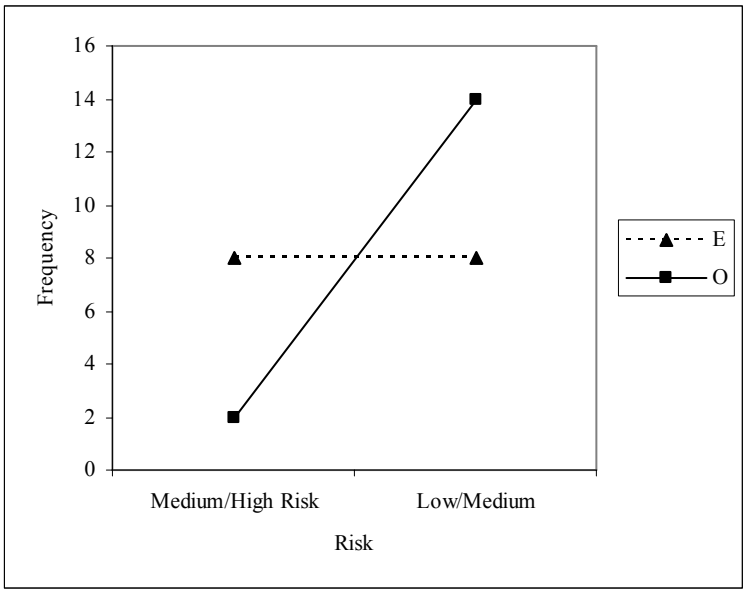

Figure 5: Adapted VORAS Q1-2.

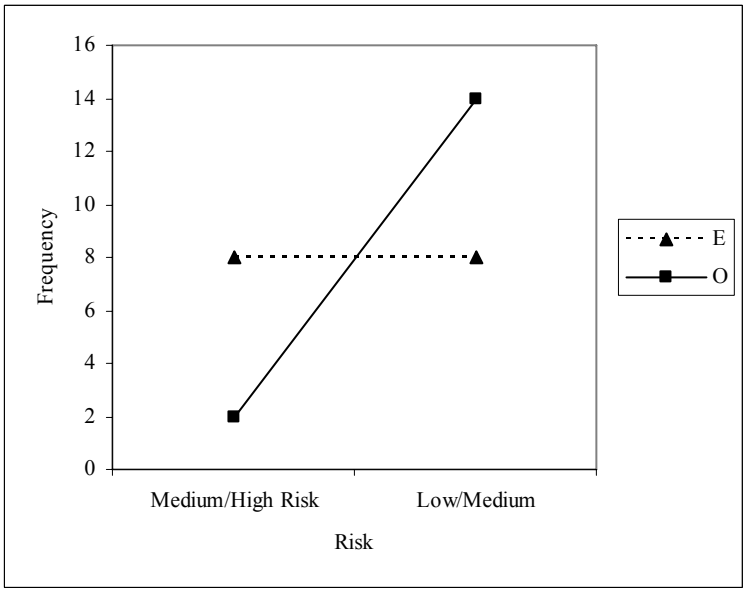

Figure 6: Un-adapted VORAS Q1-2.

Tables 11 and 12, show the Chi-square analysis of the VORAS Questions 3-7, which indicate the probability of harm. While Questions 1 and 2 held the same Chi-square value, there is a distinct difference between the adapted and un-adapted test results in Questions 3 - 7

Figures 7 and 8 show the observed frequency of harm in the adapted and un-adapted VORAS test respectively. There are statistical differences between the adapted and un-adapted VORAS versions of the scale ($\chi^2 = 0.133614$, $p \leq 1$); therefore there appears to be value in adapting the VORAS test for utilisation with ID individuals who offend.

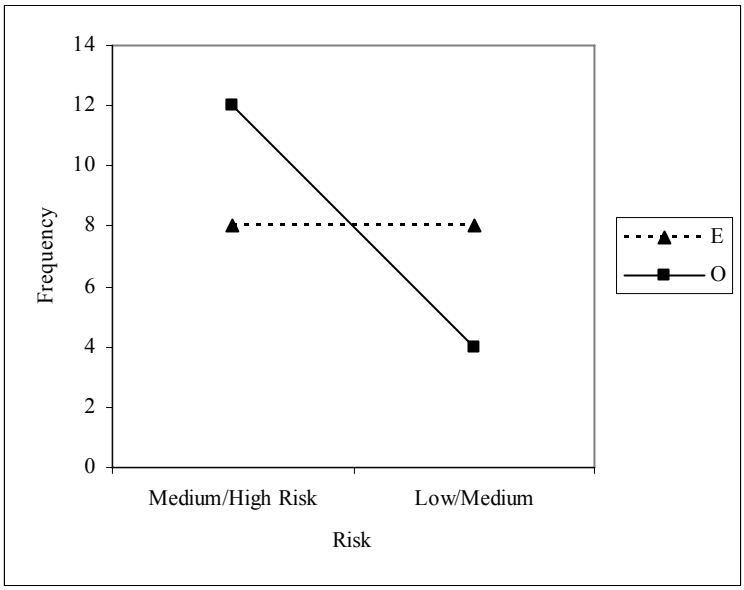

Figure 7: Adapted VORAS Q3-7.

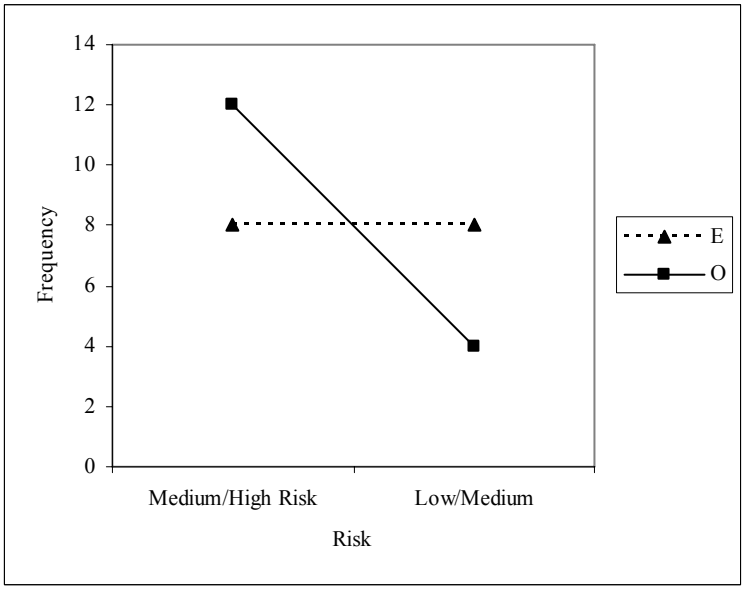

Figure 8: Un-adapted VORAS Q3-7.

3.6 ARMIDILO.

The ARMIDILO is a risk assessment tool that has been designed to ascertain the level of risk of violent, violent sexual and or deviant sexual behaviour (Boer *et al*, 2008). Comparing two current risk assessment scales, the VORAS and Static-99 with the ARMIDILO, can determine if the ARMIDILO could also be used as a risk assessment tool.

Table 6: The 16 subjects shown with their randomised reference numbers and their total scores from the three tests; ARMIDILO, Static-99 and VORAS.

Reference Number	ARMIDILO Section A	ARMIDILO Section B	ARMIDILO Section C	ARMIDILO Section D	ARMIDILO Total
718	3	0	7	1	**11**
697	3	1	10	0	**14**
206	2	1	4	-1	**6**
927	6	5	15	10	**36**
327	4	3	13	2	**22**
762	6	3	10	0	**19**
566	6	3	16	3	**28**
597	-6	0	0	0	**-6**
19	0	0	6	0	**6**
953	5	2	9	3	**19**
165	9	2	2	1	**14**
168	2	3	11	3	**19**
49	8	3	-4	-2	**5**
141	7	2	0	1	**10**
299	9	6	12	3	**30**
546	10	5	19	4	**38**
Reference Number		**Static-99 Total**	**VORAS Part A**	**VORAS Part B**	**VORAS Total**
718		**10**	3	13	**16**
697		**6**	3	9	**12**
206		**8**	2	12	**14**
927		**5**	2	6	**8**
327		**7**	2	11	**13**
762		**7**	1	8	**9**
566		**5**	2	11	**13**
597		**9**	2	13	**15**
19		**8**	0	7	**7**
953		**8**	2	9	**11**
165		**8**	4	11	**15**
168		**5**	2	8	**10**
49		**6**	5	12	**17**
141		**5**	3	11	**14**
299		**6**	0	10	**10**
546		**7**	5	14	**19**

Table 6 shows the total results of the 16 subjects for each of the three tests. The Static-99 and VORAS results are taken from the adapted test scores. The first column gives the subjects's allocated reference number.

3.7 Partial Correlation.

Partial correlations procedure identifies significant relationships between variables and obtains measures of the strength, direction and significance of the relationship between them. To test normality for all measures in determining whether a test was normally or non-normally distributed, alpha level of ≤0.05 was used. The VORAS was weakly correlated to the ARMIDILO, $r = 0.20$ In contrast the Static-99 and ARMIDILO showed a strong partial correlation of $r = 1.00$, see appendix 10.

Subject 718 obtained a high point score of 10 on the Static-99, indicating high risk and a low score of 0.36 on the ARMIDILO indicating that there may be a problem. The Static-99 specifically measures risk of sexual reoffending and does not take into account environmental issues. The difference in the scores may reflect these differences. Three subjects obtained low point scores of 5 on the Static-99 indicating low risk and a high score of between 0.71 and 1.29 on the ARMIDILO indicating that there may be a problem (see score sheets for the ARMIDILO in appendix 2). The Static-99 measure risk on the basis of convictions and does not take into account current behaviours which the ARMIDILO does. Generally the grouping of points indicates a mid range on both the ARMIDILO and the Static-99.

There appears to be a partial correlation between the ARMIDILO and the VORAS. Subject 165 scored 15 on VORAS and -0.5 on the ARMIDILO. Subject 546 obtained a high point score of 20 on the VORAS assessment, indicating high risk and a score of 1.75 on the ARMIDILO indicating that there may be a

problem. Subject 19 obtained a high point score of 7.0 on the VORAS indicating high risk and a high score of 0.17 on the ARMIDILO indicating that there may be a problem. Generally, the grouping of points indicates a high range on both the ARMIDILO and the VORAS. Subjects in the higher scoring range are considered high risk in both tests.

3.7 Internal Consistency.

Internal consistency is a measure of how well items are correlated with each other within a scale. Pair-wise correlation was used to measure internal consistency of the ARMIDILO. Data were analysed using Cronbach's alpha (1951) in this research, see appendix 7. Cronbach's alpha is a coefficient of consistency and measures how well a set of variables or items measures a single, unidimensional latent construct. Mathematically, reliability consistency is defined as the proportion of the variability in the responses to the questionnaire that is the result of differences in the respondents. The computation of Cronbach's alpha is based on the number of items on the questionnaire and the ratio of the average inter-item covariance to the average item variance.

The ARMIDILO was analysed in four parts, as shown in Table 7. The four parts are listed by acronyms representing Stable Dynamic Items (Environmental) (SDIE); Acute Dynamic Items (Environmental) (ADIE); Stable Dynamic Items (Client) (SDIC) and Acute Dynamic Items (Client) (ADIC). Nunnelly (1978) recommends a Cronbach's alpha level of 0·8 or greater as an indication of good

internal consistency and measure of reliability. The overall internal consistency using Cronbach's alpha for the ARMIDILO was high ($r = 0.85$, $p = \leq 0.05$), which is a high internal consistency, as reported in Table 7.

Table 7: ARMIDILO results using Cronbach's alpha measure of internal consistency.

Cronbach's alpha	Cronbach's alpha Based on Standardised Items	Number of Items (Questions)
.857	.870	30

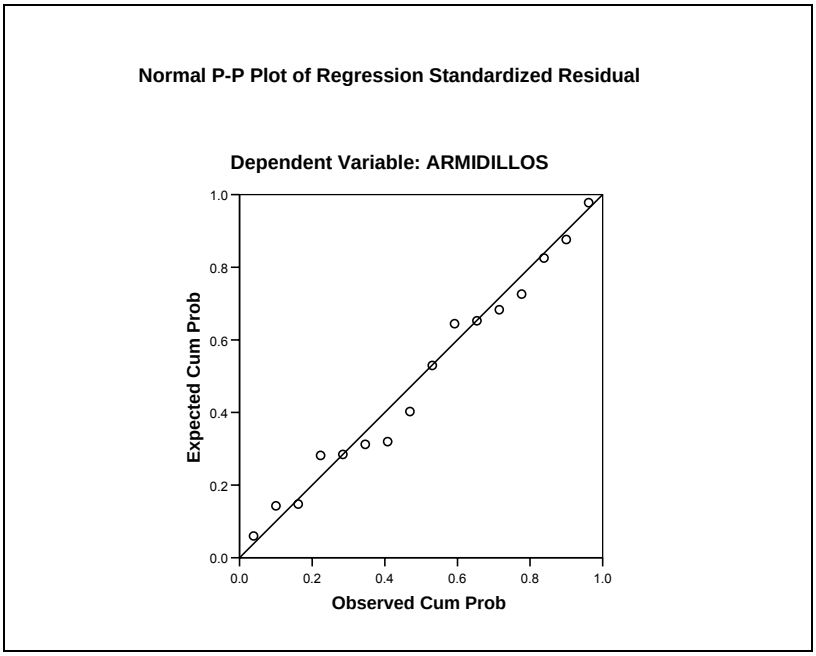

Figure 41: Prediction of DV from the ARMIDILO items.

Figure 41shows that the items are highly intercorrelated, suggesting they measure the same underlying constructs, namely risk assessment. The graph does

not show distinct anomalies in the dataset. Generally the grouping of points indicates a near perfect fit on the ARMIDILO.

To determine whether the responses in the four subsections of the ARMIDILO, SDIES, ADIES, SDIC and ADIC, accurately reflected the clients' risk management level as estimated by the total scores a multiple regression analysis was conducted. The criterion variable was the total scores attained by each care giver and client. Results show significant findings at ($F\ 4,11 = 36.541$, $p < 0.05$. Adjusted R square = 0.901). The significant variables are shown in Table 8. The SDIC subsection score indicates that this section of responses is mostly highly correlated to the assessed risk management level.

Table 8: Multiple regression analysis of ARMIDILO.

Predictor Variable	*Beta*	*P*
SDIES Subsection Total	*0.392*	*p <0.05*
ADIES Subsection Total	*0.141*	*p <0.05*
SDIC Subsection Total	*0.670*	*p <0.05*

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3.8 Summary.

A comparison of adapted and un-adapted test results from the Static-99 and VORAS showed little difference, indicating that there may be no benefit from adapting these risk assessment tests. The Static-99 was seen to have a weak partial correlation with the ARMIDILO however; the VORAS showed a stronger

correlation with the ARMIDILO, suggesting the VORAS and ARMIDILO were measuring the same variable. Multiple regression analysis of the ARMIDILO showed that the questions within the test were relevant to assessing the risk management in the participants. The questions appeared to have a reliable correlation to the latent variable and, although the ADIC section was found to have a weak predictor level the other three sections, the Stable Dynamic Items (Environmental); Acute Dynamic Items (Environmental) and the Stable Dynamic Items (Client) were seen as strongly predictive.

Chapter 4: Discussion.

The primary purpose of this study was to determine the effectiveness of the ARMIDILO in assessing the offence risk and management of ID people who offend (Boer, Tough & Haaven, 2004). The study also compared two tests that are currently used in risk assessment of sexual and non-sexual violent offenders, the Static-99 and VORAS, respectively, with the ARMIDILO, as the latter is a new and untested method of making structured judgements about risk and management od ID individuals who have acted violently against others. This chapter explores the statistical analysis of all three tests, positive and negative aspects of each test before drawing conclusions, with particular focus on the validity of the ARMIDILO.

The population in this research consisted of file records of 16 ID people who had offended and been detained under the Intellectual Disability (Compulsory Care and Rehabilitation) Act (IDCCR) 2003, who were in residential care and interviews (also on file) of their 16 care givers at the time of the assessment. Both the Static-99 and VORAS have been used as assessment risk tests on offenders within the prison systems in much of the developed world (Howells, *et al*, 1997; Hanson & Thornton, 1999). The Static-99 and VORAS tests were adapted to include 'instances' as well as 'non convictions' of violent and or sexual behaviours. Research indicates that ID people who offend are more likely to be placed in residential care rather than imprisoned (Cockram, 2005). The inclusion of instances and non-convictions was designed to eliminate a potentially misleading low score, had only the original convicted violent and or

convicted sexual violent offences been taken into consideration. People with ID require specific testing as current models do not appear to adapt appropriately. This prevents adequate training programs being provided for ID people who offend (Claire, 1993; Day, 1994; Lambrick & Glaser, 2004).

The Static-99 and VORAS were completed by direct audit of the subjects' case files, although criminal records are typically used when conducting these tests (Howells, *et al*, 1997; Hanson & Thornton, 1999). The ARMIDILO was completed by reviewing previously completed interviews of each subject and their main care giver (Boer, *et al*, 2004).

4.1 Data Analysis.

A basic analysis of the Static-99 and VORAS was conducted using the adapted score results compared to the un-adapted score results. With the exception of question 5, in the Static-99 (prior sexual offences), there was little variation between subjects' individual question scores. The adaptation to the test demonstrates that this risk factor is more prominent and therefore relevant to the testing of ID people who may not always have been convicted of serious sexual offences.

The VORAS shows a significant difference in the adapted question 3 (previous violent convictions), with the score ranging between zero and six for each subject's individual question. However, most of the scores show little difference between adapted and un-adapted scores. Exceptions are subjects 718, 165 and 953, all of whom score high in the adapted results and low in the un-adapted results. Interpretation of these findings is inconclusive as all three

subjects vary in age, residence and ethnic background. However, all three subjects were detained under the Intellectual Disability (Compulsory Care and Rehabilitation) Act (IDCCR) 2003 for sexual offences.

Bivariate correlation, shown as standardized item alpha, of Static-99 showed a weak correlation with the ARMIDILO at 0.2, whereas the VORAS showed a much stronger correlation at 1.00. As the Static-99 is predominantly a risk assessment test for sexual recidivism and the VORAS targets violent recidivism, there is limited direct relationship between these two tests. Boer *et al* suggest that VORAS is weakly related to violence (2004); however, this research indicates a stronger link. This is confirmed by the ARMIDILO demonstrating a high correlation with the VORAS in measuring the violent recidivism of subjects.

The ARMIDILO is divided into acute dynamic and stable dynamic items, for both staff and clients. The client acute dynamic and stable dynamic items include environmental, sexual and violence indicators while the staff acute dynamic and stable dynamic items indicate environmental factors (Boer, *et al*, 2008). Using Cronbach's alpha requires a level of ≥ 0.8 to demonstrate a high internal consistency. The ARMIDILO demonstrates good internal consistency at 0.857, and .87 on Standardised items (inter-rater reliability was not assessed as part of the thesis) see Table 7. The client consistency level shows a stronger correlation, it should be remembered that the staff responses were relevant to the test, as they indicated stable dynamic factors and the effect staff could have on their clients. This has been shown to be a critical variable of staff attitude to their client's behaviour (Boer, *et al*, 2008). The correlation of environmental changes in both staff and clients analysis show that they are strong and relevant.

Within the multiple regression analysis, the three assessments were first compared to determine their ability to predict violent or sexual deviant behaviour. The weak correlation of 0.26 between the Static-99 and VORAS showed there was no significant relationship with predictive certainty. Furthermore, the Static-99 and VORAS non-significant correlated with the ARMIDILO at 0.12 and 0.07 respectively. These findings indicate that the three tests are not measuring the same criterion: The Static-99 is a measure for predicting sexual recidivism (Lindsay, *et al* 2008; Hanson, *et al*, 2000) and the VORAS assesses violent recidivism (Howell, *et al*, 1997; Ward, *et al*. 1999). The ARMIDILO attempts to measure both sexual and violent recidivism in a more targeted population, namely, in developmentally and intellectually disordered offenders.

As the sample in this study was relatively small and there appeared few strong theoretical indicator predictions, the simultaneous method of analysis for the ARMIDILO is better suited to this research. The four subsections of the ARMIDILO accurately reflected the clients' risk management level as estimated by the total scores. Although the ARMIDILO measures both sexual and violent indicators, it appears to be more compatible with risk management than risk assessment. The relevance of the questions asked within the ARMIDILO showed an internal consistency of 0.93.

4.2 Static-99

4.2.1 Static-99 Positive Aspects.

There are a number of positive aspects to both the implementation of the Static-99 and the results obtained. The Static-99 was designed for analysis by non-clinical personnel such as corrections officers, facilitators and probation

officers. Research has shown that the risk assessment tool is more effective than clinical judgement alone (Dawes, *et al*, 1989; Grove, *et al*, 2000; Hanson, Morton, & Harris, 2003). This has proven to be a cost effective tool within risk assessment as people such as corrections officers are able to complete multiple assessment forms as part of their standard duties. Due to the non-judgemental scoring requirements of the tool, any personal bias is likely to be reduced (Hanson, et al, 2003; Dow, Jones, & Mott, 2005). The design of the Static-99 uses clear and concise language with a simplified scoring system. This ensures the administrator requires little training or specialised knowledge. Similarly, the range of risk scoring is elementary and again requires little training or knowledge to interpret. As there is limited bias within the scoring, this increases the reliability and validity factors to produce standardised results (Grove, *et al*, 2000). Research into risk management tools indicates that the Static-99 is an effective tool when assessing the risk factors in sexual re-offending (Hanson, 1997; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2005). Although the tool focuses predominantly on sexual recidivism, the Static-99 also covers non-violent sexual offences. Research has shown that non-sexual violence such as exhibitionism or possession of objectionable material can escalate into more serious sexual offending (Boer, *et al*, 2008). The Static-99 gives equal weight to offences committed against related victims as well as stranger victims. This is particularly relevant as the Static-99 could identify perpetrators of the increasing domestic violence issues reported in New Zealand today (Statistics New Zealand, 2007; Paterson, Carter, Gao, Cowley, Malcom & Iusitini, 2008).

4.2.2 Static-99 Negative Aspects.

Question two of the Static-99 explores whether a person has ever lived with a lover for at least two years. As this research is specifically targeted toward ID people, this question is not as relevant as it would be to general offenders. ID people are less likely to maintain a long-term sexual relationship (Boer, et al, 2008). The Static-99 fails to consider sexual or deviant behaviour before the age of 18. Sadistic or deviant behaviour such as harm to animals, exhibitionism and minor sexual assault is often recorded in people before the age of 18 as an indication of future risk behaviour (Wilson, 2004; Cocozza & Skowyra, 2003; Ogloff & Davis, 2004; Geradin & Thibat, 2004). Static-99 fails to take into account any instances of psychosis and increased impulsive responding, such as bi-polar disorder. In addition, the risk assessment fails to address any anti-social personality factors, which would include peer relationships and drug or alcohol misuse (Andrews & Bonta, 2002). These constraints of Static-99 limit the consideration of risk factors that are relevant to offenders and the offence cycle. Static-99 does not cover misdemeanours such as general hostility and threats, which would indicate a lack of personal control (Hatch, Maillette, Scalora, Huss & Baumgartner, 2001; Paradise & Cause, 2002). The risk assessment tool appears to be specifically targeting males and does not cover aspects traditionally associated with females such as impersonal sex (trading). Currently decriminalised impersonal sex , such as in New Zealand, could be associated with other offences such as drug misuse, underage sex and objectionable material

(Paradise & Cause, 2002; Hodgetts, Cullen & Radley, 2005). Finally, Static-99 fails to report on poor problem solving and self regulation. These are both factors that relate to a person's ability to resist taking part in criminal behaviour (Wilson, 2004; Hiller, Matthew, Knight & Simpson, 2006).

4.2.3 Static-99 Conclusion.

Overall there are both positive and negative aspects to the use of the Static-99 as a risk assessment tool. The fact that the Static-99 may be not only administered but also scored and utilised by non-clinical personnel ensures that the tool is extremely time and cost effective. This is highly relevant in New Zealand's growing prison population. Serious sex offenders must be identified and included in relevant programs, which could decrease their risk factors. It is important to separate low from high risk offenders in risk management programs to obtain the best results in reducing the risk of future recidivism (Ward & Stewart, 2003; Dow & Jones, 2005). The Static-99 identifies high level sexual risk factors but does not indicate how the offender can be managed. This, however, is a common theme throughout all current risk assessment tools, which the ARMIDILO is specifically designed to overcome.

4.3 VORAS.

4.3.1 VORAS Positive Aspects.

Many of the positive aspects of the Static-99 are evident in the VORAS. This includes the administration by non-clinical personnel, cost effectiveness, elimination of bias, ease of use and the reliability and validity

factors. The tool is divided into two sub sections, which give an indication of the level of harm and the probability of violent re-offending. The inclusion of level of impact and probability presents a standardised risk assessment matrix, which takes into account individuals with multiple low impact offences yet recognises the high level of risk involved (Railey, Kroner, Mills, Reitzel, Dow & Aufderheide, 2007; Lindsay, 2007). Part of the risk assessment includes the offender's age at which they first committed an offence, with higher scoring if they committed their first offence before the age of 14 (Howells, *et al*, 1997). There is significant evidence that first time offenders of a young age are more at risk of recidivism (Geradin, *et al,* 2004; Reyna & Farley, 2006). VORAS also includes factors of alcohol and drug misuse, both of which has proven to be indicators of high risk offending (Paradise & Cause, 2002; Hogetts, *et al*, 2005). The assessment tool also incorporates non-violent offences, which could be an indication of escalating serious offending, this may include violence (Eddy, *et al*, 2000; Greycar, 2003; Wilson, 2004).

4.3.2 VORAS Negative Aspects.

The VORAS shares many negative aspects with the Static-99 in terms of risk assessment. Neither tool takes into account cultural or social differences. It has been a long term practice of Māori and other cultures to implement restorative justice, which could result in a lower recidivism risk rating based on prior convictions (Lammers, 2006). Social constructs also affect conviction rates (Wills, Ritchie & Wilson, 2008). An example of this could be the introduction of the 2007 Crimes (Substituted Section 59) Amendment Bill. Social

and economic differences are not taken into consideration within the VORAS. Crimes such as domestic violence reportedly cover all social levels, although perpetrators from a wealthy, professional background are more likely to receive non-custodial sentences and therefore would not be included in the VORAS assessment (Litwack, 2001). This failure to include prior non-convicted offences is common to many risk assessment tools (Grove, *et al*, 2000; Dow, & Jones, 2005; Craig, & Hutchinson, 2005). Statistical analysis has demonstrated that the VORAS is not as reliable as other risk assessment tools (Boer, *et al*, 2004; Lindsay, *et al*, 2008).

4.3.3 VORAS Conclusion.

As with the Static-99, one of the main benefits of the VORAS as a tool of risk assessment is the ease with which is may be administered, scored and utilised. Although no specific mention of sexual offences is made, such crimes as rape can be included in both violent and sexual risk assessment. While alcohol, drug misuse and age at first offence have been extensively correlated with crime and are important, the lack of cultural and social factor inclusion limits the success of this assessment tool (Paterson, *et al*, 2008). However, the main failure of the VORAS as a risk assessment tool is that it is shown statistically to be weak in comparison to other risk assessment tools (Boer, *et al*, 2004; Lindsay, *et al*, 2008).

4.4 ARMIDILO.

4.4.1 ARMIDILO Positive Aspects.

Unlike any other risk assessment tool, the ARMIDILO takes into consideration the main caregivers influence on the ID person. Research into the

influence of the ID individuals' care-giver shows the relevance of this inclusion (Claire, 1993; Day, 1994; Inderbitzin, 2006; Evans, 2007). With one exception, the participants in this research were all under 24-hour supervision on a one-to-one basis. This entailed every aspect of the ID person's life and therefore how the carer related to the client was highly relevant (Inderbitzin, 2006; Evans, 2007). The ARMIDILO helped the caregiver focus on their lack of knowledge regarding their client. Addressing these shortcomings may help caregivers understand their clients' behaviour. This was demonstrated in the staff interviews when a staff member stated that they had wondered why a client would not initially speak to them. Their client explained after a year that living on the streets had made him reluctant to speak. The staff member stated that had they known this information, they would have altered both their expectations and interactions with the individual (Interview with client 927, 2007).

Often people with ID have limited communication skills (Claire, 1993; Underwood, Robinson, Mosholder & Warren, 2005). However, staff who have a close relationship with their clients often demonstrated that they could identify triggers in their clients' behaviour at an early stage. An example of this is a caregiver who explained that when their client started vocalising squeaking sounds, they knew that within a matter of hours their client would begin self-harming. This knowledge not only allowed the caregiver to divert the behaviour but also they were able to impart that knowledge to other staff (Interview with client 762, 2007). As previously mentioned, people with ID are more likely to exhibit deviant behaviour in times of stress. This particularly occurs when environmental changes take place (Underwood, *et al*, 2005; Cray & Hutchinson, 2005). It is interesting to note that the average length of service of the caregivers

was 14.8 years and they were predominantly mature people with an average age of 51.3 years. Research has shown that a stable environment is beneficial to the well-being of the ID person (Craig & Hutchinson, 2005). The ARMIDILO assesses the level of commitment that the caregivers have to their clients. This is not only important to the client, but also to the well-being of the caregiver. The caregiver is predominantly an employee and whether they are happy within their role affects not only their health but also their sense of personal fulfilment (Golembeski & Fullilova, 2005; Berry, *et al*, 2008). Caregivers' increased knowledge of their clients may limit offences and thereby protects not only the client but also the public. This was demonstrated by a caregiver, who had previous knowledge of the client's child abuse history, who removed their client from a reggae concert, when they noted that the client became sexually excited in the presence of a large number of children (Interview with client 327, 2008).

The ARMIDILO questionnaire section relating to clients' responses indicated the extent to which clients were aware of their own level of risk. This awareness is a factor in reducing risk as it may result in self regulation (Boer, *et al*, 2008). Similarly, clients' responses indicated varying levels of knowledge with regard to their own triggers. An example of this was when one client reported that they became overly anxious when it was suggested they should leave the house. The client demonstrated their reluctance to leave the house by screaming and, if forced to leave the house, would have become violent. The client was aware that their behaviour was unacceptable and had arranged with the caregiver a series of signals that would allow the caregiver to intervene before the inappropriate behaviour commenced (Interview with client 141, 2008). Whilst interviewing clients, it became apparent that triggers and behaviour could be

misinterpreted by their caregivers. For example, the client who objected to leaving the house stated they were frightened of the outdoors. This was a conflicting view to that of the caregiver, who accounted for their behaviour as being self-seeking (Interview with client 141, 2008). By highlighting these discrepancies, the ARMIDILO could be used to aid understanding between client and caregiver.

Any program initiated must be relevant to the ID person's level of understanding. Although the clients interviewed in this research had an IQ range of 50-70, there were extensive differences in their level of knowledge. This was demonstrated when talking about sexual issues. One client stated that they had sex with their grandparent's cat and stated that they had also had sex with another resident. On further questioning it transpired that they had mistaken the meaning of the word sex for friendship; their level of understanding on sexual issues was negligible (Interview with client 566, 2007). The ARMIDILO could highlight these deficiencies in knowledge and therefore the correct management program could be tailored to the clients' needs.

Whilst completing the questionnaires, it was noted that some clients had an almost innocent perception of issues that could place them in a high risk category. It was not uncommon for a client to report how they were able to access drugs and alcohol and in one particular case, report that they were having sex with an underage female. This unexpected information was not actively sought by the questions. This could only have come about because the ARMIDILO allows the client to elaborate on their answers and is not merely a tick-box questionnaire. Social science research has increasingly recognised the value of qualitative methodology that allows for this freedom of expression (Bryman, 2001; Clifford & Valentine, 2003; Groth & Marnat, 2003). Predominantly, ID people suffer from

depressive illness (Underwood, *et al*, 2005). This can lead to misuse of drugs and alcohol, which may result in reduced self control and therefore increased offending behaviour. There are also several questions directed at caregivers and clients focusing on mental illnesses. Research shows that certain psychoses can lead to offending behaviour (Wilson, 2004).

The ARMIDILO does not specifically identify cultural difference but the answers given by both caregivers and clients quickly indicate cultural variations. This could well impact on program design for a given client as there are cultural differences in subject matter such as sexual issues (Paterson, *et al*, 2008). It was noted that clients of European descent appeared to have very little knowledge of anything relating to sex, while clients of other cultures did not demonstrate this lack of knowledge and it may be that ID people of European descent are often treated in a child-like manner by their relatives.

Unlike the Static-99 and VORAS, the ARMIDILO covers violent behaviour and or sexual deviancy. ID people are often victims as well as perpetrators (Lindsay, *et al*, 2008) and may be victims of sexual and violent crimes (Craig & Hutchinson, 2005). How they relate to these crimes may often be re-enacted in their behaviour towards others (Lindsay, *et al*, 2008). It is therefore important that any risk assessment tool asks if the ID person has had a crime perpetrated against them. Several clients reported they had been sexually abused and had in turn committed sexual and or violent acts. Unlike other tests, the ARMIDILO incorporates positive aspects into risk management. By including protective factors within the scores, there were occasions where a client who had scored very high on the Static-99 and VORAS obtained a very low score on the ARMIDILO. This was due to the high level of supervision that limited or

prevented victim access. The ARMIDILO demonstrates that effective risk management can enhance the life of an ID person and, at the same time, protect the general public.

4.4.2 ARMIDILO Negative Aspects.

A large proportion of caregivers appeared to come from socio-economically deprived backgrounds. It would appear that education levels amongst caregivers are limited and staff training may not fully meet the needs of the client. This became evident in the question 'tell me a bit about your clients', where caregivers generally answered by saying whether or not they liked their client or found them easy. It became apparent whilst conducting the interviews that staff members had ascertained the main behavioural issues of the client but had little knowledge of how to deal with those issues. Staff often expressed a wish to obtain more training in their client's specific needs, for example, autism, schizophrenia and bi-polar disorder. A solution to this problem may be that more senior staff are also asked the staff interview questions.

One of the main issues that arose in administering the ARMIDILO was the level of clients' understanding. It became clear when conducting the ARMIDILO interviews that sexual knowledge was limited among some clients. For example, question 3.1 'have you ever had sex with someone?' assumes that the person knows what sex is. The variety of answers indicated that some clients had no knowledge of what sex is. It is therefore imperative that anyone conducting interviews with ID people ascertains their level of knowledge and understanding

of the themes involved. Another problem encountered was when the impulsivity of the client was questioned. Question 10.1 asks 'do you sometimes act before thinking?' Without exception, the replies to this question demonstrated the ID person took this literally; the answers ranged from "I wash up" (interview with client 697) to "I go to sleep" (interview with client 718). These are all physical actions rather than thought processes. The ID person has difficulty in comprehending concepts (Lindsay, 2007; Boer, *et al*, 2008). This is also demonstrated by question 11.2 'have you ever been so upset that you wanted to hurt yourself?' The answers to this were again very literal and focussed on physical events such as "I burnt my arm when I set fire to the house" (interview with client 49). It is possible to elicit the answer required by more direct questions, which may indicate a need to readdress some of the questions within the ARMIDILO and re-word questions dealing with concepts.

The ARMIDILO contains questions that verify whether or not the client is telling the truth. Any person will portray themselves in the best possible light and an ID person is no different. This became evident in the interviews when people denied their offences, blamed other people, or simply failed to recall the incident. This had an impact on the client's risk rating as awareness of behavioural issues contributed to the overall risk factor score. One manner in which this could be addressed is to reconsider the series of questions addressing behavioural awareness from the overall score calculation. This tendency to distort the truth is a recurring problem with questionnaires and one that has no simple solution (Bryman, 2001). Another consideration when administering the ARMIDILO is the effect that it could have on clients. One particular client became agitated during the interview, as they felt that their past offences would impact on their

present situation. A debriefing period followed the questionnaire, during which time the client was reassured and any concerns they had addressed. The interviewer found that, following the interviews, this debriefing period was necessary and it is felt that this may be an indispensable inclusion to administering the ARMIDILO questionnaire.

Another consideration in the administration of the ARMIDILO is the financial and logistical costs involved. On average, it takes three hours to administer the ARMIDILO, introductions to caregivers and clients and the debriefing period add an hour to the total time. The four hours per questionnaire significantly increases the administration costs compared to the hour required for the Static-99 and VORAS. The logistics of administering the ARMIDILO are also considerable; with the interviewer either travelling to the client's place of residence or clients travel to the interviewer's location, both of which involve additional costs.

It is well documented that any research is impacted upon by the researcher (Clifford & Valentine, 2003). This interviewer induced bias can dramatically influence responses (Kobayashi, 1994). This was particularly evident in the ARMIDILO questionnaire as it was vital to establish a rapport with the caregivers and clients in order to elicit answers, especially regarding some concepts that the individuals were not comfortable discussing. For example, question 3.6 'is it okay to play with yourself/masturbate?' which may have been an uncomfortable topic. The essential relationship between interviewer and interviewee requires not only empathy toward the caregiver and client, but also an understanding of

fundamental interaction. This may limit the people who could effectively administer the ARMIDILO.

The scoring and scoring guide of the ARMIDILO may require further development to facilitate ease of use. The complex nature of the scoring could result in multiple interpretations that could bias the overall risk rating. It may be advantageous to readdress and simplify the current scoring system. Another consideration is the use of quantitative scoring in this study as it became apparent that questions and answers were more conducive to a qualitative analysis.

4.5 Research Findings.

This research has focused on the ARMIDILO as an effective risk assessment and management tool. This research has shown that there are three main aspects in which the ARMIDILO goes beyond both the Static-99 and VORAS, which are: effectively testing recidivism; program initiation and individual client needs. There are other contributing factors to the effectiveness of the ARMIDILO, including whether or not the ARMIDILO effectively tests recidivism, if programs could be initiated on the findings of the ARMIDILO and to what the extent to which the individual needs of the client are addressed. Deductive findings incorporate issues such as the impact staff have on clients, staff training and physical environmental issues. It should also be noted that this is the first research using the ARMIDILO and further development of the test is required.

4.5.1 Effectiveness of the ARMIDILO.

The hypothesis of this research is that the ARMIDILO tests recidivism more effectively than current risk management tools. The Static-99 and VORAS have been used effectively to measure recidivism (Hanson & Morton-Bourgon, 2005; Kroner, *et al,* 2007; Craig, *et al*, 2008). As previously stated, although the Static-99 and VORAS have been adapted to suit this population, they demonstrate many shortcomings. The ARMIDILO goes some way to address shortcomings and could be used as a tool to measure the client's attitudes and compliances, both of which have been linked to recidivism (Boer *et al*, 1997; Hanson & Harris, 2000; Quincy, 2006). By recognising the protective factors within the score, it can be seen how the client is being protected from further offending. It can also be seen that, if these protective factors are not in place, the client may continue to commit further offences. The protective factors in the ARMIDILO cover the supervision of the client and the client's attitude. This unique method of scoring gives the ARMIDILO the advantage over current risk assessment tools by targeting specific individual needs. The needs are linked to the risk management of any offender (Ward & Brown, 2004; Ward & Marshall, 2004) and although it could be argued that all offenders have needs, the ID person has more complex needs as they often exhibit other psychopathy (Wilson, 2004).

4.5.2 Program Initiation.

A key aspect of the ARMIDILO trial was to determine which programs could be initiated to address clients' recidivism issues. Static-99 looks specifically at sexual offending and VORAS at violence, whereas the ARMIDILO explores both sexual and violent behaviour. By covering both sexual deviancy and violent offending, the ARMIDILO analyses the extent of both problems. The ARMIDILO not only looks at the past history of the client, but also their attitudes towards the future. This can redefine the exact issues that the client has. An example of this is where a client exhibited violent behaviour but the ARMIDILO results revealed that the violence was not a result of any particular situation, rather, the client's cognitive behavioural issues. In this case, a program of anger management would have been ineffective, while a program initiated to address the issues of their agoraphobia would have a greater possibility of success. Current risk assessment tools are used to distinguish high risk from low risk offenders (Barbaree, *et al*, 2001; Kroner, *et al*, 2001). The criteria for attending these programs are the type of offence committed and the level of risk (Kroner, *et al*, 2001). The ARMIDILO can score the risk of a client but it can also give indications of the individual's risk and programmes designed for their specific needs (Boer, et al, 2008).

4.5.3 Deductive Findings.

Staff input makes the ARMIDILO unique. The VORAS and Static-99 focus entirely upon the offender and fail to take any environmental issues into consideration. The ARMIDILO responses demonstrated the caregivers' aspirations for more specific client-oriented training. Although there are financial considerations, staff members within both a prison and a residential environment have a high impact on residents. The measure of this impact is revealed in the ARMIDILO by assessing how the clients relate to caregivers and whether they see them as a contributing factor to their recidivism. The caregivers' level of commitment to their clients and also their job satisfaction reflects upon their client within their physical environment and client's possible recidivism.

As demonstrated by statistical analysis of the three tests, the ARMIDILO displays adequate constructive validity, content validity and statistical reliability. The Static-99 and VORAS effectively measure risk assessment and based on those two tests alone, the level of recidivism for the ID person can be assessed. However, only the ARMIDILO goes further to demonstrate the risk management needed for the ID person. The main points found within this research are that the effectiveness of testing recidivism and initiating programs to meet individual needs are more beneficial to the development of the ID person than either the Static-99 or the VORAS. Programming can be initiated, which not only addresses the needs of the client but also their personal development and hopefully allow them to live as risk-free lives as possible. New Zealand has gone a long way in initiating a better lifestyle for people with ID who offend. Large institutions such

as Tokanui Hospital have been closed and small, residential homes provided to address the needs and care for the ID person. The ARMDILLO will assist in these changes and may help all stakeholders in the ultimate aim in providing a safe and healthy working environment for staff and clients.

Chapter 5: Conclusion.

There have been various debates in recent years over whether clinical judgement is better than specific empirical analysis tools (Grove, *et al*, 2000; Craig, *et al*, 2008). This thesis explores a different form of addressing the needs of ID people who have sexual and or violent offending behaviours. ARMIDILO is the first known instrument that specifically addresses the needs of the offending ID person. In comparing the ARMIDILO with two current recidivism tools, the Static-99 and VORAS, the ARMIDILO proved to be an effective risk and management assessment tool. The ARMIDILO takes into consideration the cultural as well as social needs of the client and could, therefore, have a universal application. Although there are some questions that need rewording or redefining, overall, the questionnaire uses simple and easily understood questions. Unlike questionnaires using scales such as the Likert that are easily scored (Clifford & Valentine, 2003; Groth-Marnat, 2003), the ARMIDILO does not have ease of scoring and some refinement is required to reduce the impact of personal bias.

The hypothesis for this research was that the ARMIDILO would be a more effective tool than current assessments such as the VORAS and Static-99, as it not only measures recidivism in sexual and or violent offenders but also provides management structures. This research has demonstrated that the hypothesis is correct. The ARMIDILO has proven to be a more effective risk management tool for ID people who offend than current risk assessment tools.

In this research both the Static-99 and VORAS show a high level of risk in this research population. The ARMIDILO also provided a risk score and highlighted whether the risk was sexual, violent, or both. Additionally, factors have been identified that may be used to reduce recidivism. The ARMIDILO was constructed by experts with extensive experience in the field of ID offenders. Their combined knowledge and experience make the ARMIDILO a research tool that specifically examines risk factors within a specialised population. While some adjustments are needed, the ARMIDILO could be used in its present form to facilitate the initiation of programs directed at the needs of the individual client.

This research was initiated to evaluate whether the ARMIDILO was a more effective risk assessment tool than those currently available. It became apparent that, although the ARMIDILO could measure risk assessment, its primary function is to assess the ID person who offends and initiate relevant management programs. The ARMIDILO enables the client to identify their current dynamic risk factors, which could assist in the development of programmes to address their specific needs. This would be beneficial to the client and how they see their risks, in contrast to what is perceived by others as their risk needs. As the ARMIDILO can be statistically analysed, it would be possible to implement a base measurement. This would allow program facilitators to categorise groups within the population and therefore place people within programs based upon their various levels of risk. This is in line with current risk needs assessment analysis.

This is the first occasion that the ARMIDILO has been used for research purposes in New Zealand and therefore there were certain difficulties

encountered, not only with the administration of the test, but also the test itself. Any research requires ethical approval to safeguard the rights of an individual and to maintain the integrity of the research. In this instance, the numerous health care providers involved with ID people who offend required multiple ethical approvals. As there are no other risk assessment tools specifically designed for ID people who offend, the results obtained cannot be statistically validated at this time. In addition, there were logistical difficulties in the implementation of the test. The ARMIDILO is time consuming and complex, placing a great deal of emotional and physical stress on all parties. To avoid interviewer stress, the number of consecutive interviews should be limited or avoided.

The ARMIDILO allows caregivers an opportunity to voice their concerns in the management of ID people who offend. Administration by an external interviewer reduced caregivers' fears of repercussions. This facilitated how they perceived their job needs and the tools they required to ensure job satisfaction and personal development. These advancements for the caregivers would be to the benefit of their clients. Similarly, the clients were able to develop their own ideas and have some insight into their behavioural problems. In addition, facilitators of program management such as the Regional Forensic Psychiatric Service (RFPS) have access to these questionnaires and could develop programs for the specific needs of their clients. As the clients answered the questions at their own level of understanding, any programs could be targeted to this level. Although specifically cultural issues are not addressed in the ARMIDILO, caregivers and clients present with cultural differences, which may be highly relevant when conducting any management programs. The ARMIDILO specifically addressed the programs previously undertaken and how the client felt about them. This information also

highlighted the need to implement further programs. It may be, that by using the ARMIDILO as a risk management tool, the safety and wellbeing of all people involved would be promoted.

There are a number of suggested areas for future research. The initial research was undertaken with 26 subjects and it would be difficult to say whether this small population is a representative sample of ID people in residential care who offend. Further research with a larger population may provide reliable validity. The research was conducted by one individual; therefore to establish reliability and validation, it would be necessary for several researchers to trial the ARMIDILO. In addition to the size of the population, other areas for further research could include gender and age. In this research, 98 per cent of subjects were male and therefore it is impossible to comment on or assume any gender differences. The population researched was between 18 and 55 years of age; research into ID youth who offend requires further investigation. It would be invaluable to the validation of the ARMIDILO if, following the initial research, programs were implemented to address individual needs and then re-testing conducted. This would demonstrate if the ARMIDILO is an effective risk management tool and how effective the programs were.

Currently, in New Zealand, a person with developmental intellectual learning disability lives in residential care within the community, where their personal development and their ability to live a full and safe life is encouraged. The ARMIDILO is a tool that could be used to further achieve these goals, whilst helping to maintain a safer society.

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Appendices

Appendix 1: ARMIDILO Questionnaire

STAFF INTERVIEW

C. Stable Dynamic Environmental Factors

1. Attitude towards Intellectually, Disabled Individuals

1. How would you define your role in relation to your clients; what are the important client outcomes you are employed to achieve?

_____

_____

_____

2. Do you like this work? How long have you been doing this sort of work?

_____

_____

_____

3. What do you like about it (this sort of work)? What do you get out of it?

_____

_____

_____

4. Tell me a bit about your clients (assuming the interviewee is a key worker; obviously if the interviewee is a parent, then use "son" or "daughter" in place of client).

_____

_____

_____

5. What do you like best/worst about your clients?

_____

_____

_____

6. Do any of your clients present special challenges for you? How about (_____)[1] ?

_____

_____

_____

7. Why do you think your clients behave the way they do? More specifically, (_____)?

_____

_____

_____

8. Do you think you need any special training to do your work more effectively?

_____

_____

_____

2. Communication among Supervisory Staff

1. Are there gaps in the information sharing process that need fixing?

_____

_____

_____

[1] Whenever an underlined space (_____) is provided, that is for the first name of the client being assessed.

2. Have there been times when critical information was not communicated to you? Has this impacted your ability to do your job effectively? How could this be fixed?

_____

_____

_____

3. What information (if any) is kept confidential? What information is shared among staff and under what circumstances does this occur?

_____

_____

_____

4. How do you share critical information about a client with staff members who need to know? For example, if (_____) did something violent to another person, how and when would you let other staff members know? Would you ever involve the police? How would you do that?

_____

_____

_____

3. Client-Specific Knowledge by Supervisory Staff

1. What are the challenging (or offensive, or violent) behaviours that your client has problems with and when do they occur?

_____

_____

_____

2. When or how do you know a challenging behaviour is likely to happen; what are his/her triggers for these behaviours?

_____

_____

_____

3. What maintains the challenging behaviour?

_____

_____

_____

4. What do you think works best to control your client's challenging behaviour?

_____

_____

_____

5. What do you think needs to be done to help your client decrease his/her behaviour? Is this feasible in this setting? What would be ideal to help manage his/her challenging behaviour?

_____

_____

_____

6. How might the client behave away from this service/setting?

_____

_____

_____

4. Consistency of Supervision

1. Does your client try to manipulate other staff members or residents? How?

_____

_____

_____

2. Does your client manage to get preferential treatment from any of the other staff? Has he/she tried to manipulate you into getting preferential treatment?

_____

_____

_____

3. Do you find that your client's parents (or other supportive people external to the residential setting) reinforce negative behaviour patterns? Like what?

_____

_____

_____

4. Do you have any suggestions for more effective management of your client?

_____

_____

_____

5. Do you feel that your client is not being supervised effectively by some staff members? How is this affecting your client's well-being?

_____

_____

_____

5. Situational Consistency

1. How dependent on consistency is your client? How do changes in consistency affect your client?

_____

_____

_____

2. How does your client adjust to changes in routine, staffing or cancelled visits? Can you provide an example?

_____

_____

_____

3. Does your client react badly to changes, or does he/she manage changes pretty well? Can you give an example?

_____

_____

_____

6. Unique Considerations (include environmental suitability)

1. Do you feel that the client's needs are well met in his/her current living situation? Why/why not?

_____

_____

_____

2. What needs are not being met well in your opinion? How could this be done more effectively? How could that benefit your client?

_____

_____

_____

3. Does your client have any unique needs or risk factors that complicate how well his/her risk can be managed? Can you describe (an) example(s)?

_____

_____

_____

4. Are there any interactional difficulties with other clients that occur routinely? What happens and how does (_____) react?

_____

_____

_____

D. Acute Dynamic Environmental Factors (within the past 3 months)

1. Changes in Social Relationships

1. Has anything happened recently with your client's family or friends that upset him/her? What happened? How did he/she react?

_____

_____

_____

2. Have any of your client's friends or family members moved recently? How did that affect him/her? How long did it take him/her to get over it?

_____

_____

_____

2. Personnel or monitoring changes

1. (If there any new personnel) How does (_____) adjust to new support workers? Does he/she try to get away with things he/she couldn't with the regular staff? Can you give me an example?

_____

_____

_____

2. (If his/her monitoring levels have been changed and if the client is aware of the change) Why were his/her monitoring levels changed? How did (_____) react to that?

_____

_____

_____

3. Situational changes

1. (If the client was moved within the past 3 months) How is (_____) coping with the move? Do you think he/she understands why they had to move?

_____

_____

_____

2. What do you think your client thinks about the new place? Do you think they miss their old place?

_____

_____

_____

4. Changes in victim access

1. Who has your client spent time with lately? Does he/she spend time with new residents in a manner that suggests he/she is grooming them or becoming abusive?

_____

_____

_____

2. Do you think that there are any new opportunities for (_____) to get into problems, such as offending in any way?

_____

_____

_____

3. Does (_____) like to hang out and wait for anyone from work or school because he/she seems to find them sexy or cute?

_____

_____

_____

4. Do you have any concerns about him/her offending or hurting anyone (or him/herself)?

_____

_____

_____

5. Changes in access to intoxicants

1. Does your client have any history of using alcohol or drugs? (If yes, "how did he/she get the alcohol or drugs?")

_____

_____

_____

2. Do you have any concerns about your client in terms of him/her trying to use alcohol or drugs?

_____

_____

_____

6. Unique considerations

1. Has your client any changes in his/her living arrangements that he/she is having problems with?

_____

_____

_____

2. Are there any residents or staff members that are problematic for your client that we haven't discussed yet?

_____

_____

_____

3. Are there any recent social, family, or anything else that has happened that we haven't discussed and which may affect your client's ability to manage his/her behaviour effectively?

_____

_____

_____

Thank-you very much for your patience.

CLIENT INTERVIEW

Stable Dynamic Client Factors

1. Attitude Towards and Compliance with Supervision

1. Do you know why you have to live here?

_____

_____

_____

2. What do you think about the rules?

_____

_____

_____

3. Do you think you need the rules? Why? (If not, why not?)

_____

_____

_____

4. What would you like to be different with the rules?

_____

_____

_____

5. Do you like your support worker? (or use equivalent term: support, key, case worker)

_____

_____

_____

6. What does your key worker help you with?

_____

_____

_____

2. Attitude Towards & Compliance with Treatment

1. Who are the people trying to help you keep safe? (e.g., key worker, probation officer)

_____

_____

_____

2. How are they trying to help you? (e.g., programmes, medication, training programmes)

_____

_____

_____

3. Do you think it (treatment, medication, training programmes) is helping you?

_____

_____

_____

4. What have you learnt in the programme?

_____

_____

_____

5. What's the best/worst thing about the programme?

_____

_____

_____

6. How much longer do you think you need this help?

_____

_____

_____

7. How will you know when you're ready to stop taking treatment?

_____

_____

_____

3. Sexual Deviance

1. Have you ever had sex with someone? Describe it for me. Did you like it, or did someone force you do to something sexual with them?

_____

_____

_____

2. What do you like sexually (or what sorts of things turn you on)?

_____

_____

_____

3. Have you ever got in trouble because of doing something sexual? What happened?

_____

_____

_____

4. Do you like magazines or catalogues with sexy pictures in them? Like what?

_____

_____

_____

5. When is sex good or OK? When is it not OK? (Check for deviant interests or abuse history)

_____

_____

_____

6. Is it OK to play with yourself/masturbate? Has this ever got you into trouble?

_____

_____

_____

4. Inappropriate Preoccupation[2]

1. How often would you like to do _____ (if you could get away with it)?

_____

_____

_____

[2] For this item the assessor should know from the staff member whether there is an inappropriate preoccupation of some concern. A client may have a sexual preoccupation, but they may also have a preoccupation with fire-setting, stealing, shoplifting, amongst others.

2. Why do you _____ ?

_____

_____

_____

3. Do you feel that doing _____ is a problem for you? Could you stop if you wanted to?

_____

_____

_____

5. Victim Selection and Acquisition/Grooming Behaviour

1. If you wanted to have sex with someone, how would you go about doing that?

_____

_____

_____

2. Are you allowed to have sex with other guys in the residence (or prison, etc)? Have you been able to have sex even if it's not allowed? How did you manage that?

_____

_____

_____

3. Do you pick on other guys in the residence? How do you do that? Why do pick on some guys and not others? How about some staff – do you pick on some staff? Why?

_____

_____

6. Emotional Coping Ability

1. What sorts of things make you angry?

_____

_____

_____

2. Do people tell you that you have a bad temper? Do you lose it easily?

_____

_____

_____

3. (Ask the client about his visitors [or staff members] and try to find out how he/she reacted last time someone didn't show up when they were supposed to; or, how he/she reacted when a bus or ride or teacher [or anyone] didn't show up as scheduled). For example, "how did you feel when your Mom didn't show up to visit yesterday? Or, "what would you do if the bus was late?"

_____

_____

_____

7. Self-Efficacy

1. Do you like living in this place? Where would you like to live someday? What would you like to do some day for a living?

_____

_____

_____

2. Do you have plans for the future? What are they?

_____

_____

_____

3. What is the biggest problem you have at the moment? How can you solve that?

_____

_____

_____

8. Relationship Skills[3]

1. How easy is it for you to make friends? Tell me about your best friend.

_____

_____

_____

2. Do you ever feel lonely? How do you cope with that?

_____

_____

_____

3. Have you ever had a girlfriend/boyfriend? Tell me about the relationship. How about now? What is special about a girlfriend or boyfriend)?

_____

_____

_____

[3] Relationship skills in this context have to do with intimate relationships and friendships, not familial relationships.

4. Have you ever been married? If not, ask “do you think you’d like to get married someday?”

_____

_____

_____

5. Do you have children? How do you get along with them? (If the client does not have children, “would you like to have kids some day?”)

_____

_____

_____

9. Substance Abuse

1. Do you drink alcohol? (If yes: how much do you drink at a time?)

_____

_____

_____

2. Do you smoke dope or use drugs? (If yes: how often/much?)

_____

_____

_____

3. Have drugs or drinking caused any problems for you?

_____

_____

_____

10. Impulsivity

1. Do you sometimes act before thinking? Can you give me an example?

_____

_____

_____

2. What's the silliest thing you've ever done on the spur-of-the-moment?

_____

_____

_____

3. Have you done risky things on a dare? Like what?

_____

_____

_____

4. Do you get bored easily? What do you do when you get bored?

_____

_____

_____

11. Use of Violence or Threats towards Self or Others

1. Do you ever feel like you're going to lose your temper? When does that happen? How do people know when you're about to lose it?

_____

_____

_____

2. Have you ever been so upset that you wanted to hurt yourself?

3. Have you ever been so upset you wanted to hurt someone else? What is the worst you've ever hurt someone? How about yourself?

12. Mental Health and Other Unique Considerations

1. Have you ever seen a doctor for any mental health problems? Like what?

2. Do you take any medications for your moods or anything like that? How does it help? How do you know if you are getting unwell? What do you do when that happens?

Acute Dynamic Client Factors

1. Changes in Attitude or Behaviour toward Supervision or Treatment

1. What do you think about all the rules/restrictions you have to pay attention to?

How do you cope with these rules/restrictions?

_____

_____

_____

2. Who are the people trying to help you? What do you think about their help?

What else do you need to help you do well?

_____

_____

_____

3. Do you attend the programmes you are supposed to? Are they helpful?

_____

_____

_____

2. Changes in Inappropriate Preoccupation[4]

1. How much have you been thinking about _____ – the

same/more/less?

_____

_____

_____

[4] For this item the assessor should know from the staff member whether there is an inappropriate preoccupation of some concern. A client may have a sexual preoccupation, but they may also have a preoccupation with fire-setting, stealing, shoplifting, amongst others.

2. Have you had any thoughts or feelings about _____ that have been building up? How do you handle this?

_____

_____

_____

3. Changes in Victim-Related Behaviours

1. Do you like to hang out and wait for anyone from work or school because you find them sexy or cute? Have you tried to have sex with them? (This sort of questions are best predicated on the knowledge that the client has been (or has tried to be) involved with the other person sexually or has a history of such involvement).

_____

_____

_____

2. Do you pick on anyone in the residence? Why do you do that? (Again, this type of question is based on a reasonable history of victimizing others).

_____

_____

_____

4. Changes in Emotional State or Regulation

1. How have you been feeling lately? (If up and down, or mostly down, why?).

_____

_____

_____

2. Have things ever got so bad that you've thought about ending it all? (What caused that situation? When was the last time you felt like that? What stopped you?).

_____

_____

_____

5. Changes in Ability to use Coping Strategies

1. Are you on any medication prescribed by a doctor? What and how much?

_____

_____

_____

2. Have you been using alcohol or drugs in the last 3 months? How much?

_____

_____

_____

3. Has your drinking/using drugs caused any problems for you?

_____

_____

_____

6. Changes to Mental Health Status and Other Unique Considerations

1. Have you had any changes in your mental health? Are your meds working?

_____

_____

_____

2. Have there been any big changes with the important people in your life in the last few months (family and staff/professionals)? What has that been like for you?

_____

_____

_____

3. Have you made any new friends in the last few months? Where did you meet them? What do you do together?

_____

_____

_____

Acute Dynamic Environmental Factors

1. Changes in Social Relationships

1. Has anything happened recently with your family or friends that upset you? Can you tell me about it? What happened? How did you react?

_____

_____

_____

2. Have any of your friends or family members moved recently? How did that affect you? Were you sad? How did you get over it? How long did that take you?

_____

_____

_____

2. Personnel or monitoring changes

1. (If there any new personnel) How do you like your new support worker? Is she/he strict? Can you get away with stuff that you couldn't with your last worker?

_____

_____

_____

2. (If his/her monitoring levels have been changed and if the client is aware of the change) Why did the staff change your level? How do you feel about that?

_____

_____

_____

3. Situational changes (if any)

1. How are feeling about your move from your old residence to here? Do you know why you had to move? What do you think about your new place?

_____

_____

_____

4. Changes in victim access

1. Who have you spent time with lately? Are there any new people who have come into your service? Tell me about them.

_____

_____

_____

2. What do you think about the new residents or staff members (if any)?

_____

_____

_____

3. Are there any new kids around that you find annoying? Who? Why? What do you feel like doing to that kid?

_____

_____

_____

4. Are there any new kids or visitors that you find attractive? What about them is attractive to you? Do you like to hang out and wait for anyone from work or school because you find them sexy or cute?

_____

_____

_____

5. Changes in access to intoxicants

1. Have you been using alcohol or drugs recently? (If yes, "how did you get the alcohol or drugs?")

_____

_____

_____

2. Is alcohol or drugs easier or harder to get here lately than before? (If yes, "why is that?")

_____

_____

3. If you really wanted to, how could get your hands on alcohol or drugs? (If yes, "how would you do that?")

_____

_____

_____

6. Unique considerations

1. Have you had any changes in your living arrangements recently that upset you? How about any new residents or anything else that you are having problems with?

_____

_____

_____

2. (If the client has been moved to a new facility recently and especially if newly imprisoned) Have you had any major problems living here? Like what?

_____

_____

_____

Appendix 2: ARMIDILO Score Sheet

ARMIDILO SCORING SHEET

Name: **Age:**

Specify time period for evaluating recent change: 3 Months

RISK FACTOR CATEGORIES:

Stable Dynamic Items (Environmental Factors) (Staff) Section A	*Presence* *-2 to +2*	**Recent Change (+, 0, -)**	**Critical Item?**
1. Attitude towards intellectually, learning or developmentally disabled individuals			
2. Communication among supervisory staff			
3. Client specific knowledge by supervisory staff			
4. Consistency of supervision			
5. Situational consistency			
6. Unique considerations			
MEAN TOTAL SUB-SECTION SCORE:			
Acute Dynamic Items (Environmental Factors) (Staff) Section A	*Presence* *-2 to +2*	**Recent Change (+, 0, -)**	**Critical Item?**
1. Changes in social relationships			
2. Personnel or monitoring changes			
3. Situational changes			
4. Changes in victim access			
5. Changes in access to intoxicants			
6. Unique considerations			
MEAN TOTAL SUB-SECTION SCORE:			
MEAN TOTAL SECTION SCORE: (Part A)			

Stable Dynamic Items (Client) Section B	*Presence* **-2 to +2**	**Recent Change (+, 0, -)**	**Critical Item?**
1. Attitude toward and compliance with supervision			
2. Attitude toward and compliance with treatment			
3. Sexual deviance			
4. Inappropriate preoccupation			
5. Victim selection and acquisition / grooming behaviour			
6. Emotional coping ability			
7. Self-Efficacy			
8. Relationship skills			
9. Substance abuse			
10. Impulsivity			
11. Use of violence or threats towards self or others			
12. Mental health and other unique considerations			
MEAN TOTAL SUB-SECTION SCORE			
Acute Dynamic Items (Client) Section B	*Presence* ***-2 to +2***	**Recent Change (+, 0, -)**	**Critical Item?**
1. Changes in attitude or behaviour toward supervision or treatment			
2. Changes in inappropriate preoccupation			
3. Situational changes			
4. Changes in emotional state or regulation			
5. Changes in ability to use coping strategies			
6.Changes to mental health status and other unique considerations (e.g., access to intoxicants)			

MEAN TOTAL SUB-SECTION SCORE:			
Acute Dynamic Items (Environmental Factors) (Client) Section B	**Presence -2 to +2**	**Recent Change (+, 0, -)**	**Critical Item?**
1. Changes in social relationships			
2. Personnel or monitoring changes			
3. Situational changes			
4. Changes in victim access			
5. Changes in access to intoxicants			
6. Unique considerations			
MEAN TOTAL SUB-SECTION SCORE:			
MEAN TOTAL SECTION SCORE: (B)			

Summary of Risk Manageability Rating: (Part A)

Summary of Risk Manageability Rating: (Part B)

<u>Total</u> Summary of Risk Manageability Rating

<u>Risk Manageability Rating</u> **Low** **Moderate** **High**

Assessment completed by:
Date of assessment:

Appendix 2.1: ARMIDILO Scoring Guide

1. Attitude towards Intellectually, Disabled Individuals

Rationale

Supervision of intellectually, learning disabled, developmentally disabled or mentally retarded clients (collectively referred to as "ID" clients in this manual) is a difficult task for many reasons. The cognitive, emotional and behavioural difficulties that define this client group are very complex and varied requiring skilled intervention and patience. Non-compliance with rules by ID clients is arguably a constant feature of this client group. However, ID clients are often more non-compliant with insensitive staff members. "Challenging" behaviour is often violent and even sexually violent towards other clients, staff members, and members of the public and it is rare that ID clients get charged such behaviour, particularly if such behaviour occurs in residential care. As a result of the complex nature of the work and clients, staff member attitude is a critical variable in effective work with this client group.

Related Questions – Staff member(s)

1. Do you like this work? How long have you been doing this sort of work?

2. What do you like about it (this sort of work)? What do you get out of it?

3. Tell me a bit about your clients (assuming the interviewee is a key worker).

4. What do you like best/worst about your clients?

5. Do any of your clients present special challenges for you?

6. Do you think you need any special training to do your work more effectively?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

2. Communication among Supervisory Staff

Rationale

Effective communication amongst the supervisory team (e.g., care or support workers, clinicians, probation officers) is essential for effective risk management. Anyone who has worked in residential care with ID clientele knows that there are times when information, sometimes critical information, is not passed along to subsequent shifts and the lack of information can cause client management problems. Often such gaps in communication is due to lack of basic training about ID clients, such as the importance of consistency in terms of responses to client behaviours, understanding background factors and triggers for challenging behaviours, or relevant environmental cues. If a staff member does not know what to communicate it is difficult to communicate effectively! The importance of structured team meetings to review communication strategies and the client's progress and support plan is critical to effective client management (McVilly, 2002). A review of the client's file ought to provide evidence of such planning (including action, opportunity and teaching plans where suitable), client compliance with such plans, and communication regarding the client's triggers (or

"red flags") or other issues that relate to changes in monitoring or management needs.

Related Questions – Staff member(s)

1. Are there gaps in the information sharing process that need fixing? How?

2. Have there been times when critical information was not communicated to you? Has this impacted your ability to do your job effectively? How could this be fixed?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

3. Client-Specific Knowledge by Supervisory Staff

Rationale

It is crucial that support workers and other staff members working with ID clients are aware of the client's behavioural patterns, particularly in terms of violent or sexually violent challenging or offensive behaviour. These sorts of behaviours occur in predictable patterns variously called offence patterns, behavioural progressions, relapse cycles, etc, but all of these terms describe the same thing: a pattern of behaviour, thoughts and feelings that individuals progress through, with some variability over time, when acting violently. Staff members need understand these patterns and associated triggers to help the client avoid progressing along towards new violent acts. This includes understanding the client's manipulative strategies in setting up situations to offend such as gaining access to potential victims. Clearly key support workers are best placed for

developing such knowledge and communicating it to others. However, it is important to remember that although staff members are paid professionals, they are also people who come to form relationships with their clients and may make risk underestimations over time.

Related Questions – Staff member(s)

1. What are the challenging (or offensive) behaviours that your client has problems with? What are his/her triggers for these behaviours? What maintains it?

2. What do you think works best to control your client's violent behaviour?

3. What do you think needs to be done to help your client decrease his/her violence? Is this feasible in this setting? What else can be done to help him/her?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

4. Consistency of Supervision

Rationale

Intellectually disabled (ID) clients are arguably more dependent on consistent care and supervision from front-line staff (e.g., support workers) than non-ID clients as a result of their disabilities. Nonetheless, ID clients are adept at exploiting inconsistencies amongst staff. In addition, staff members may find themselves treating clients differentially as a result of the differing personalities and behavioural patterns of the individual clients. While this is somewhat of a natural human tendency (to focus positive attention on those who provide us with reinforcement), this also speaks to the importance of maintaining professional

behaviour and boundaries. ID clients are able to discern differential treatment (e.g., favouritism) and this reinforces positive and negative behaviour patterns. This is an area of supervision for all staff members, and peer feedback is crucial to maintaining firm, fair, and friendly (in that order) treatment of all clients, regardless of social desirability.

Related Questions – Staff member(s)

1. Does your client try to manipulate other staff members or residents? How?

2. Does your client manage to get preferential treatment from any of the other staff? Has he/she tried to manipulate you into getting preferential treatment?

3. Do you find that your client's parents (or other supportive people external to the residential setting) reinforce negative behaviour patterns? Like what?

4. Do you have any suggestions for more effective management of your client?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

5. Situational Consistency

Rationale

This item assumes that the current setting that the client is living in is suitable to meeting his/her needs. If this is not the case, then this item is moot as a risk management item as an unsuitable environment is a risk-increasing factor for the client (e.g., for violent behaviour, for mental health deterioration). If the

current living environment is unsuitable for the client, this is probably best addressed as a "unique consideration" under item 6 (the next item), but given that it is a prerequisite to the importance of situational consistency is it raised here first. If the current living environment is suitable, it is arguable that individuals with intellectual disabilities are more dependent on a consistent living situation than non-ID clients. Also, the greater the level of ID, the more important this issue becomes to the client and his/her management.

Related Questions – Staff member(s)

1. Do you feel that the client's needs are well met in his/her current living situation? Why/why not? What needs are not being met well in your opinion? How could this be done more effectively? How could that benefit your client?

2. How dependent on consistency is your client? How do changes in consistency affect your client? Does your client react badly to changes, or does he/she manage changes pretty well? Can you give an example?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

6. Unique Considerations (include environmental suitability)

Rationale

ID clients often have idiosyncratic environmental (including staffing) needs that affect their risk manageability. A primary example is that of environmental suitability (noted in item 5 as a pre-requisite to evaluating the importance of situational consistency). Another example is that of the influence of the client's family. Most often, the client's family is a source of support.

However, family issues, such as the long-term impacts of marital separation, deaths, relocations, and simple aging, compromise the ability of the family to provide support. Family members may also lack insight into the personal problems of the client, such as hygiene, mental health problems or risk issues.

More generally, all ID clients have unique risk-related factors that compromise their manageability. Examples include unusual levels of sex drive that make the presence of new residents a potent risk factor, unusual negative side-effects from medication (or changes in medication), unusual negative sensitivity to relocation or changes in routine. Of course, some of these issues are related to different diagnostic problems (e.g., autism), but overall, staff members need to be aware how these and other environmental considerations affect their clientele.

Related Questions

1. Does your client have any unique needs or risk factors that complicate how well his/her risk can be managed? Can you describe (an) example(s)?

2. How does your client adjust to changes in routine, staffing or cancelled visits?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

1. Changes in Social Relationships

Rationale

Changes in supportive relationships are generally beyond the control of ID clients, and these changes differentially affect the manageability of individual

clients. In this item, we are concerned mostly about the client's ability to cope with change in relationships, including intimate or familial relationships, and friendships. For example, the immediate impacts of family-related issues, such as marriage break-ups, deaths, or relocations compromise the ability of the family to provide support, but also disrupt the client's manageability. Also, peer relationships, particularly close and supportive friendships will affect the client's ability to cope in the short term.

The ability to cope with change is more of a stable dynamic feature of the client, but the immediate impact of change is obviously an acute feature. The client's ability to discuss the possible effects of acute changes in environmental factors may be quite difficult for the client given problems with abstraction and ID, but a focus on recent events (if any) may prove instructive to discuss with the client.

Related Questions – Client

1. Has anything happened recently with your family or friends that upset you? Can you tell me about it? What happened? How did you react?

2. Have any of your friends or family members moved recently? How did that affect you? Were you sad? How did you get over it? How long did that take you?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

2. Personnel or Monitoring Changes

Rationale

The focus of this item is on recent changes in personnel and/or monitoring of the client that could affect manageability, and trying to understand why these changes in manageability have occurred. If new personnel are well-trained and observant, their presence may still elicit new behaviours (or repeated reactions to new staff that were predictable given the case history) that may prove difficult to manage. However, good training and observation skills ought to minimize changes in client manageability. Changes in monitoring due to a period of well-managed behaviour may not go unnoticed by ID clients and lower levels of concern and monitoring may well be related to resumptions in the problem behaviours. Enhanced monitoring levels are best withdrawn very gradually whilst being adjusted according to risk level at all times. That is, if a client is considered a relatively high risk client for violence of any sort, then monitoring (or enhanced monitoring) should always be higher (and withdrawn more slowly) than that for a lower risk client, regardless of recency of last violent episode.

Related Questions – Client

1. (If there any new personnel) How do you like your new support worker? Is she/he strict? Can you get away with stuff that you couldn't with your last worker?

2. (If his/her monitoring levels have been changed and if the client is aware of the change) Why did the staff change your level? How do you feel about that?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

3. Situational Changes

Rationale

Movement from one location to another, or from one type of residential setting to another (e.g., moving from one residential care setting to another; or, moving from residential care to prison or vice versa), has idiosyncratic effects on clients. Changes in emotional state caused by such events can be very difficult for someone with an ID to cope with effectively given the lack of control by the client and the lack of understanding for the relocation. Hence, ID clients may be likely at these times to act impulsively, including disengaging from services/support, absconding or breaching residential or supervision conditions as a result of feeling various negative emotions.

Preparation of the client for such moves by the staff, such as engaging the client in move-related activities (unless the relocation is for legal reasons), may reduce the negative changes in emotional regulation. If the client views such changes as desirable, the negative changes may be minimized.

Related Questions – Client

1. How are feeling about your move from your old residence to here? Do you know why you had to move?

2. What do you think about your new place? Is it o.k., or do you really miss your old place?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

4. Changes in Victim Access

Rationale

The risk of offensive or challenging behaviour of a violent or sexual variety increases when individuals have frequent or unsupervised access to potential victims and such changes in victim access may come about without active planning by the client. Changes in residential location (previous item) may cause unintended changes in victim access. For example for an individual with a sex offence, changes in the community or residence may result in providing the client with situations where they have more contact with their preferred victim group (e.g., children, vulnerable individuals, new staff members). Similarly, clients with violent behaviour histories may gain access to new potential victims as a result of changes in the community or the client's residence.

Related Questions – Client

1. Who have you spent time with lately? Are there any new people who have come into your service? Tell me about them.

2. What do you think about the new residents or staff members (if any)?

3. Are there any new kids around that you find annoying? Who? Why? What do you feel like doing to that kid?

4. Are there any new kids or visitors that you find attractive? What about them is attractive to you? Do you like to hang out and wait for anyone from work or school because you find them sexy or cute?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

5. Changes in Access to Intoxicants

Rationale

Sudden changes in access to intoxicants may result in increases or decreases in client manageability. If a client exercises little control over substance abuse, they are then more susceptible to temptation in this regard. Decisions to not abuse drugs or other substances when faced with increased availability are all indicative of increased risk manageability. Ironically, incarceration often results in increased access to drugs compared to residential placements. Increased access, along with impaired risk coping ability, often results in ID clientele being highly susceptible to drug or alcohol use, especially in the presence of peer-pressure. A decreases in access of intoxicants is obviously related to increased manageability, regardless of the client's ability to control his/her substance abuse problems.

Related Questions

1. Have you been using alcohol or drugs recently? (If yes, "how did you get the alcohol or drugs?")

2. Is alcohol or drugs easier or harder to get here lately than before? (If yes, "why is that?")

3. If you really wanted to, how could get your hands on alcohol or drugs? (If yes, "how would you do that?")

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

6. Unique Considerations

Rationale

Unexpected changes (or combinations of changes) in the client's environment, may have unforeseen changes in a client's manageability and violence potential. Impulsive maladaptive decisions by a client may be made in reaction to emotional dysregulation caused by an expected reaction to a change in medication, or a medication-alcohol interaction, or a television show triggering a memory. Regardless of staff training or preparation it is not possible to be ready for all considerations that could affect a client's ability to manage risk. Examples include being arrested for violent or sexually violent behaviours, sometimes of which the client has no memory or has come to view as consensual. While being arrested is arguably always upsetting, it is probably less understandable and perhaps more frightening for clients with ID. Such an experience would involve sudden relocation, changes in staffing, changes in support (or at least access), changes in social relationships, and perhaps changes in terms of access to intoxicants. Such a global acute change environment would have tremendous capability compromise a client's ability to management his/her risk.

Related Questions – Client

1. Have you had any changes in your living arrangements that you are having problems with?

2. (If the client has been moved to a new facility recently and especially if newly imprisoned) Have you had any major problems living here? Like what?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

1. Attitude Towards and Compliance with Supervision

Rationale

Supervision involves adherence to Court orders or conditions/guidelines (or both) within residential and vocational services and the community. Lack of cooperation with supervision is related to the likelihood of reoffending by offenders with a history of sexual offending (Boer, Hart, Kropp, & Webster, 1997; Hanson & Harris, 2000) or violent offending (Quinsey, Harris, Rice, & Cormier, 2006). In the intellectually disabled (ID) population, the degree of insight and executive functioning enabling comprehension of the importance of complying with supervision is compromised compared to individuals without such disability. The assessor is also interested in attempts to evade supervision, disobey rules, manipulate supervisory staff, including their key worker (or personal support provider), or be non-compliant with medication. Look for evidence of increases of level of supervision intensity to manage the client for periods of time.

Related Questions – Client

1. Why do you have to live here?
2. What do you think about the rules?
3. Do you think you need the rules? Why? (If not, why not?)
4. What would you like to be different with the rules?
5. Do you like your key worker? (or use equivalent term for key worker)
6. What does your key worker help you with?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

2. Attitude Towards & Compliance with Treatment

Rationale

The willingness to comply with and response to treatment is of importance for risk management. A negative attitude toward intervention has been associated with sexually violent recidivism (Dempster & Hart, 2002) and failure to complete treatment has been found to be a consistent marker for both sexual and general recidivism (Hanson & Bussière, 1998). There is reliable evidence that offenders who attend and cooperate with treatment programmes are less likely to reoffend than those who reject intervention. Short periods of treatment and unplanned discharge have been associated with recidivism in offenders with intellectual disabilities (Lindsay, 2002). Look for evidence of the clients' ability to recognise offence precipitants, choose prosocial strategies, or insight into offensive behaviours.

Related Questions – Client

1. Who are the people trying to help you keep safe?
2. How are they trying to help you?
3. Do you think it (treatment) is working?
4. What have you learnt in the programme?
5. What's the best/worst thing about the programme?
6. How much longer do you think you need this help?
7. How will you know when you're ready to stop taking treatment?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

3. Sexual Deviance

Rationale

Persistent deviant sexual behaviour is hypothesised as a result of deviant sexual preferences, which are mediated by distorted cognitions toward victims, selective attention and inappropriate sexual arousal (Lindsay, 2004). Intellectually disabled (ID) clients (sexual offenders or not) often have problems with sexual deviance. There is ample evidence of the importance of this factor as a causal mechanism behind sexually violent behaviour. It is logical that challenging behaviour of a sexually aberrant nature may also be based on sexual deviance. Self-reported deviant fantasies has been found to be related to risk much as deviance determined by plethysmographic (PPG) or sexual arousal testing (e.g., Hanson & Bussière, 1998). Recent meta-analyses (e.g., Craig, Browne, Stringer,

& Beech, 2005) have consistently found deviant sexual interests as a primary determinant of sex offender recidivism.

Related Questions – Client

1. Do you like sex? Have you ever had sex with someone? Describe it for me.

2. What do you like sexually? What sorts of things turn you on?

3. What do you when you are turned on (sexually aroused)?

4. What sorts of things turn you on? Can you describe that for me?

5. Do you ever get in trouble when you get turned on? What happened?

6. Do you like magazines or catalogues with sexy pictures in them? Like what?

7. When is sex good or OK? When is it not OK? (Check for deviant interests)

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

4. Inappropriate Preoccupation

Rationale

Intellectually disabled (ID) clients are as likely to be preoccupied by sexual urges as non-ID clients and are more likely to lack socio-sexual knowledge, as well as have experienced negative early sexual experiences (including sexual abuse), limited opportunities to establish sexual relationships and demonstrate sexual naiveté than non-ID clients (Hudson, Wales, Bakker, &

Ward, 2002; Luiselli, 2000; Lindsay, 2002). A lack of appropriate sexual attitudes and developmental delay in relation to social situations may lead to offending (Caparulo, 1991). Appropriate social skills and acceptable behaviour in sexual relationships, consent, intimacy, risks and responsibility are typically a core treatment component for ID sex offenders. Such treatment may help them control their sexual thoughts or acting on sexual impulses commonly known to be related to sexually offensive behaviour (Hanson & Harris, 2004).

Related Questions – Client

1. How often would you like to have sex (if you could get away with it)?
2. How often do you masturbate? How often would you like to masturbate?
3. Is it OK to play with yourself/masturbate? Has this ever got you into trouble?
4. Does having sex/masturbating make you feel better?
5. Have you ever been in trouble because of having sex? Why is that?
6. When you get really turned on, how do you deal with this?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

5. Victim Selection and Acquisition/Grooming Behaviour

Rationale

Sex offenders with intellectual disabilities may be more likely to commit sex offences than non-ID individuals, offending against younger children, male

children and across victim categories (Blanchard, Watson, Choy, Dickey, Klassen, Kuban, & Feren, 1999). A high frequency of grooming behaviour (i.e., manipulating a potential victim for sexual purposes) has been found in this population, and this behaviour is typically less sophisticated that that used by non-ID sex offenders (Parry & Lindsay, 2003). Grooming and acquisition of potential victims is generally of a predictable nature and it is important to note if the client is deviating from his/her pattern or if the pattern is being replicated in some fashion. It is likely that these issues would be problematic for ID clients who have not been charged with sexual offences, but show sexually challenging behaviours.

Related Questions – Client

1. If you wanted to have sex with someone, how would you go about doing that?
2. How do you know someone wants to have sex with you?
3. Have you ever had sex with someone who didn't want to have sex with you?
4. Are you allowed to have sex with other guys in the residence (or prison, etc)? Have you been able to have sex even if it's not allowed? How did you manage that?
5. Have you ever hurt anybody when you had sex? Have you been hurt by someone else when you had sex?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

6. Emotional Coping Ability

Rationale

This item describes whether a client is able to competently self-manage their emotional state and deal with unpredicted or adverse events in their lives. Heightened levels of emotions or stress may overburden clients with intellectual disabilities and predispose them to react in antisocial or inappropriate ways. Examples of behaviour that supports this item would be poor behavioural controls as evidenced by incident reports of physical and verbal abuse by the client towards staff or other clients (or members of the public). Or, evidence of reactive violence where little effort seems to be made by the client to control anger or other negative mood states and oppositional interactions with others (e.g., supervisory staff, other clients). As well, clients may show poor problem-solving ability when under stress or experiencing difficult emotions. Clients will show different degrees of ability, for example, to cope with change, particularly if the change is due to changes such as those that are due to unpredictable events (e.g., an unexpected move to a new facility, or a death in their family).

Related Questions – Client

1. What sorts of things make you angry?

2. Do people tell you that you have a bad temper? Do you lose it easily?

3. (Ask the client about his visitors [or staff members] and try to find out how he/she reacted last time someone didn't show up when they were supposed to; or, how he/she reacted when a bus or ride or teacher [or anyone] didn't show up as scheduled). For example, "how did you feel when your Mom didn't show up to visit yesterday? Or, "what would you do if the bus was late?".

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

7. Self-Efficacy

Rationale

A lack of personal power, low-self esteem and lack of assertiveness have been related to reoffending in sex offenders with intellectual disabilities (Hayes, 1991; Hudson, et al., 1999; Lindsay, Elliot, & Astell, 2004). Problem-solving, communication skills and assertiveness are common areas of treatment for ID sex offenders (Clark, Rider, Caparulo, & Steege, 2004) implying deficits in personal problem-solving and general coping ability for ID sex offenders and other ID clients. In addition, deficits in formulating reasonable plans are also known to be related to risk for sexual violence (Boer, et al., 1997) and general violence (Webster, Douglas, Eaves, & Hart, 1997). For ID clients, it is likely that their ability to plan is somewhat underestimated or at least underused given that their support network may not feel the client is able to plan effectively, or this role has been usurped by the support person(s) in the client's life.

Conversely, the ability to withstand urges and "do the right thing" contribute to a sense of self-efficacy or resilience in the face of adversity or temptation.

Related Questions – Client

1. Do you like living in this (type of residence)? Where would you like to live?

2. Do you enjoy your life? What would you like to do (or become) some day?

3. Do you feel you can change things you do not like? How can you do that?

4. Do you have plans for the future? Do people listen to your plans for the future?

5. What is the biggest problem you have at the moment? How can you solve that?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

8. Relationship Skills

Rationale

Relationship problems including an inability to understand normal sexual relationships, a lack of relationship skills (in intimate and non-intimate relationships), difficulty mixing with the opposite sex and poor peer relations have been noted as typical characteristics of ID sex offenders (Lindsay, 2002). These same difficulties may well be equally profound in ID clients who exhibit other sorts of challenging behaviours, including interpersonal violence of a sexual or non-sexual nature. In addition, the risk literature widely acknowledges the inability to form lasting intimate relationships or maintain non-abusive

relationships as increasing risk for sexual (e.g., Boer, et al., 1997; Hanson & Thornton, 1999, 2003), physical (Webster, et al., 1997), or spousal violence (Kropp, Hart, Webster, & Eaves, 1995). Perhaps less problematic in terms of violence likelihood, but ID clients often profess good interpersonal relationships or skills, only to show minimal social interactions, estrangement from family, and negative peer relations.

Related Questions – Client

6. How easy is it for you to make friends? Tell me about your best friend.
7. Do you ever feel lonely? How do you cope with that?
8. Do you have a girlfriend/boyfriend? Tell me about the relationship.
9. Have you ever been married? Have you ever wanted to?
10. Do you have children? How do you get along with them? (If they don't have children, "would you like to have kids some day?")

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

9. Substance Abuse

Rationale

Substance abuse includes the use of illicit drugs and the misuse of alcohol or prescription medication. Substance abuse is a reliable predictor of reoffending in ID offenders in general (Klimecki, Jenkinson, & Wilson, 1994), and the likelihood of offending is increased if the individual is dependent upon substances or uses illicit drugs (Winter, Holland & Collins, 1997). ID clients may have difficulties in relationships, employment, financial management, or

accommodation due to substance abuse. Clients may also have limited understanding of the role that substance abuse plays in their offensive or challenging behaviour, and perhaps make choices that elevate substance abuse over prosocial choices for treatment, relationships, or other activities that would increase their manageability.

Related Questions – Client

1. Do you drink alcohol? What?
2. How many glasses of alcohol a day do you drink?
3. How many glasses of alcohol a week do you drink?
4. Do you smoke dope or use drugs? How often/much?
5. When was the last time you used drugs?
6. Have drugs or drinking caused any problems for you?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

10. Impulsivity

Rationale

Impulsivity refers to behaviour which is not planned and is committed without any consideration of the consequences on self and others. There is an extensive literature relating impulsivity to violent and non-violent offending. ID sex offenders are alleged to show a pattern of impulsivity, an inability to delay gratification and poorly controlled behaviour (Glaser & Deane, 1999).

Impulsivity, either on its own or as a feature of personality disorder, is widely acknowledged as increasing risk for sexual (e.g., Boer, et al., 1997; Craig, et al., 2005), physical (Webster, et al., 1997), or spousal violence (Kropp, et al., 1995). Evidence of impulsivity would include client problems with boredom, distractibility, impatience, over-reactivity to real or perceived insults, low stress tolerance, problems with emotional regulation in reaction to disappointments, criticism, failures, or mistakes (e.g., mood fluctuations, behavioural outbursts).

Related Questions – Client

1. When people put you down how do you react?
2. Do you sometimes act before thinking? Can you give me an example?
3. What's the silliest thing you've ever done on the spur-of-the-moment?
4. Have you done risky things on a dare? Like what?
5. Do you get bored easily? What do you do when you get bored?
6. Do people pick on your mistakes? How do you feel when that happens?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

11. Use of Violence or Threats towards Self or Others

Rationale

Aggression is frequently activated by internal distress and for people with deficits in emotional expression; violence may be a default response in anger-provoking situations for ID clients (Taylor, Novaco, Gillmer, & Robertson, 2004).

Aggressive behaviour has been established as a widely occurring problem, especially in institutional care facilities for ID clients (Taylor, 2002). Complaints about staff, insulting behaviour, making threats of violence towards staff, suicidal or self-harm threats, and antisocial attitudes are possible risk markers for ID clients.

Self-harm risk and other-harm risk (history of actual of or threats thereof) are seen as reliable risk markers for violence by violent and sexually violent offenders (e.g., Boer, et al., 1997; Webster, et al., 1997; Kropp, et al., 1995).

Related Questions – Client

1. Do you ever feel like you're going to lose your temper? When does that happen? How do people know when you're about to lose it?
2. Do you warn people when you are about to lose your temper?
3. Have you ever been so upset that you wanted to hurt yourself?
4. Have you ever been so upset you wanted to hurt someone else?
5. When you're really wound up, do you ever break or throw things?
6. What is the worst you've ever hurt someone? How about yourself?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

12. Mental Health and Other Unique Considerations

Rationale

ID clients often have potent but idiosyncratic issues that compound risk manageability. Examples include: family-related problems, profound lack of sex knowledge, lack of insight into personal problems such as hygiene, speech impediments, physical disability, or mental health problems. In regards to the latter, ID clients experience a similar spectrum of mental health problems to non-ID persons, but arguably at a higher frequency and greater disruptiveness to overall functioning. Offenders with ID have a higher prevalence rate of mental illness than those who do not offend (Smith & O'Brien, 2004). Major mental illness is a likely causal factor that may lead to impulsive or irrational decisions to act in a sexually violent manner (Dempster & Hart, 2002), loosen inhibitions or promote aberrant behaviour (Lindsay, 2004). The psychiatric assessment process for an individual with an intellectual disability may require collateral sources of information further than that in the general population. The ability to recognise the onset of symptoms, likely decompensation periods, seek appropriate treatment and comply with treatment regimes indicates the ability to self-manage mental illness.

Related Questions – Client

1. Have you ever seen a doctor for any mental health problems? Like what?
2. Do you take any medications for your moods or anything like that? How does it help? How do you know if you are getting unwell? What do you do when that happens?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

1. Changes in Attitude or Behaviour Towards Supervision or Treatment

Rationale

A prosocial lifestyle is more likely when compliance with supervision is maintained. Similarly, there is evidence that treatment involvement and programme completion is associated with lower offence rates by violent and sexual offenders (Hanson & Bussière, 1996). Individuals can reject supervision or treatment through a variety of behaviours, such as lying, absconding, disengagement, being non-disclosive, missing appointments, hostility or confrontation. Sudden rejection of treatment may also be reflective of a lack of insight regarding treatment needs or a return to offensive behaviour.

Related Questions

1. What do you think about all the rules/restrictions you have to pay attention to? How do you cope with these rules/restrictions?

2. Who are the people trying to help you? What do you think about their help?

What else do you need to help you do well?

3. Do you attend the programmes you are supposed to? Are they helpful?

4. Are you taking any programmes right now that seem to be a waste of time?

5. Does your support worker (and perhaps probation/parole officer) help you?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

2. Changes in Sexual Preoccupation

Rationale

Impulsive poor choices in relation to sexual behaviour also reflect poor ability to manage risk opportunities (e.g., when a new group home resident moves in that the client finds sexually attractive and the client begins to groom the person despite making a commitment to minimize sexually inappropriate behaviour). However, a change in sexual preoccupation from an inappropriate target (person or behaviour) may be evidence of decreased risk. A new and appropriate sexual partner may also be a protective factor, taking an offender out of his/her offending pattern and into an appropriate sexual pattern that is sufficiently reinforcing to indefinitely forestall offending. This item concerns the extent to which the individual is fixated on sexual matters and sees them as a central part of their life, using them as everyday coping skills. As an acute item, the focus is on recent changes that affect manageability, and trying to understand why these changes have occurred.

Related Questions

1. How much have you been thinking about sex – the same/more/less?
2. How important is sex these days?
3. Have you had any sexual thoughts or feelings that have been building up?

How do you handle this? What's been happening in your day before these feelings?

4. What TV programmes or magazines do you like to look at? Do any of these turn you on? How often do you look at these each day? Is this any more than usual?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

3. Changes in Victim Access

Rationale

The risk of offensive or challenging behaviour of a violent or sexual variety increases when individuals have frequent or unsupervised access to potential victims. It is important to consider the opportunities for an individual with a sex offence history to have contact/grooming/interaction with potential victims and whether they have attempted to set up situations where they have more contact with their preferred victim group (e.g., children, vulnerable individuals, new staff members). Similarly, clients with violent behaviour histories may view new residents or staff members as new potential victims. Support workers should be aware of how changes in victim access may community access, and access within residences as well.

Related Questions

1. Who have you spent time with lately? Are there any new people who have come into your service? Tell me about them.

2. What do you think about the new residents or staff members (if any)?

3. Are there any new kids around that you find attractive (or annoying)?

4. Are there any visitors that you find attractive? What about them is attractive to you? Do you like to hang out and wait for anyone from work or school because you find them sexy or cute?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

4. Changes in Emotional State or Regulation

Rationale

Changes in emotional state and/or changes in ability to manage emotions have been shown to be reliably related to increases or decreases in risk (Hanson & Harris, 2004). However, this factor has yet to be validated as a risk-related factor for ID clients. Nonetheless, it is logically related to risk and the ability of a client to manage his/her ongoing risk. Negative changes in emotional regulation caused by external events (e.g., missing a bus, missing an appointment, a friend or family member not showing up for an appointment or visit, or more serious events such as sickness or death of someone important) can be very difficult for someone with an ID to cope with effectively. For example, ID clients may be more likely at these times to act impulsively, including disengaging from services/support,

absconding or breaching supervision conditions as a result of feeling a high level of negative emotions.

Positive changes in emotional regulation can also be caused by external events (e.g., the re-establishment of contact between a family member and the ID person, an opportunity to visit family for a vacation, a new employment or volunteer position that the client saw as desirable).

Related Questions

1. How have you been feeling lately? (If up and down, or mostly down, why?)

2. Have things ever got so bad that you've thought about ending it all? (What caused that situation? When was the last time you felt like that? What stopped you?)

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

5. Changes in Ability to use Coping Strategies

Rationale

This is a broad item and the assessor needs to be aware of the coping strategies that the individual client needs to use to do well. These are strategies largely under the client's volitional control such as medication compliance, substance abuse control, or deviation from routine patterns (e.g., attending work or school). If a client has unforeseen fluctuations in their mental illness, this is outside the client's control and should be assessed using the next item. However,

if a client is aware of the need to be on his/her medication, and knows if he/she does not take the medication he/she becomes depressed or otherwise ill, then this is a coping strategy the client is deciding not to use. Similarly, if a client is aware that he/she has a substance abuse problems, and knows that programme attendance is important to help manage the problem, then non-attendance or non-compliance with programming is a decision to not use coping strategies. Conversely, decisions to comply with medication, take appropriate programming, maintain a predictable routine (and cope relatively well with change), not abuse drugs or other substances are all indicative of increased risk manageability.

Related Questions

1. Are you on any medication prescribed by a doctor? What and how much?
2. Have you been using alcohol or drugs in the last 3 months? How much?
3. How were you feeling before drinking/using? Who were you with?
4. Has your drinking/using drugs caused any problems for you?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

6. Changes to Mental Health Status and Other Unique Considerations

Rationale

Unexpected changes in mental health status or supportive relationships (or the inability to cope with such changes), or impulsive maladaptive decisions are examples of unique considerations that affect a client's ability to manage risk.

Other examples include transitioning to a new accommodation or facility which will involve new residents (some of whom may represent increases in risk for the client as potential victims or be of risk to the client as potential abusers) and may involve changes in other risk-related variables such as access to intoxicants or potential victims outside of the residence. While most ID clients can cope with some changes, there are client-specific factors that compromise such adaptability. Dual-diagnosis issues provide particularly unique interactions that can compromise a client. For example, a client who has bipolar illness plus alcohol dependence may not have sufficient insight to know that alcohol use and medication non-compliance would interact synergistically to increase their risk for violence.

Related Questions

1. Have you had any changes in your mental health? Are your meds working?
2. Have there been any big changes with the important people in your life in the last few months (family and staff/professionals)? What has that been like for you?
3. Have you made any new friends in the last few months? Where did you meet them? What do you do together?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

1. Changes in Social Relationships

Rationale

Changes in supportive relationships are generally beyond the control of ID clients, and these changes differentially affect the manageability of individual clients. In this item, we are concerned mostly about the client's ability to cope with change in relationships, including intimate or familial relationships, and friendships. For example, the immediate impacts of family-related issues, such as marriage break-ups, deaths, or relocations compromise the ability of the family to provide support, but also disrupt the client's manageability. Also, peer relationships, particularly close and supportive friendships will affect the client's ability to cope in the short term.

The ability to cope with change is more of a stable dynamic feature of the client, but the immediate impact of change is obviously an acute feature. The client's ability to discuss the possible effects of acute changes in environmental factors may be quite difficult for the client given problems with abstraction and ID, but a focus on recent events (if any) may prove instructive to discuss with the client.

Related Questions – Client

1. Has anything happened recently with your family or friends that upset you? Can you tell me about it? What happened? How did you react?
2. Have any of your friends or family members moved recently? How did that affect you? Were you sad? How did you get over it? How long did that take you?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

2. Personnel or Monitoring Changes

Rationale

The focus of this item is on recent changes in personnel and/or monitoring of the client that could affect manageability, and trying to understand why these changes in manageability have occurred. If new personnel are well-trained and observant, their presence may still elicit new behaviours (or repeated reactions to new staff that were predictable given the case history) that may prove difficult to manage. However, good training and observation skills ought to minimize changes in client manageability. Changes in monitoring due to a period of well-managed behaviour may not go unnoticed by ID clients and lower levels of concern and monitoring may well be related to resumptions in the problem behaviours. Enhanced monitoring levels are best withdrawn very gradually whilst being adjusted according to risk level at all times. That is, if a client is considered a relatively high risk client for violence of any sort, then monitoring (or enhanced monitoring) should always be higher (and withdrawn more slowly) than that for a lower risk client, regardless of recency of last violent episode.

Related Questions – Client

1. (If there any new personnel) How do you like your new support worker? Is she/he strict? Can you get away with stuff that you couldn't with your last worker?

2. (If his/her monitoring levels have been changed and if the client is aware of the change) Why did the staff change your level? How do you feel about that?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

3. Situational Changes

Rationale

Movement from one location to another, or from one type of residential setting to another (e.g., moving from one residential care setting to another; or, moving from residential care to prison or vice versa), has idiosyncratic effects on clients. Changes in emotional state caused by such events can be very difficult for someone with an ID to cope with effectively given the lack of control by the client and the lack of understanding for the relocation. Hence, ID clients may be likely at these times to act impulsively, including disengaging from services/support, absconding or breaching residential or supervision conditions as a result of feeling various negative emotions.

Preparation of the client for such moves by the staff, such as engaging the client in move-related activities (unless the relocation is for legal reasons), may

reduce the negative changes in emotional regulation. If the client views such changes as desirable, the negative changes may be minimized.

Related Questions – Client

1. How are feeling about your move from your old residence to here? Do you know why you had to move?

2. What do you think about your new place? Is it o.k., or do you really miss your old place?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

4. Changes in Victim Access

Rationale

The risk of offensive or challenging behaviour of a violent or sexual variety increases when individuals have frequent or unsupervised access to potential victims and such changes in victim access may come about without active planning by the client. Changes in residential location (previous item) may cause unintended changes in victim access. For example for an individual with a sex offence, changes in the community or residence may result in providing the client with situations where they have more contact with their preferred victim group (e.g., children, vulnerable individuals, new staff members). Similarly, clients with violent behaviour histories may gain access to new potential victims as a result of changes in the community or the client's residence.

Related Questions – Client

1. Who have you spent time with lately? Are there any new people who have come into your service? Tell me about them.

2. What do you think about the new residents or staff members (if any)?

3. Are there any new kids around that you find annoying? Who? Why? What do you feel like doing to that kid?

4. Are there any new kids or visitors that you find attractive? What about them is attractive to you? Do you like to hang out and wait for anyone from work or school because you find them sexy or cute?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

5. Changes in Access to Intoxicants

Rationale

Sudden changes in access to intoxicants may result in increases or decreases in client manageability. If a client exercises little control over substance abuse, they are then more susceptible to temptation in this regard. Decisions to not abuse drugs or other substances when faced with increased availability are all indicative of increased risk manageability. Ironically, incarceration often results in increased access to drugs compared to residential placements. Increased access, along with impaired risk coping ability, often results in ID clientele being highly susceptible to drug or alcohol use, especially in the presence of peer-pressure. A

decreases in access of intoxicants is obviously related to increased manageability, regardless of the client's ability to control his/her substance abuse problems.

Related Questions

1. Have you been using alcohol or drugs recently? (If yes, "how did you get the alcohol or drugs?")

2. Is alcohol or drugs easier or harder to get here lately than before? (If yes, "why is that?")

3. If you really wanted to, how could get your hands on alcohol or drugs? (If yes, "how would you do that?")

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

6. Unique Considerations

Rationale

Unexpected changes (or combinations of changes) in the client's environment, may have unforeseen changes in a client's manageability and violence potential. Impulsive maladaptive decisions by a client may be made in reaction to emotional dysregulation caused by an expected reaction to a change in medication, or a medication-alcohol interaction, or a television show triggering a memory. Regardless of staff training or preparation it is not possible to be ready for all considerations that could affect a client's ability to manage risk. Examples include being arrested for violent or sexually violent behaviours, sometimes of which the client has no memory or has come to view as consensual. While being

arrested is arguably always upsetting, it is probably less understandable and perhaps more frightening for clients with ID. Such an experience would involve sudden relocation, changes in staffing, changes in support (or at least access), changes in social relationships, and perhaps changes in terms of access to intoxicants. Such a global acute change environment would have tremendous capability compromise a client's ability to management his/her risk.

Related Questions – Client

1. Have you had any changes in your living arrangements that you are having problems with?

2. (If the client has been moved to a new facility recently and especially if newly imprisoned) Have you had any major problems living here? Like what?

Scoring Key:

Risk Manageability Ratings				
-2	**-1**	**0**	**+1**	**+2**
A Definite Protective Factor	A Possible Protective Factor	No Problem, Neutral	May be a Problem	YES, a Problem

Appendix 2.2: ARMIDILO Design

The stable dynamic Items (environmental) (staff) (SDIES) includes questions such as: Do you like this work? How long have you been doing this work? Tell me about your client? Do any of you clients present special challenges for you? These questions are direct to staff, care givers and or parents to ascertain their level of attitude towards the DILD person. It has been reported that the people who have close contact with the DILD person can influence them and their attitude is a critical variable (Berry, Shah, Cook, Geater, Barrowclough, Wearden, 2008; LaSala, Connors, Taylor, Phipps, 2007).

The second subsection deals with acute dynamic Items (environmental) (staff) (ADIES). Research into people with DILD frequently reports their difficulty in coping with change (Davies, & Girauld-Saunders, 2006). Within this sub section are such question as: Are there any recent social, family, or anything else that has happened that we haven't discussed, and which may affect your client's ability to manage his/her behaviour effectively? Has your client any changes in his/her living arrangements that he/she is having problems with? What do you think your client thinks about the new place? Do you think they miss their old place? The questions covering changes to a client's environment also include; who has your client spent time with lately? Does he/she spend time with new residents in a manner that suggests he/she is grooming them or becoming abusive? These questions are specifically directed at the changes the client may have to victim access (Levenson, & Morin, 2006). Changes in the use or access to intoxicants are covered by questions such as; do you have any concerns about your client in terms of him/her trying to use alcohol or drugs?

The third section within the ARMIDILO covers the stable dynamic Items (client) (SDIC). This section is the longest part of the questionnaire and covers 12 main points. The first point is the client's attitude toward and compliance with supervision. Some of the questions in this category are: Do you know why you have to live here? What do you think about the rules? Do you think you need the rules? Research has shown that a lack of compliance by the client may result in re-offending (Boer, *et al*, 1997; Hanson & Harris, 2000; Quinsey, *et al*, 2006). The attitudes and compliance with treatment is evaluated through questions for example: Who are the people trying to help you keep safe? How are they trying to help you? Do you think it (treatment, medication, training programmes) is helping you? What have you learnt in the programme? How will you know when you're ready to stop taking treatment? The client's attitude, insight and compliance with treatment can affect their self management and ability to cope with their own behaviour.

Leading on from this is the sexual deviance, sexual preoccupation and victim selection and acquisition/grooming categories. Many DILD people have limited access to intimate relationships and are often victims of abuse which may distort their views of acceptable sexual practices (Lindsay, 2002; Craig, & Hutchinson, 2005). The questions in these categories include: Have you ever had sex with someone? Describe it for me. Did you like it, or did someone force you do to something sexual with them? Have you ever got in trouble because of doing something sexual? What happened? When is sex good or OK? When is it not OK? Are you allowed to have sex with other guys in the residence (or prison, etc)? Have you been able to have sex even if it's not allowed? How did you manage that?

Section six of the stable dynamic items covers the emotional coping ability of the client. The client was asked such questions as: What sorts of things make you angry? (Ask the client about his visitors [or staff members] and try to find out how he/she reacted last time someone didn't show up when they were supposed to; or, how he/she reacted when a bus or ride or teacher [or anyone] didn't show up as scheduled). For example, "how did you feel when your Mom didn't show up to visit yesterday? Or, "what would you do if the bus was late?" The answers to these questions gave an indication of self government and whether the client was aware and able to control themselves in stressful situations. A follow on to self government was self-efficacy. Many people with DILD are treated the same as adults treat small children. This leads to the DILD person having feelings of powerlessness, low self esteem and assertiveness (Boer, et al, 2008). The questions in this category cover: Do you like living in this place? Where would you like to live someday? What would you like to do some day for a living? Do you have plans for the future? What are they? What is the biggest problem you have at the moment? How can you solve that?

Relationships are not without difficulty to people in general and particularly for people with DILD. Often they have difficulty in communicating their feelings and may have poor role models within their environment. Not only sexual relationships but peer relationships can be difficult for the DILD person as they are more vulnerable to violent and or sexual risk due to their inability to form normal healthy relationships: How easy is it for you to make friends? Tell me about your best friend. Have you ever had a girlfriend/boyfriend? Tell me about the relationship. How about now? What is special about a girlfriend or

boyfriend)? These questions look at the clients relationship skills with sexual and non-sexual partners.

The section on substance abuse covers drugs and alcohol. Although drugs and alcohol may affect all people, the abuse of drugs and alcohol has been found to affect the recidivism of the DILD person to a greater degree (Boer, et al, 2008). Within this section, the client was asked: do you drink alcohol? (If yes: how much do you drink at a time?); do you smoke dope or use drugs? (If yes: how often/much?); have drugs or drinking caused any problems for you? These questions ascertain whether or not the client is aware of their behaviour under the influence of drugs and/or alcohol and also gives an indication of their ability to cope with substance abuse (Caan, Falshaw, & Friendship, 2004).

Section ten deals with the clients' impulsivity, this relates to both sexual and violent offending. Some of the indications of problems with impulsivity are increases in behavioural outbursts and mood fluctuations. The questions relating to this topic are: Do you sometimes act before thinking? Can you give me an example? Do you get bored easily? What do you do when you get bored? What's the silliest thing you've ever done on the spur-of-the-moment?

Sections eleven and twelve deals with threats of violence to self or others, mental health issues and other unique considerations. Often, a person with DILD resorts to aggressive, violent behaviour towards others and, in some cases, themselves. Self harming can be an indication of the risk of violent offending (Boer *et al*, 2007). Examples f these questions are: Have you ever been so upset that you wanted to hurt yourself? Have you ever been so upset you wanted to hurt someone else? What is the worst you've ever hurt someone? How about yourself? Often, people with DILD exhibit manifest forms of behaviour such as poor

speech, poor eating habits, hygiene, a lack of empathy, inappropriate behaviours and inappropriate social skills. This may be a contributing factor to additional mental illness that the DILD person can suffer from. It is likely the DILD person may also suffer from other psychological illnesses, such as bi-polar, autism, schizophrenia and other psychiatric ailments. The DILD persons' ability to recognise and/or be treated effectively for these illnesses can have an impact on their violent or deviant behaviour. The questionnaire focuses on these issues with questions such as: Have you ever seen a doctor for any mental health problems? Like what? Do you take any medications for your moods or anything like that? How does it help? How do you know if you are getting unwell? What do you do when that happens?

Acute dynamic items (client) (ADIC) is the second part of the client section of the questionnaire. This covers any changes that the client has experienced over the past year. The items one to six look at the changes in the clients' attitude or behaviour towards supervision or treatment, sexual preoccupation, victim related behaviour, emotional state, coping strategies, mental health status and any other unique considerations. Due to the variety of themes investigated, the questions range from how have you been feeling lately? (If up and down, or mostly down, why?)' to 'have you been using alcohol or drugs in the last 3 months? How much?' The impact of change beyond the DILD persons' control may act as a catalyst for deviant behaviour as a client may feel the only recourse they have is to act violently to the situation.

A key aspect of the ARMIDILO design is the score sheet. The score sheet is also divided into four sections. In part one and two the scores from the caregivers' answers are recorded and in parts three and four, the scores from the

clients' answers are recorded. The scores range from -2 to +2, which are risk management ratings. A score of -2 is defined as a definite protective factor, -1 is a possible protective factor, 0 indicates no problem, +1 that there may be a problem and +2 there is a problem. Each section is summed then divided by the number of subsections, which calculates the mean for each section. The score from each section is then added and divided by four, giving a total score for the ARMIDILO questionnaire.

Appendix 3.1: Adapted Static-99 Assessment

Static- 99 Coding Form

Family Name: **First Name:** **Reference:**

D.O.B: **Date Coded:** **Assessor:**

Risk Factor	Codes	Evidence	Wt	Score
1. Young	Aged 25 or older Aged 18 – 24.99	*Offender's age at time of assessment for current risk level or age at time of exposure to risk*	0 1	
2. Ever Lived With	Ever lived with lover for at least two years? Yes No	*Single if offender has never lived with an adult for at least two years*	 0 1	
3. Index non-sexual violence	No Yes	*Count index non-sexual violence convictions (not behaviour) and must involve the intention to harm or restrain the victim, plus non-adjudicated offences*	0 1	
4. Prior non-sexual violence	No Yes	*Count prior non-sexual violence convictions (not behaviour) and must involve the intention to harm or restrain the victim*	0 1	
5. Prior sex offences	Charges Convictions None None 1-2 1 3-5 2-3 5+ 4+	*Count historical convictions and charges even if they were dropped later, plus non-adjudicated offences*	 0 1 2 3	
6. Prior sentencing dates (excluding index)	3 or less 4 or more	*Count the number of distinct occasions offender has been sentenced for criminal offences. Offences must be of sufficient seriousness to be eligible for sentence of supervision or imprisonment*	0 1	
7. Any convictions for non-contact sex offences	No Yes	*Count number of convictions for non-contact sexual offences – includes exhibitionism, possession of obscene material etc, plus non-adjudicated offences*	0 1	
8. Any unrelated victim	No Yes	*A related victim is one where marriage would normally be prohibited. Step-relationships lasting less than two years considered unrelated.*	0 1	
9. Any stranger victim	No Yes	*A victim is considered a stranger if the victim did know the offender 24 hours before the offence.*	0 1	
10. Any male victim	No Yes	*Any sexual offence involving a male victim*	0 1	
		TOTAL SCORE **High**		

TRANSLATING STATIC-99 SCORE INTO RISK CATEGORIES

Score	**Label for Risk Category**
0, 1	**Low**
2, 3	**Medium – Low**
4, 5	**Medium – High**
6+	**High**

Appendix 3.2: Un-adapted Static-99 Assessment

Static- 99 Coding Form

Family Name: **First Name:** **Reference:**

D.O.B: **Date Coded:** **Assessor:**

Risk Factor	Codes	Evidence	Wt	Score
1. Young	Aged 25 or older Aged 18 – 24.99	*Offender's age at time of assessment for current risk level or age at time of exposure to risk*	0 1	
2. Ever Lived With	Ever lived with lover for at least two years? Yes No	*Single if offender has never lived with an adult for at least two years*	 0 1	
3. Index non-sexual violence	No Yes	*Count index non-sexual violence convictions (not behaviour) and must involve the intention to harm or restrain the victim*	0 1	
4. Prior non-sexual violence	No Yes	*Count prior non-sexual violence convictions (not behaviour) and must involve the intention to harm or restrain the victim*	0 1	
5. Prior sex offences	Charges Convictions None None 1-2 1 3-5 2-3 5+ 4+	*Count historical convictions and charges even if they were dropped later*	 0 1 2 3	
6. Prior sentencing dates (excluding index)	3 or less 4 or more	*Count the number of distinct occasions offender has been sentenced for criminal offences. Offences must be of sufficient seriousness to be eligible for sentence of supervision or imprisonment*	0 1	
7. Any convictions for non-contact sex offences	No Yes	*Count number of convictions for non-contact sexual offences – includes exhibitionism, possession of obscene material etc.*	0 1	
8. Any unrelated victim	No Yes	*A related victim is one where marriage would normally be prohibited. Step-relationships lasting less than two years considered unrelated.*	0 1	
9. Any stranger victim	No Yes	*A victim is considered a stranger if the victim did know the offender 24 hours before the offence.*	0 1	
10. Any male victim	No Yes	*Any sexual offence involving a male victim*	0 1	
		TOTAL SCORE **High**		

TRANSLATING STATIC-99 SCORE INTO RISK CATEGORIES

Score	**Label for Risk Category**
0, 1	**Low**
2, 3	**Medium – Low**
4, 5	**Medium – High**
6+	**High**

Appendix 4.1: Adapted VORAS Assessment

I.D:		Date:		VORAS
Family Name:		D.O.B.		
First Name:				
Location:	Hamilton Forensic Unit, Waikato DHB			
	(A) Level of harm			
1. Current Violent Offences	Violence without bodily harm		(Score 1)	_____
	Violence with bodily harm		(Score 2)	_____
	Injuries life threatening		(Score 3)	_____
	Injuries causing death		(Score 5)	_____
2. Most serious offence not including current offences or incidents	Non violent		(Score 0)	_____
	Violence without bodily harm		(Score 1)	_____
	Injuries life threatening		(Score 2)	_____
	Injuries causing death		(Score 3)	_____
			(Score 4)	_____
		Total Score	**(A)**	_____
	(B) Probability			
3. Previous violent offences or instances	No previous convictions/instances		(Score 0)	_____
	1 previous convictions/instances		(Score 1)	_____
	2-4 previous convictions/instances		(Score 2)	_____
	5 or more convictions/instances		(Score 3)	_____
4. Previous non-violent Offences or instances	No previous convictions/instances		(Score 0)	_____
	1 previous convictions/instances		(Score 1)	_____
	2-4 previous convictions/instances		(Score 2)	_____
	5 or more convictions/instances		(Score 3)	_____
5. Age at first offence	Age 25 or more		(Score 1)	_____
	Age 21 - 24		(Score 2)	_____
	Age 15 - 20		(Score 3)	_____
	Age 14 or below		(Score 4)	_____
6. Use of alcohol	Non drinker of alcohol		(Score 0)	_____
	Occasional use of alcohol		(Score 1)	_____
	Binge drinker		(Score 2)	_____
	Moderate regular use of alcohol		(Score 3)	_____

	Heavy regular use of alcohol		(Score 4)	_____
7. Other drug misuse	Non user of drugs		(Score 0)	_____
	Occasional user. Non intravenous		(Score 1)	_____
	Moderate-heavy user. Non-intravenous		(Score 2)	_____
	Intravenous drug user		(Score 3)	_____
	Party drug user		(Score 4)	_____
		Total Score	**(B)**	_____
(A) Level of harm	1 to 4	Low	Medium	_____
	5 to 9	Medium	High	_____
(C) Risk	1 to 10	Low	Medium	_____
Probability (of violent re-offending)	11 to 21	Medium	High	_____

Appendix 4.2: Un-adapted VORAS Assessment

I.D:		Date:	VORAS
Family Name:		D.O.B.	
First Name:			
Location:	Hamilton Forensic Unit, Waikato DHB		
	(A) Level of harm		
1. Current Violent Offences	Violence without bodily harm	(Score 1)	_____
	Violence with bodily harm	(Score 2)	_____
	Injuries life threatening	(Score 3)	_____
	Injuries causing death	(Score 5)	_____
2. Most serious offence not including current offences	Non violent	(Score 0)	_____
	Violence without bodily harm	(Score 1)	_____
	Injuries life threatening	(Score 2)	_____
	Injuries causing death	(Score 3)	_____
		(Score 4)	_____
		Total Score **(A)**	_____
	(B) Probability		
3. Previous violent offences	No previous convictions	(Score 0)	_____
	1 previous convictions	(Score 1)	_____
	2-4 previous convictions	(Score 2)	_____
	5 or more convictions	(Score 3)	_____
4. Previous non-violent offences	No previous convictions	(Score 0)	_____
	1 previous convictions	(Score 1)	_____
	2-4 previous convictions	(Score 2)	_____
	5 or more convictions	(Score 3)	_____
			_____
5. Age at first offence	Age 25 or more	(Score 1)	_____
	Age 21 - 24	(Score 2)	_____
	Age 15 - 20	(Score 3)	_____
	Age 14 or below	(Score 4)	_____
6. Use of alcohol	Non drinker of alcohol	(Score 0)	_____
	Occasional use of alcohol	(Score 1)	_____
	Binge drinker	(Score 2)	_____
	Moderate regular use of alcohol	(Score 3)	_____
	Heavy regular use of alcohol	(Score 4)	_____
7. Other drug misuse	Non user of drugs	(Score 0)	_____
	Occasional user. Non intravenous	(Score 1)	_____

	Moderate-heavy user. Non-intravenous		(Score 2)	_____
	Intravenous drug user		(Score 3)	_____
	Party drug user		(Score 4)	_____
		Total Score	**(B)**	_____
(A) Level of harm	1 to 4	Low	Medium	_____
	5 to 9	Medium	High	_____
(C) Risk	1 to 10	Low	Medium	_____
Probability	11 to 21	Medium	High	_____
(of violent re-offending)				

Appendix 5: ARMIDILO Authors

Douglas Boer

Associate Professor Douglas P. Boer BSc, MSc, PhD Alberta, is the Clinical director at the University of Waikato. His interests are in the field of clinical psychology (see appendix 5a) particularly experimental psychopathology, group and individual treatment of offenders, and the design of culturally-appropriate risk assessment methods for Aboriginal offenders, violent offenders, and intellectually disabled client (University of Waikato, 2008).

James Haaven

James Haaven, MA is a consultant in private practice and trainer in the field of assessment, treatment and program development of sexual offending behaviour of persons with developmental disabilities. James Haaven has 33 years of experience in working with sexual offending behaviour in persons with developmental disabilities (see appendix 5b). He was the director of the Social Skills Unit and the Social Rehabilitation Unit at Oregon State Hospital in Salem, Oregon. Mr. Haaven is a trainer and consultant for the prison services in their Adapted Sex Offender. He has provided consultation for sexually violent predator programs, development of community transition programs and state-wide delivery systems for sex offender services (NCNIES Inc, 2008).

Frank Lambrick

Frank Lambrick is a Senior Clinician in the State-wide Forensic Service Victorian Department of Human Services, Victoria, Australia, Frank Lambrick is a registered psychologist with over 20 years of experience primarily within the forensic disability field (see appendix 5c). He provides advice to disability service providers in relation to practice improvement issues and strategies to enhance systemic practice, particularly for people with complex needs (Office of the Senior Practitioner, 2007).

William Lindsay

Dr William Lindsay is Head of Clinical Psychology Services and a Consultant Clinical Psychologist. Dr. Lindsay is a Professor of Learning Disabilities (see appendix 5d) at Tayside Primary Care NHS (National Health Service) and at the University of Abertay, Dundee, Scotland (University of Glasgow Story, 2007).

Keith McVilly

Dr. Keith McVilly is a Lecturer in Disability Studies at RMIT (Royal Melbourne Institute of Technology) University. Dr. McVilly has worked as a direct support worker, clinical psychologist, service manager, and researcher with people with developmental, acquired and degenerative disability (see appendix 5e), together with family members and support staff. He is currently the

Australasian representative to the Board of the International Association for the Scientific Study of Intellectual Disability (IASSID) (RMIT, 2008).

Joseph Sakdalan

Joseph Sakdalan, BSc MA PhD Ateneo de Manila MPH Melb. PGDipPsych (Clin) Massey. Dr. Sakdalan is the programme director for the ID service of the Mason Clinic in Auckland, New Zealand.

Melanie Smith.

Melanie (Mel) Smith, BSocSci., MSocSci., PGDipPsych (Clin) Waikato. Ms Smith is a private practitioner in the area of ID offenders. She has ample experience in this area having worked for Community Living Trust for a number of years. Ms Smith's duties included assessment of ID clientele using risk assessment tests.

Appendix 6: Figures 9 – 40 shows the adapted and un-adapted results from the Staic-99 and VORAS assessments.

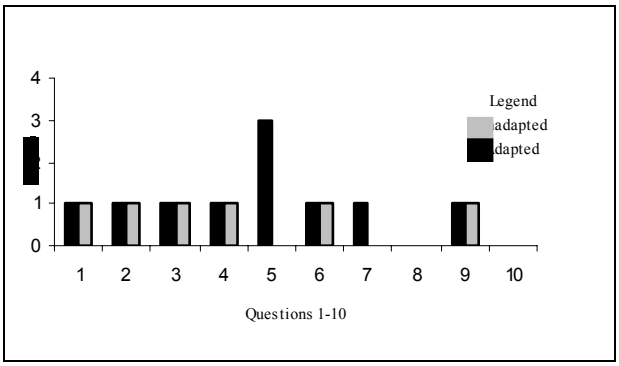

Figure 9: Subject 718 Static-99 results.

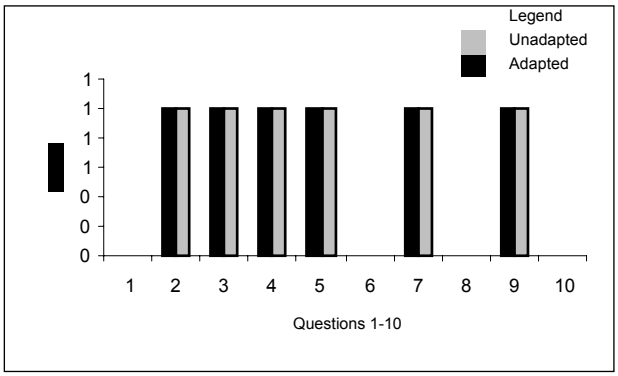

Figure 10: Subject 697 Static-99 results.

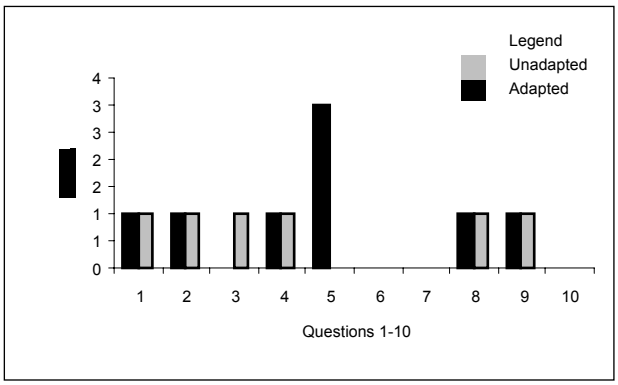

Figure 11: Subject 206 Static-99 results.

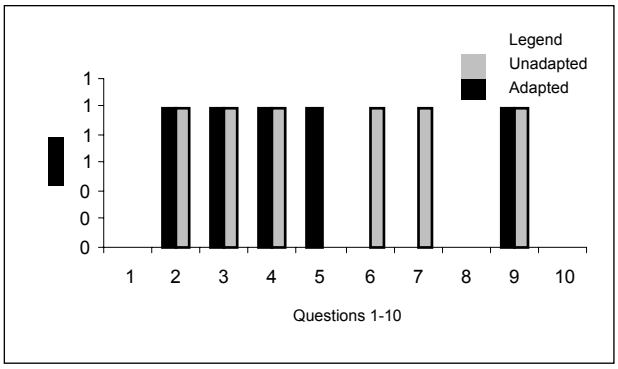

Figure 12: Subject 927 Static-99 results.

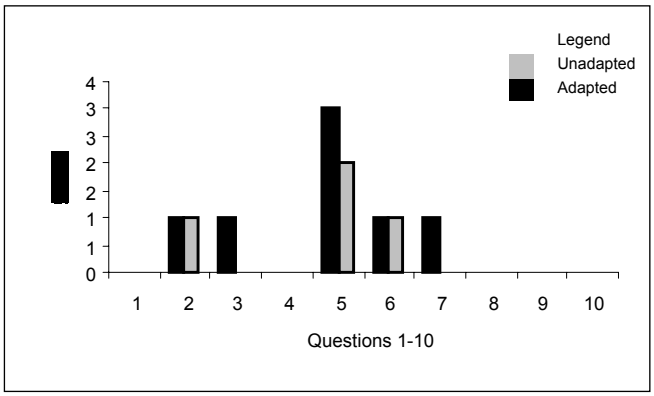

Figure 13: Subject 327 Static-99 results.

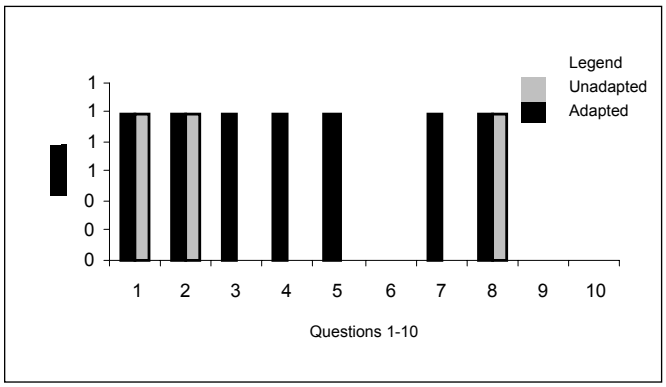

Figure 14: Subject 762 Static-99 results.

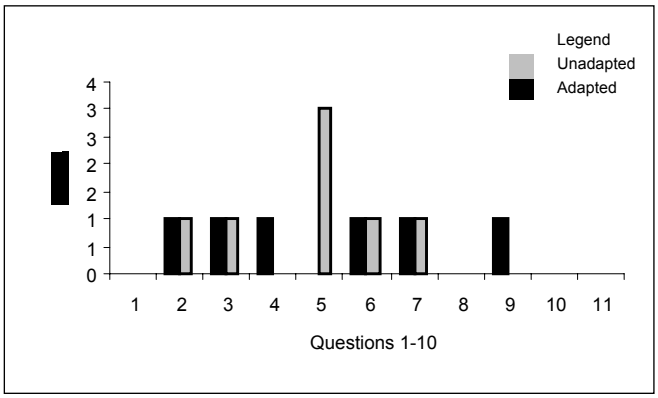

Figure 15: Subject 566 Static-99 results.

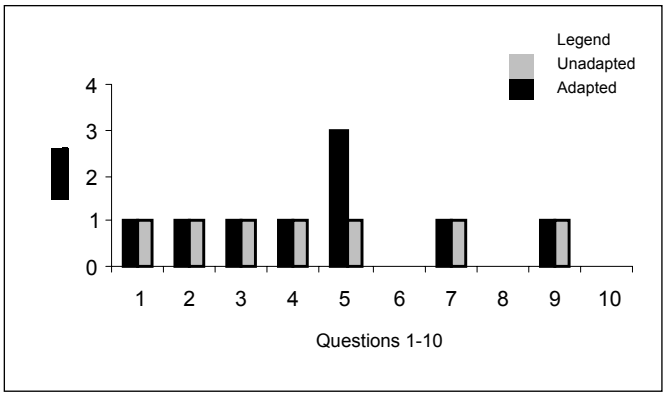

Figure 16: Subject 597 Static-99 results.

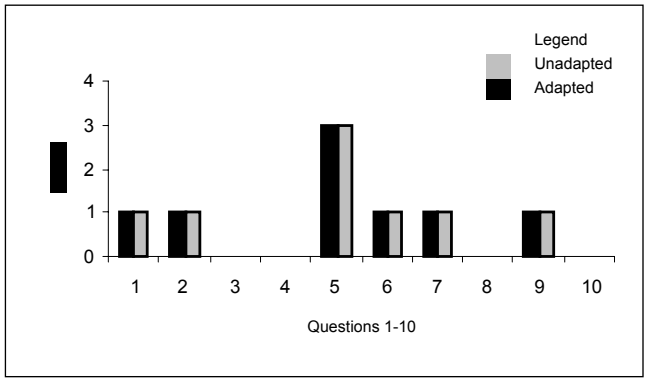

Figure 17: Subject 19 Static-99 results.

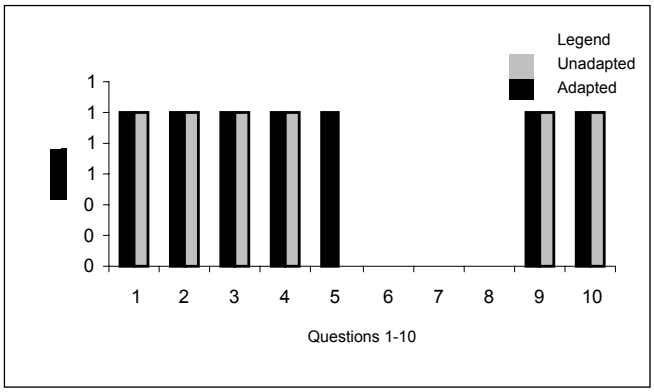

Figure 18: Subject 165 Static-99 results.

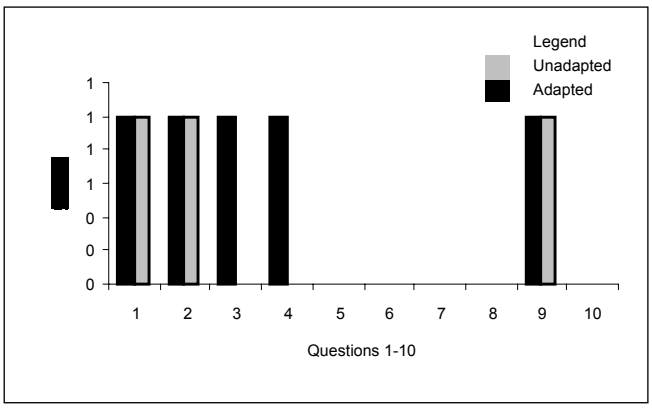

Figure 19: Subject 168 Static-99 results.

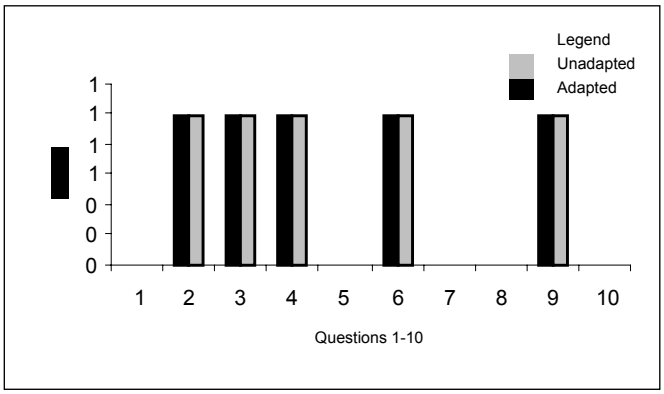

Figure 20: Subject 49 Static-99 results.

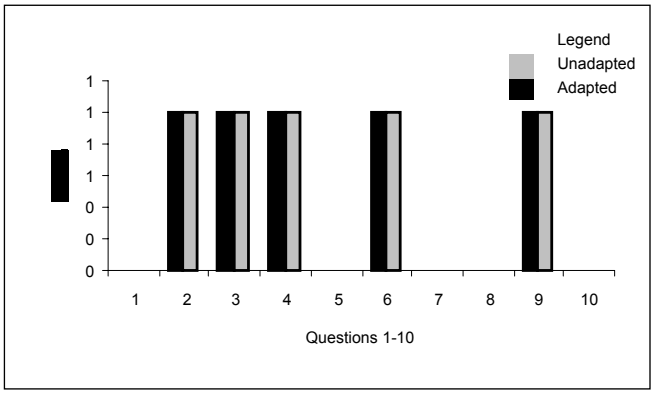

Figure 21: Subject 546 Static-99 results.

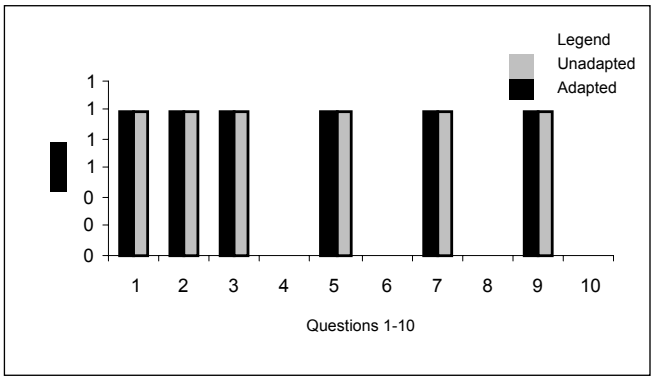

Figure 22: Subject 299 Static-99 results.

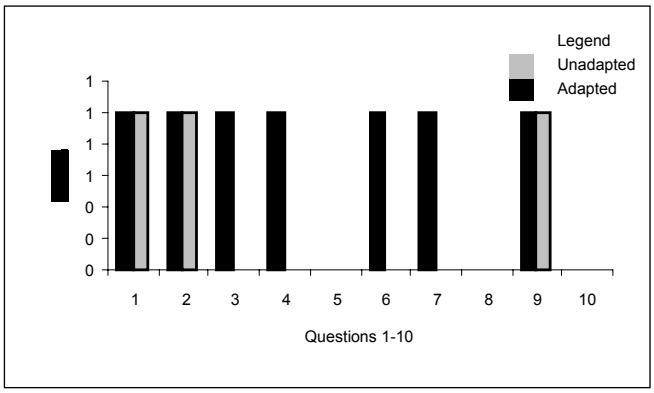

Figure 23: Subject 566 Static-99 results.

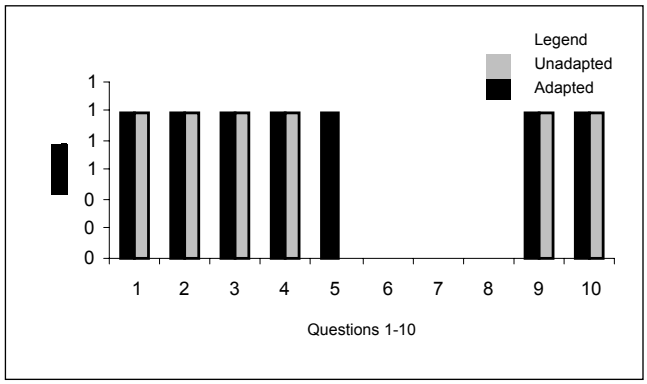

Figure 24: Subject 953 Static-99 results.

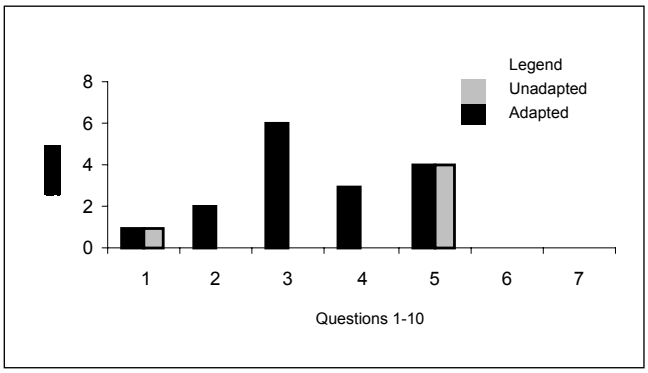

Figure 25: Subject 718 VORAS results.

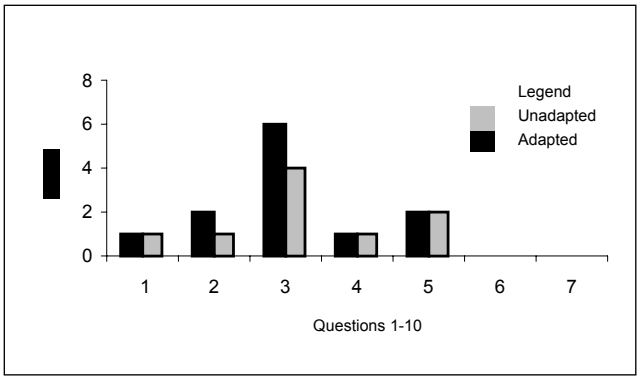

Figure 26: Subject 697 VORAS results.

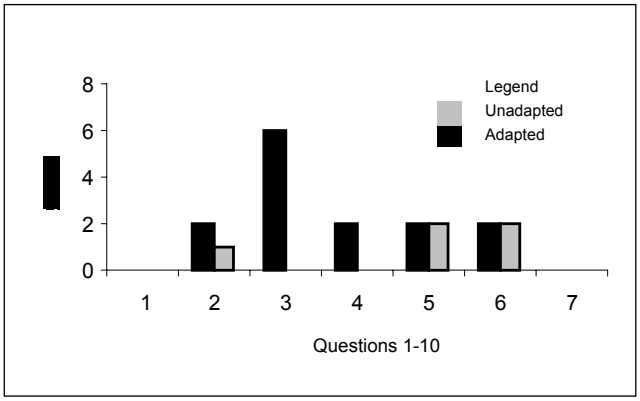

Figure 27: Subject 206 VORAS results.

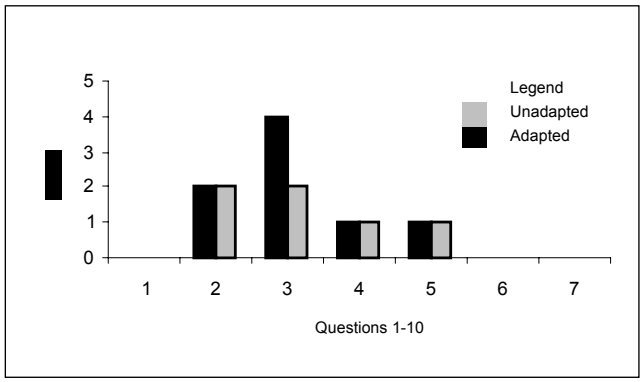

Figure 28: Subject 927 VORAS results.

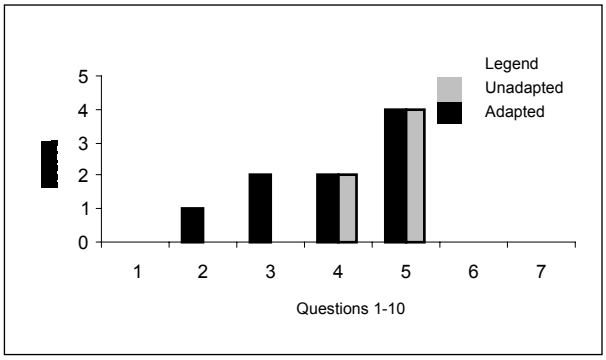

Figure 29: Subject 327 VORAS results.

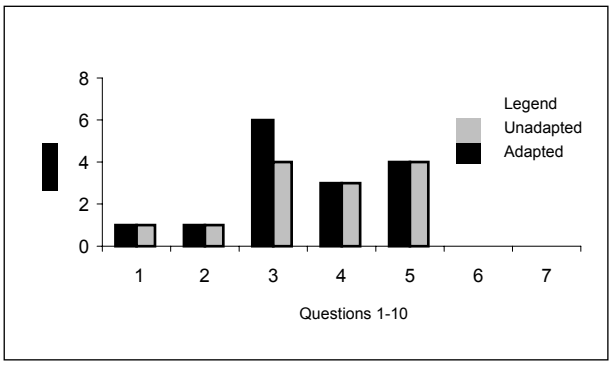

Figure 30: Subject 762 VORAS results.

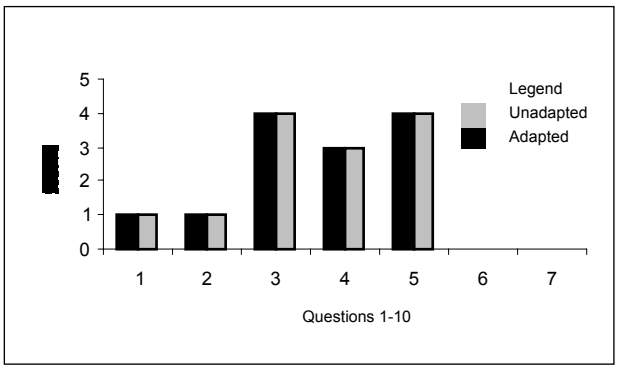

Figure 31: Subject 566 VORAS results.

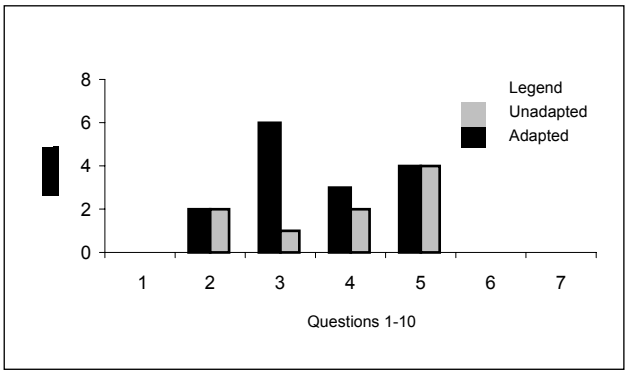

Figure 32: Subject 597 VORAS results.

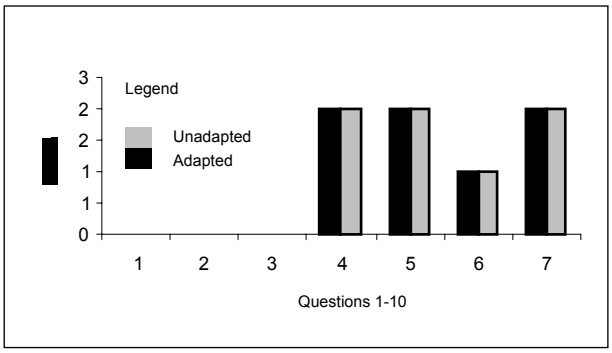

Figure 33: Subject 19 VORAS results.

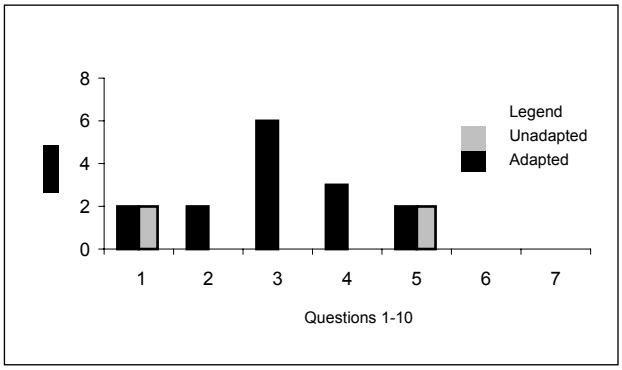

Figure 34: Subject 165 VORAS results.

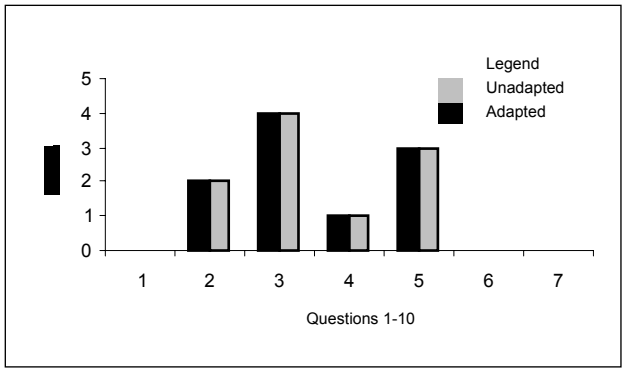

Figure 35: Subject 168 VORAS results.

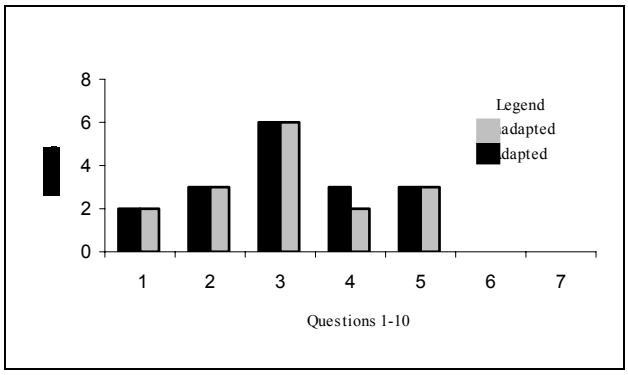

Figure 36: Subject 49 VORAS results.

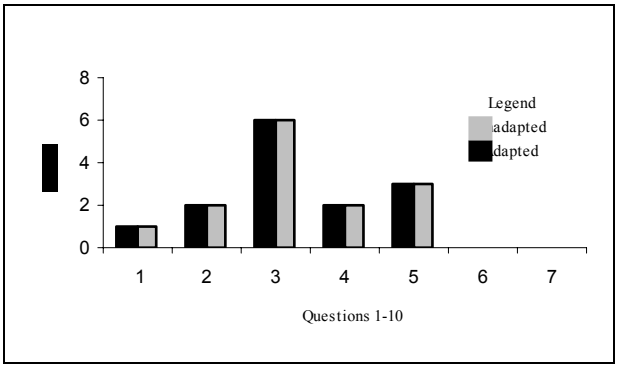

Figure 37: Subject 141 VORAS results.

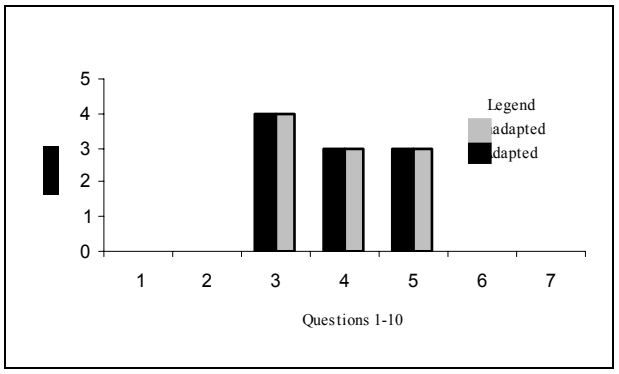

Figure 38: Subject 299 VORAS results.

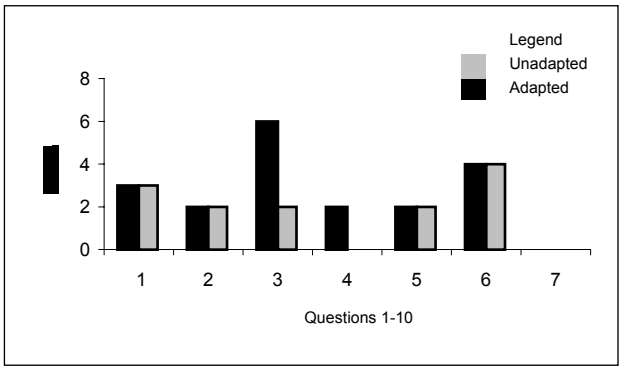

Figure 39: Subject 546 VORAS results.

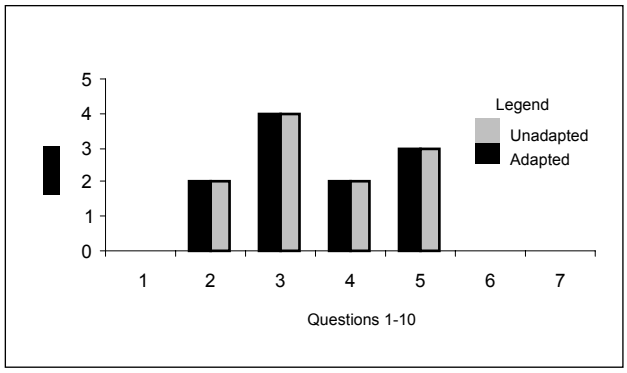

Figure 40: Subject 953 VORAS results.

Appendix 7: ARMIDILO analysis using Cronbach's alpha.

Case Processing Summary

Cases Valid	N	%
Cases	16	94.1
Excluded (a)	1	5.9
Total	17	100.0

a Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.857	.870	30

ARMIDILO Item Statistics

	Mean	Std. Deviation	N
Q1	-.2500	1.65328	16
Q2	.6250	1.31022	16
Q3	1.1250	1.08781	16
Q4	1.0625	.99791	16
Q5	.8750	.88506	16
Q6	.9375	.77190	16
Q7	.4375	.62915	16
Q8	.4375	.51235	16
Q9	.1875	.40311	16
Q10	.2500	.77460	16
Q11	.9375	.92871	16
Q12	.1875	.40311	16
Q13	.5000	1.09545	16
Q14	.6875	1.19548	16
Q15	.5000	.81650	16
Q16	1.0625	.85391	16
Q17	.2500	.57735	16
Q18	.5625	.81394	16
Q19	.6250	.95743	16
Q20	.1875	.83417	16
Q21	1.0000	.81650	16
Q22	.9375	.77190	16
Q23	1.1875	.83417	16
Q24	.6250	.71880	16
Q25	.5000	.51640	16
Q26	.3125	.70415	16
Q27	.1250	.61914	16
Q28	.1875	.65511	16
Q29	.3750	.71880	16
Q30	.1875	.83417	16

Appendix 8: Static-99 Chi-squared analysis of the adapted and un-adapted Static-99 results.

Adapted	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
High Risk	11	4	7	49	12.25	0.000134
Moderate/ High	5	4	1	1	0.25	
Moderate/ Low	0	4	-4	16	4	
Low	0	4	-4	16	4	

Un-adapted	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
High Risk	8	4	4	16	4	0.036733
Mod/High	3	4	-1	1	0.25	
Mod/Low	5	4	1	1	0.25	
Low	0	4	-4	16	4	

Appendix 9: VORAS Tables showing Chi-squared analysis of the adapted and un-adapted VORAS results.

Adapted	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/ High Risk	11	8	3	9	1.125	0.133614
Low/Medium	5	8	-3	9	1.125	

Un-adapted	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/High Risk	6	8	-2	4	0.5	0.801252
Low/Medium	10	8	2	4	0.5	

Adapted Q.1-2	O	E	(O – E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/ High Risk	2	8	-6	36	4.5	0.0027
Low/ Medium	14	8	6	36	4.5	

Un-adapted Q.1-2	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/ High Risk	2	8	-6	36	4.5	0.0027
Low/ Medium	14	8	6	36	4.5	

Adapted Q3-7	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/ High Risk	12	8	4	16	2	0.0455
Low/ Medium	4	8	-4	16	2	

Un-adapted Q3-7	O	E	(O - E)	(O-E) ²	(O-E) ²/E	X²
n=16	Observed Frequency	Expected Frequency	Difference	Difference Squared	Difference Squared Weighted by Expected Frequency	Chi
Medium/ High Risk	6	8	-2	4	0.5	0.317311
Low/ Medium	10	8	2	4	0.5	

***Appendix** 10**:** Partial correlation and the significance (one-tailed) difference of the dependent variable ARMIDILO with independent variables, Static-99 and VORAS.*

Control Variable ARMIDILO	Partial Correlation Results	Independent Variable Static-99	Independent Variable VORAS
VORAS	Correlation	1.000	.208
	Significance (1-tailed)	.	.228
Static-99	Correlation	.208	1.000
	Significance (1-tailed)	.228	.