Dr. J. Doe, Ltd.[1]

Consulting and Clinical Forensic Psychologist

Psychological Assessment Report on Mr. Timothy Smith (DOB: April 1st, 1970)

Location of Service: Forensic Intellectual Disability Service, Anytown, Anystate, USA

Date of Report: December 1, 2010

Referral Information

Mr. Smith (Timothy) was referred to the undersigned in March of this year for risk-relevant treatment and assessment by Mr. Floyd Christopher, Clinical Nurse Specialist and Service Coordinator, Regional Forensic Intellectual Disability Service (FIDS).

Mr. Smith was charged with two sexual assault offences (touching) against his 9 year old niece in April of 2009 and was subsequently found not fit to stand trial. These current offences are described a number of times in his file and will not be repeated in this report. Mr. Smith is currently placed in a Regional Intellectual Disability Supported Accommodation Service (RIDSAS), namely, Hunter's Lodge at 123 Main street, Anytown. He is provided with 24 hour support and supervision in this setting.

Information Reviewed for the Purpose of this Report

I have reviewed Mr. Smith's FIDS file, including a specialist assessor's report, care and rehabilitation plans, psychiatric assessments, management plans and current treatment notes prior to the completion of this report.

Mr. Smith's residential care staff were interviewed for the purposes of this report. The staff provided their informed verbal consent to be interviewed according to the guidelines of the "Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend - Sexually version (ARMIDILO-S) instrument designed by Boer, Haaven, and colleagues (2009).

Finally, I reviewed Mr. Smith's treatment notes. At the time of this report, he had completed 8 individual sessions and 25 treatment groups since March of 2010.

Past Assessments

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[1] Example report using the ARMIDILO-S instrument.

There are a number of reports on file that are relevant to the current report and any future risk-relevant treatment or management reports to be completed on Mr. Smith. The following reports were on Mr. Smith's FIDS file, and there may be more assessment reports available that were not provided to the undersigned. However, the following assessments were adequate for the purposes of this report.

The Specialist Assessor's Report completed by Dr. N. Harris (June 5, 2009) provided a psychosocial background as well as an assessment of Mr. Smith's intellectual and adaptive functioning. According to Dr. Harris, Mr. Smith's level of intellectual disability is "mild", although the IQ score of 61 found by Dr. Harris (which is the same found by another psychologist in a previous report) bordered on the "moderate" range. Given that the 95% confidence interval for an IQ score of 61 is from 55 to 66, there is a good chance (approximately a 50% chance) that the measured IQ score of 61 may be an overly optimistic estimate of his "true score" and the descriptor of "mild" disability is perhaps incorrect as his true IQ may well lie in the "moderate" range of intellectual disability (ID). Given these issues, it may be more appropriate to state that Mr. Smith has a "mild to moderate" level of ID.

In addition, Dr. Harris found that she could not provide an estimation of Mr. Smith's "adaptive functioning" (an assessment largely of skills by a person or persons who know the client well). However, Dr. Harris provided an overview of adaptive functioning areas that she saw as deficient and these deficiencies provided support for her finding of intellectual disability for Mr. Smith. At the time of Dr. Harris's assessment, Mr. Smith was not found to be suffering from any mental disorder, although Dr. Harris reported that Mr. Smith had received treatment for major depressive disorder in the past as well as being admitted to a psychiatric unit for "mood dysregulation subsequent to a seizure".

Approximately a month and a half subsequent to Dr. Harris's report, Mr. Smith was seen and reviewed by Dr. Kunimoto (psychiatrist). Dr. Kunimoto found that Mr. Smith was suffering from depression and prescribed anti-depressant medication.

Treatment Progress

According to his treatment file, Mr. Smith attended all but one scheduled appointment to date (and I believe the missed session was due to a scheduling error by staff). Mr. Smith cooperated with treatment but was apparently difficult to interview. It was reported that he was often inattentive and occasionally could not answer even the simplest questions. It was the treating psychologists' impression that he was either over-medicated or had an attention deficit problem (not necessarily to the level of a disorder, but perhaps more evidence of autistic spectrum disorder or ASD) as well as depression.

Mr. Smith's individual sessions were apparently discontinued because he proved such a difficult interviewee and simply refused to discuss his offences. More recently, the possibility of a more serious disorder, such as an emerging psychosis (as opposed to ASD), had been raised by treatment staff. Over the past few months, Mr. Smith has been observed laughing or giggling to himself, as well as attending to private stimuli at

inappropriate times. At the end of this report, I have recommended further psychiatric investigation to determine if there are any other psychiatric concerns.

Mr. Smith's progress in group therapy was described as "mixed". Apparently, he would arrive with the other clients, socialize minimally, and then spend an inordinate amount of group time asleep or apparently not listening. According to the group notes, he almost never made an intelligible contribution to the group discussion - although there were occasional moments of good involvement. He rarely interacted with the other clients during the mid-group break - he often went for a nap at this time on one of the couches in the waiting room. However, the staff have reported that his level of impulsiveness has decreased in the residential care setting. Nonetheless, he has had a number of outbursts - for example on one occasion, he apparently erupted into anger without warning while waiting for his turn to play pool.

Risk Assessment

Ms. Harris's specialist assessor's report provided a risk assessment section which noted that Mr. Smith was "at elevated risk of re-offending" and she was noted this estimation was based on the "aforementioned factors contributing to his offending, in the absence of support and oversight to manage his risk". The "aforementioned factors" that had been mentioned in the preceding section of Dr. Harris's report included Mr. Smith's "low frustration tolerance, poor impulse control, lack of anger management skills, impaired insight, and empathy deficits". Further, Dr. Harris noted that Mr. Smith has "few incentives to avoid offending, in terms of goals and engagement in meaningful activities ... seizure activity may contribute to periods of dysregulation of mood and behaviour".

The Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend - Sexually version (ARMIDILO-S) was completed for the present report.

The ARMIDILO-S is comprised of environmental (including staff) and client factors that are viewed as logically related to the risk for sexual violence by the client being assessed (the degree of empirical support varies from item to item). All items are dynamic in nature, however, the environmental and client items are divided into "stable" and "acute" (essentially, slowly changing and quickly changing - the latter are viewed particularly in response to environmental stressors) items. The information used to score the individual items is collected by interviewing the staff who work with the client and, of course, by interviewing the client. The results of the ARMIDILO-S provides an overview of risk-relevant issues and also an overview of protective factors, the combination of which then informs a risk management strategy for the client. The time frame for the current ARMIDILO-S assessment is the past 9 months (March, 2010 to December, 2010).

Stable client factors seen as risk-decreasing (strengths) for Mr. Smith include his compliance with supervision and treatment, lack of substance abuse problems, and well-controlled mental health issues.

Acute client factors that are seen as risk-decreasing (strengths) include Mr. Smith's ongoing compliance with supervision and treatment requirements, an apparent lack of sexual behaviour issues, a lack of substance abuse problems, and an improvement in his emotional state (increasingly positive over time).

Stable client factors seen as risk-increasing (problematic) for Mr. Smith include his ongoing attraction to children (he seems to become aroused by the presence of any child), difficulties coping with his emotions (e.g., if he is nagged, ignored, or provoked he may get aggressive, but occasionally his aggression appears unprovoked and impulsive). Also, his lack of supportive relationships is problematic - besides his mother (who is unable to care for him because of her own health issues) and the care staff, he has virtually no social support. Mr. Smith has problems with impulsivity (although this factor is somewhat characteristic of all persons with an ID), however, Mr. Smith is quite impulsively aggressive, and as Dr. Harris noted Mr. Smith has problems with "low frustration tolerance, poor impulse control, lack of anger management skills" - all of which are related to impulsivity. Another risk issue is that of mental health concerns (an ongoing depressive illness that is stable on medication, as well as potentially other mental health problems - see below). Another stable client factor of risk relevance is Mr. Smith's lack of insight about his offensive behaviour and how that behaviour has estranged him from his family (this latter concern, and his lack of empathy were also noted by Dr. Harris). His ongoing desire to reunite with his family, despite their stated lack of interest, besides being linked to his lack of insight, is an obvious sign that he is not considering any other plans at this time.

Acute client factors that were of concern include Mr. Smith's potentially deteriorating mental health status. As noted earlier in this report, Mr. Smith seems to be experiencing some residual symptoms of autism or potentially early signs of a psychotic disorder - apparently attending to internal stimuli and laughing/giggling to himself without any explanation. The possibility of more serious mental health problems has been a concern for some time - he appeared to have some attention deficit problems during our individual sessions and was often very difficult to keep on task or get to answer questions in a logical manner. Mr. Smith also has had a recent emergency admission to the hospital following a seizure and was seen by the crisis team (no follow-up was seen as necessary).

Stable environmental factors that were seen as risk-reducing (protective) factors for Mr. Smith were evaluated following a group interview with four of the residential care staff. All staff exhibited a positive and caring attitude toward Mr. Smith as well as an in-depth understanding of his treatment needs. There was good communication among the staff and the staff members seemed to understand Mr. Smith's risk issues very well. They opined that Mr. Smith's sexual offences occurred in a situation where no one was telling him what he could and could not do - hence he was confused and frustrated. In the preceding nine months to the date of this report, Mr. Smith has been stable in the residential care setting. The situational and supervision consistency (e.g., no changes in supervisory level) have been risk-reducing features of his environment.

Acute environmental factors that were seen as risk-reducing included the fact that Mr. Smith is now attending church, and oddly, his lack of support by his mother and her partner may help reduce his risk as they commonly had alcohol in their home. The residential care staff's consistent close-monitoring of Mr. Smith has also been an important risk-reducing factor. The residential care staff also have been giving Mr. Smith the consistent message that it would not be wise to return home at this time as his family are not interested or willing to be involved with him or support him given his history of family-directed sexually violent behaviour.

There were no stable environmental factors that were seen as risk-increasing (problematic) at the time of this assessment.

There were several acute environmental factors of concern. The staff were of the opinion that Mr. Smith's plans to live in the community may be problematic given his lack of social support and actual fear of his release by his family. The staff were also concerned that this lack of support, in combination with his lack of insight about how his family is basically abandoning him because of his behaviour is a recipe for failure upon his release in my opinion. If Mr. Smith is allowed to return unsupervised to the Anytown area, it is quite likely that he will seek out his family members and this could easily result in further aggression and victimization - especially since they are now unsupportive, afraid, and have been victimized in the past.

Overall, the ARMIDILO-S indicates that Mr. Smith's risk is best managed in a residential care setting that provides consistent supervision and intervention. In his current situation, his risk for violence is low and manageable. There are a large number of protective (risk-reducing) factors associated with his current supervised living situation. Also, his sexual violence potential is family-related - if he were allowed to return to the Anytown area, his risk would escalate to moderate to high. The reasons for the escalation in risk include his lack of family support (and his lack of insight in this regard), his ongoing mental health problems, and his lack of insight regarding his family, He seems unaware that his family does not want further involvement (with the possible exception of his mother) with him and his number one priority is to return to the Anytown area and live near his family. Mr. Smith shows no insight as to why these plans could be problematic.

The ARMIDILO-S indicates that his risk is manageable in his current situation and in absence of another feasible plan, and in view of ongoing forensic and mental health issues (some of which are still under investigation by psychiatry and neurology) this may be the best option to keep his risk at the lowest level possible.

Overall Findings and Recommendations

1. Mr. Smith is functioning well in his current setting. He is a dependent client and while the file indicates he is capable of independent living, he does not seem distressed in the least by letting others cook and clean for him. While it may mean more work for the staff, it is recommended that he is encouraged to participate in cooking and cleaning up after him, as well as basic housekeeping to prepare for his eventual release to the community.

2. The current residential setting is currently providing the support and supervision needed to manage Mr. Smith's risk of reoffending. However, he is not being sufficiently challenged to work towards independence at this time. It is important that if his order is extended that the focus of independent living becomes paramount. It was clear to me that the staff were working on trying to help re-establish contact with Mr. Smith's family, but were somewhat stuck in terms of letting Mr. Smith know that their efforts had not resulted in a positive outcome as doing do would likely result in some increase in his negative behaviours.

3. Mr. Smith has little or no insight regarding his family of origin's lack of support for his release. This issue has been repeatedly broached with him in a consistent manner by the care staff to help him realize that he needs to formulate an alternative plan, but it seems that he has not accepted this direction and remains focused on returning to Anytown. It would appear that his best option - at least until he develops the insight of the need for a new plan - would be to remain living in care, perhaps moving towards a supported living arrangement, once he has some independent living skills.

4. Mr. Smith continues to need help with his problem-solving skills and emotional management skills. He is attending the FIDS program and this is supplemented by individual sessions as deemed required. As noted earlier, progress has been slow, but it has apparently made a difference in terms of his mood and reactivity at the residential centre.

5. To my knowledge, Mr. Smith's ongoing treatment needs cannot be met in Anytown and it is my recommendation that he continue under an extension of his order so that he can continue to receive risk-relevant treatment for his aggressive challenging and offending behaviour.

6. It is recommended that Mr. Smith be evaluated again by psychiatry to see if there are any new or emerging psychiatric concerns. It is possible that the occasional subtle episodes of giggling or talking to invisible companions are related to ASD symptoms or an emerging psychosis.

7. In summary, I found that Mr. Smith is currently receiving the intervention and support services needed to manage his risk. His release plans, should his order cease in February are not comprehensive or safe in terms of his risk to others (in particular his family). If he were to continue under an order, future treatment efforts need to be redoubled to prepare him for release to a different area with an association to support services that can address his ongoing treatment and management needs.

I hope these findings are of help in this case. If there are any further questions, please do not hesitate to contact me.

Sincerely,

Dr. Doe
Registered Clinical Psychologist