

Association for the Treatment of Sexual Abusers

Assessment, Treatment,
and Supervision of
Individuals with Intellectual
Disabilities and Problematic
Sexual Behaviors

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Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors

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The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence-based practice, public policy, and community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or are at risk to abuse.

ATSA is an association of individuals from around the world committed to achieving a high level of professional excellence. ATSA promotes the philosophy that empirically based assessment, practice, management, and policy strategies will: enhance community safety, reduce sexual recidivism, protect victims and vulnerable populations, transform the lives of those caught in the web of sexual violence, and illuminate paths to prevent sexual abuse.

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EXECUTIVE SUMMARY

Professionals providing treatment, supervision, and management to adult persons who have sexually offended recognize the unique needs of those individuals who have concomitant intellectual disabilities and problematic sexual behaviors (IDPSB). Problematic sexual behaviors are defined in this context as sexually offensive conduct that places either the client or others at risk for harm or social prejudice. The prevalence of persons with IDPSB varies between studies, but the results suggest that persons with IDPSB are over-represented in the criminal justice system. As a result, many practitioners providing assessment and treatment services to adults who have committed sexual offenses will at some point encounter persons with IDPSB. In this document, the following areas related to persons with IDPSB are explored:

- Standardized assessment
- Promising and effective treatment interventions
- Specialized supervision considerations.

Standardized Assessment for Persons with IDPSB

Policy and practice guidelines are emergent regarding persons who have sexually abused. In particular, issues remain with respect to best practices in the assessment, treatment, and case management of adults with IDPSB. In order to accurately provide treatment for this population, a comprehensive assessment is required specific to the individualized needs of clients, including an identification of risk factors. Problems have been noted in cases where standardized assessment measures originally designed for persons who are not intellectually disabled are used with persons with IDPSB. This document provides suggestions regarding appropriate assessment strategies—including risk assessment instruments—and emphasizes the necessity of proper identification of intellectual disability status. Failure to accurately identify deficits in cognitive abilities serves to decrease the potential for accurate assessment and, hence, effective case management.

Promising and Effective Treatment Interventions for Persons with IDPSB

Research has suggested that treatment for persons who have sexually abused can decrease sexual offense recidivism (Hanson, Bourgon, Helmus, & Hodgson, 2009; Lösel & Schmucker, 2005). However, in order for treatment to be effective, it must be individualized to meet the needs of the client, and no one treatment model meets the needs of all persons with IDPSB. This paper addresses the problems inherent in some of the more popular treatment models, most of which were developed primarily for clients who are not intellectually disabled. In addition, this paper offers suggestions regarding treatment modifications applicable to adult persons with IDPSB.

Specialized Supervision Considerations for Persons with IDPSB

Persons with IDPSB often receive community support services through local developmental disabilities agencies for adults. Yet, professionals who work with clients who have intellectual disabilities often do not possess knowledge or expertise related to sexually problematic behavior. Appropriate supervision and case management require cooperation and collaboration between the criminal justice system and social service entities. This document discusses two aspects of effective work with persons with IDPSB: chaperone training and the use of standardized risk assessment measures.

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Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors

Gerry D. Blasingame, Douglas P. Boer, Laurie Guidry,
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INTRODUCTION

The assessment and treatment of persons with intellectual disabilities and problematic sexual behaviors (IDPSB) is part of the overall scope of practice for members of ATSA who work with individuals adjudicated for the commitment of sexual crimes, as well as those persons who have not been adjudicated but who are receiving treatment or services for their sexual behavior problems. This introduction will briefly outline the various sections of the informational packet, as well as introduce the overall topic of the assessment and treatment of persons with IDPSB. In the context of this review, problematic sexual behaviors are those in which inappropriate, maladaptive, or dysfunctional sexual conduct places the client or others at risk for harm.

Persons with IDPSB who become involved with the criminal justice system experience a variety of disadvantages compared to persons with problematic sexual behaviors who do not have intellectual disabilities (ID), including social isolation, greater incidence of mental illness, and higher than average exposure to poverty (Hayes, 2012). In addition, a number of studies have shown that persons with ID have low levels of knowledge about sexuality (see Lunsky, Frijters, Griffiths, Watson, & Williston, 2007) and experience greater problems negotiating consent for sexual interactions than persons without ID (although these issues can improve with appropriate interventions—see Dukes & McGuire, 2009). Persons with ID who live in institutional settings may have their sexual rights diminished by policies or practices (see Aunos & Feldman, 2002) that often differ from prison, civil commitment, and community settings for reasons that may involve protection of the person with ID from others or vice versa. Aunos and Feldman (2002) noted in their review that disapproval of intimacy among persons with ID increased with greater degrees of intimacy between clients. It is commonly known that sexual interactions between persons with IDPSB in some custodial settings may increase the likelihood of new restrictions, charges, or prosecution, especially where issues of consent are raised. Given the known difficulties of some persons with ID in terms of sexuality and establishing consent, sexual interactions between persons with IDPSB are frequently poorly considered (and understood) attempts to establish intimacy based on a desire for social acceptance and possibly friendship. The issues of “what is allowed” and why limits exist regarding sexual expression may require greater explanation so that persons with IDPSB will have a better understanding of what is expected of them with respect to sexual expression.

Some countries (e.g., Australia, Canada, the United States, and the United Kingdom) have established policies and practices regarding specialized treatment programs for persons with IDPSB, some of which were based on the seminal work of Haaven and colleagues (Haaven, Little, & Petre-Miller, 1990). Since that time, treatment programs for persons with IDPSB have been greatly expanded in terms of

theoretical and practical approaches, including cognitive-behavioral interventions (e.g., Blasingame, 2005), self-regulation applications of the relapse prevention model (e.g., Keeling, Rose, & Beech, 2006), and an integrative treatment workbook that incorporates current principles of effective treatment for persons who have sexually offended (e.g., relapse prevention and the Good Lives Model—see Lindsay, 2009). All or most of these programs adhere to aspects of the Risk-Need-Responsivity (RNR) model of Andrews and Bonta (2010) but, given that the risks, treatment needs, and learning styles of persons with IDPSB often differ markedly from those of persons without intellectual disabilities, additional modifications have been necessary.

A study by Jones (2007) noted that the overall international prevalence of persons with IDPSB can vary between 2% and 40% of the total number of persons with adjudicated sexual offense histories, depending on how ID is defined or measured. However, if one looks at standardized IQ testing methodologies, then the issue of prevalence becomes clearer, especially when we consider the apparent over-representation of persons with IDPSB in the criminal justice system. Taking into account the standard error of measurement of most standardized IQ tests, an individual generally needs to score two or more standard deviations below the mean of 100 IQ points to be eligible for a diagnosis of intellectual disability. Therefore, the normal distribution of IQ would suggest that less than 3% of all individuals would score 70 points or less on a standardized IQ test. The vast majority of prevalence studies of adjudicated persons with IDPSB offer percentages 10 to 15 times higher than that suggested by the normal distribution, again suggesting an overall over-representation of persons with IDPSB in the criminal justice system (Guay, Ouimet, & Proulx, 2005; Petersilia, 2000).

The development of tools for assessing treatment needs and risk has not evolved at the same pace as the development of treatment programs, but there are a number of developments detailed in this document. This informational packet will provide examples of “best practices” when working with persons with IDPSB, an area that may seem highly specialized to some practitioners. However, if one looks only at adjudicated persons with IDPSB, as noted above, it is estimated that up to a third or more of the total number of individuals with adjudicated sexual offense histories also have an intellectual disability (Jones, 2007). Hence, it is very likely that anyone working with persons convicted of sexual offenses will encounter persons with IDPSB at some point in the course of his or her work. Thus it is essential that practitioners be informed about effective assessment and treatment options for this unique group of clients to ensure that efforts to reduce reoffense risk are as effective as possible. Readers will notice that this document is, by its brevity, not all inclusive, but there are many resources noted in the body of this packet that will provide additional information to practitioners. It is beyond the scope of this informational packet to be exhaustive on any one topic, and this certainly may be said of each section herein. It is hoped that each section will pique readers’ interest to the relevant issues in working with adult persons with intellectual disabilities and problematic sexual behavior, in addition to providing references and resources that will help enrich their knowledge and practice repertoire.

ASSESSMENT

OVERVIEW The initial assessment of persons with IDPSB will be dependent on the nature of the referral question. Many initial assessment referrals will be concerned with issues such as whether the person being assessed has an intellectual disability, what the individual's risk level for future sexual violence may be, or whether the person has a concurrent mental disorder. This section will address the assessment of treatment needs regarding sexual behavior; however, it is also important to ensure that attention is paid to specific referral issues.

DIAGNOSTIC ISSUES Persons with ID are variously described in the current assessment and treatment literature as mentally retarded, learning disabled, developmentally delayed, and intellectually disabled. In the present document, we follow the lead of the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (American Psychiatric Association [APA], 2013), which has dropped the term "mental retardation" used in DSM-IV-TR (APA, 2000) and adopted the more internationally accepted term "intellectual disability" that the DSM-5 notes is the "equivalent term for the ICD-10 diagnosis of 'intellectual developmental disorders.'" A person may be diagnosed with an intellectual disability using DSM-5 if that person meets three diagnostic criteria (p. 33):

1. **Criterion A:** The person has "deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing" (p. 33). DSM-5 explains in detail how this criterion may be comprehensively assessed using IQ tests (see page 37).
2. **Criterion B:** The person has "deficits in adaptive functioning that result in failure to meet developmental socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community" (pp. 33, 37–38).
3. **Criterion C:** The person experiences the "onset of intellectual and adaptive deficits during the developmental period" (p. 33).

DSM-IV-TR differentiated the degree of mental retardation according to IQ ranges. In DSM-5, the coding of current severity of intellectual disability is "defined on the basis of *adaptive functioning and not IQ scores*" (emphasis added), because it is adaptive functioning that determines the "level of supports" that the individual will require (p. 33). DSM-5 provides a three-page table describing at length how someone in the mild, moderate, severe, and profound levels of intellectual disability would differ in the conceptual, social, and practical domains, with clear examples for children, adolescents, and adults within each domain and across levels (pp. 34–36). For new and experienced practitioners alike, the DSM-5 section on intellectual disability is a very useful piece of applied scholarship.

ASSESSMENT OF TREATMENT NEEDS

1. **Sexual Interests:** Given the importance of sexual deviations as a risk issue, the assessment of sexual interests, particularly sexual preferences, is an important pre-treatment issue. Many authors acknowledge

that sexual preference and sex drive are also issues for persons with IDPSB, given evidence of persistent offending noted in some clients (e.g., Lindsay, 2009). Having a good understanding of sexual interests and preferences is important in determining treatment planning. Unfortunately, assessment options for persons with IDPSB have not been well founded in the research, as noted in the following.

Some authors (e.g., Keeling, Beech, & Rose, 2007) recommend using the *Multiphasic Sex Inventory II* (MSI II—Nichols & Molinder, 2000) to assess sexual interests. The Grade 7 reading level of this instrument may be problematic for persons with IDPSB, and the tests are lengthy (560 items); however, it is available on audiotape for persons with learning or reading difficulties. Unfortunately, the MSI II has not been validated with persons with IDPSB. Penile plethysmography (PPG—see Freund & Blanchard, 1989) is often used to assess sexual preferences in persons who have sexually offended; however, issues of validity and reliability of PPG with persons with IDPSB remain, despite a lengthy history of its use with this group (see Wilson & Burns, 2011). A promising development in this area is the *Abel–Blasingame Assessment System for Individuals with Intellectual Disabilities* (ABID—Abel & Blasingame, 2005). The ABID is a viewing time and questionnaire method for the assessment of sexual interests that has been validated on a large sample of persons with IDPSB (Blasingame, Abel, Jordan, & Weigel, 2011). Although validated tools for assessment are relatively scarce, having a systematic inquiry into the client’s sexual interests can provide useful information, over and above reviewing documentation as part of the assessment.

2. **Attitudes Supportive of Offending:** There is a range of options for assessing attitudes and beliefs related to sexuality, victims, and offending for persons with IDPSB. The *Questionnaire on Attitudes Consistent with Sex Offending* (QACSO—Broxholme & Lindsay, 2003) is a well-validated instrument for the assessment of attitudes supportive of offending for persons with IDPSB. The QACSO has good psychometric support for use with persons with IDPSB, although the lack of North American research samples is potentially problematic for widespread adoption without cross-validation. This instrument assesses attitudes regarding a variety of offending areas, including sex with children, dating abuse, voyeurism, and homosexual assault.

Some of the measures of offense-supportive attitudes have been based on instruments designed for persons who have sexually offended who do not have an intellectual disability. The *Abel–Becker Cognition Scale* (ABCS—Abel, Becker, & Cunningham-Rathner, 1984) has been adapted for persons with IDPSB (see Kolton, Boer, & Boer [2001], as reported by Keeling, Beech, and Rose, 2007).

3. **Sexual Knowledge:** The literature regarding persons who have sexually offended who are not intellectually disabled suggests that low levels of sexual knowledge are not predictive of reoffending; however, there is some cause to believe that this may not be the case for persons with IDPSB (see Lunsky et al., 2007). Part of this is likely due to the fact that many persons with ID do not have the same educational opportunities regarding sexuality (Wilson & Burns, 2011). The *Assessment of Sexual Knowledge* (ASK—Galea, Butler, Iacono, & Leighton, 2004) is an instrument that examines sexual knowledge, as well as cognitive distortions related to sexual offending for persons with IDPSB. Another tool in this area with very good psychometric properties is the *Socio-Sexual Knowledge and Attitudes Assessment Tool–Revised* (SSKAAT-R—Griffiths & Lunsky, 2003; Lunsky et al., 2007).

Many instruments addressing sexual knowledge in persons with IDPSB are subject to criticisms regarding small sample sizes, item transparency, or lack of replication—potentially leading to problems in reliability and validity.

4. **Socio-Affective Functioning:** This area of assessment refers to how well a client is able to relate to others socially and emotionally (e.g., social inadequacy, anger, loneliness). Many of these issues may be explored by clinical interview, but there are also many instruments available in this area for use with persons with IDPSB.

Instruments with acceptable psychometric properties for use in this area with persons with IDPSB include the *UCLA Loneliness Scale–Revised* (Russell, 1996) and the *Relationship Questionnaire* (Bartholomew & Horowitz, 1991). A study by Williams, Wakeling, and Webster (2007) studied six instruments adapted for use with persons with IDPSB. These included the *Sex Offender’s Self-Appraisal Scale* (Bray & Foreshaw, 1996), the *Sex Offender’s Opinion Test* (Bray, 1997), and four instruments adapted for use with persons with IDPSB by Her Majesty’s Prison Service (UK), including the *Adapted Victim Empathy Consequences Task*, the *Adapted Relapse Prevention Interview*, the *Adapted Self-Esteem Questionnaire*, and the *Adapted Emotional Loneliness Scale*. Other than the last instrument, these adapted assessments were based on instruments designed by Thornton (see Williams et al. [2007] for the original and adapted references); all were found to have reasonable psychometric properties; and all but the last instrument showed expected pre/post-treatment changes.

The *Novaco Anger Scale* (Novaco, 2003) has ample data for use with persons with intellectual disabilities in general, but there is less data support for use of this instrument with persons with IDPSB in particular.

5. **Self-Management:** Deficits in planning, problem solving, and the ability to regulate impulses are related to offending risk. Relevant instruments include the *Adapted Relapse Prevention Interview* (see Williams et al., 2007), the *Social Problem Solving Inventory–Revised* (D’Zurilla, Nezu, & Maydeu-Olivares, 2002), and the *Barratt Impulsiveness Scale* (11th edition—Patton, Sanford, & Barratt, 1995).

RISK ASSESSMENT Persons with intellectual disabilities often do not have—or, at times, are not allowed to have—the same range of life experiences as those who are not intellectually disabled. These differences require sensitive application of differential diagnostics and risk assessment processes, which can present significant challenges for evaluators. Evaluating risk posed by clients with intellectual disabilities sometimes requires a degree of creativity. As noted above, many of the tools traditionally used in evaluating sexual offense risk were created for use with non-intellectually disabled, male adult clients. For this reason, traditional tools may not be very helpful with some clients, but may still be useful with others. Thankfully, the research and practice literature regarding intellectual disability and problematic sexual behavior is starting to grow, to the extent that there are now more tools designed specifically for this clientele.

The last 15 to 20 years have been witness to considerable growth in the methods and technologies available to professionals seeking to evaluate the risk for reoffense posed by persons who have engaged in sexually abusive behavior, regardless of disability status. Whereas historical evaluators were

forced to rely on anecdotal research reports and unstructured clinical judgment (see Monahan, 1981), contemporary assessors now have a variety of tools available to assist in anticipating future offending.

There is good reason to propose that these new tools have improved our ability to assess and manage risk and that their use may also help explain the significant decreases in observed rates of sexual reoffending (see Finkelhor & Jones, 2004; Helmus, 2009; Wilson, Cortoni, Picheca, Stirpe, & Nunes, 2009). However, the *majority* of the most popular tools in our business were developed for the *majority* of clients—male adults with histories of sexual offending. This means that assessment, treatment, and management professionals working with other groups, such as females, juveniles, and individuals with mental illness or intellectual disabilities, have been at something of a disadvantage—at least until recently. In this short review, we will consider the processes and tools available to clinicians attempting to assess the level of risk that persons with IDPSB pose to the community.

The Risk-Need-Responsivity model (Andrews & Bonta, 2010) provides practitioners with a set of overarching principles regarding risk potential, treatment/criminogenic need areas, and individual client characteristics and learning styles. The risk principle is particularly pertinent, in that a comprehensive risk assessment will provide significant guidance regarding client placement, treatment need, and ongoing case management concerns. In conducting assessments—particularly risk assessments—we must gather as many details as we can about the individual who committed the offense, his or her circumstances, and any other relevant details that will help us understand what happened, why it happened, and what the chances are that it might happen again. Risk assessment data are also used to compose risk management plans (see Supervision section).

To adequately and comprehensively assess risk of reoffending, it is important to consider a wide variety of factors and variables, both historical and contemporary. As with other populations, persons who sexually offend are unlikely to present risk in only one area; that is, they often pose a risk to engage in other antisocial or dysfunctional actions. In order to gather sufficient information to make useful judgments about risk, a number of domains and procedures should be considered. When obtaining assessment information from these sources, it is worth considering that all self-reports include some degree of bias due to different demand situations of the persons offering the data. This is why accessing multiple sources of information is an important part of increasing the reliability of assessment processes. The following sources may be considered:

- A structured interview between the person who has committed the offense and the individual performing the assessment
- Self-reports, from both victims (or victim statements, when available) and client
- Collateral contacts (family, friends)
- Police reports, prior criminal justice reports, etc.
- Other official documents, such as court transcripts, judge's reasons for sentencing, pre-sentence reports, etc.

- Any prior mental health reports, psychological tests, actuarial risk assessment measures, results of sexual preference/interest testing, etc.
- Actuarial risk assessment instruments (ARAI) and measures of dynamic risk/criminogenic need.

PARAPHILIAS AND SEXUAL DEVIANCE Anomalies in sexual preference and behavior are generally known as paraphilias (e.g., pedophilia, exhibitionism, sexual sadism—see APA, 2013). In two influential meta-analyses, Hanson and associates (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; see also Mann, Hanson, & Thornton, 2010) identified sexually deviant interests as being a particularly robust predictor of future offending. Blasingame (in press) suggested that psychosexual variations may be assessed using penile plethysmography, measures of attention or viewing behavior, self-report questionnaires, or clinical interviews. Blasingame also notes that application of these methods to persons with intellectual disabilities requires a degree of adaptation of the procedures involved. For example, some commentators have questioned the applicability of traditional measures of sexual interest and arousal with persons with intellectual disabilities (see Wilson & Burns, 2011)—especially given that many of these procedures were standardized on non-intellectually disabled persons. The *Abel–Blasingame Assessment System for Individuals with Intellectual Disabilities* (ABID—Abel & Blasingame, 2005; see also Blasingame et al., 2011) is an information-gathering system designed specifically for individuals with very low cognitive functioning. In addition to a viewing time protocol, the ABID includes a number of self-report questionnaires administered by the evaluator, all of which assist in providing information regarding client sexual interests and preferences.

ACTUARIAL RISK ASSESSMENT INSTRUMENTS (ARAI) The following are examples of static ARAI in current common use:

- *Static-99R* (Helmus, Thornton, Hanson, & Babchishin, 2012)
- *Mn-SOST-3* (Duwe & Freske, 2012)
- *Sex Offender Risk Appraisal Guide* (SORAG—Quinsey, Harris, Rice, & Cormier, 2005).

Additionally, dynamic ARAI are available, such as:

- *Structured Risk Assessment—Forensic Version* (SRA-FV—Thornton, 2002)
- *Violence Risk Scale: Sexual Offender Version* (VRS-SO—Olver, Wong, Nicholaichuk, & Gordon, 2007)
- *Sexual Offender Treatment Intervention and Progress Scale* (SOTIPS—McGrath, Lasher, & Cumming, 2012)
- *Stable-2007* (Hanson, Harris, Scott, & Helmus, 2007).

Structured professional judgment frameworks are also available (e.g., *Sexual Violence Risk-20* [SVR-20—Boer, Hart, Kropp, & Webster, 1997] and the *Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend—Sexually* [ARMIDILO-S—Boer et al., 2012]), in addition to a multitude of specialized indices designed to assess important aspects of clients' cognitive and behavioral presentations as well as historical factors (see Appendix in Wilson & Burns, 2011). At present, there is no static ARAI specifically produced for persons with IDPSB, and there is only a small amount of research reporting on the utility of existing scales with this population.

One early report (Tough, 2001) suggested that the *Rapid Risk Assessment of Sex Offender Recidivism* (RRASOR—Hanson, 1997) performed slightly better than the popular *Static-99R* (Hanson & Thornton, 2000; Helmus, 2009); however, subsequent cross-validation research has suggested that the latter—as well as the *Static-2002R*—is likely to provide more accurate ratings in this population (Hanson, Sheahan, & VanZuylen, 2013). It is reasonable to expect that other static ARAs (e.g., *Violence Risk Appraisal Guide/Sex Offense Risk Appraisal Guide* [VRAG/SORAG]—Quinsey et al., 2005; *Risk Matrix-2000* [RM-2000]—Thornton et al., 2003) would also provide assistance in anchoring risk judgments; however, additional research is required (see Lindsay et al., 2008). The concept of “anchoring” risk judgments with static ARAs comes from the literature showing that clinical judgment is often too subjective to provide a solid foundation (Monahan, 1981). Research demonstrating the value added by “objective” processes (see Quinsey et al., 2005) shows that the majority of the variance in risk assessment of persons who have sexually offended is likely to be tapped by actuarial methods focusing on static/historical variables. Notwithstanding research supporting the use of static ARAs, some researchers have questioned the validity of such indices for use with persons with intellectual disabilities (e.g., Wilcox, Beech, Markall, & Blacker, 2009). Practitioners in the field frequently note that persons with intellectual disabilities seem to be at a disadvantage in regard to some of the factors included in *Static-99R* (e.g., “Ever Lived with a Lover”—see Hanson et al., 2013). This is due, in part, to the likelihood that persons with intellectual disabilities will face greater challenges in regard to dating and may more often be found in group housing environments with peers of the same gender. Overall, additional research will be required, but at the present time there is support for the judicious use of static ARAs in anchoring risk judgments made about persons with intellectual disabilities and problematic sexual behavior.

Regarding the potential for violence and general reoffending, there are other static and/or dynamic ARAs that may be used. For example, the *Level of Service Inventory–Revised* (LSI-R—Andrews & Bonta, 1995) is a tool commonly used for evaluation of general risk potential, whereas the VRAG (Quinsey et al., 2005) is a helpful predictor of engagement in violence, including in regard to persons with intellectual disabilities (see Lofthouse et al., 2013). Although not strictly a measure of risk to engage in violence, there is support for the proposition that those clients who present with highly entrenched antisocial values and attitudes (e.g., psychopathy as measured by the *Psychopathy Checklist–Revised* [PCL-R]—see Hare, 2003) are at greater risk in this domain (see Quinsey et al., 2005). Research has shown that this construct of highly entrenched antisociality is also applicable for persons with intellectual disabilities (Morrissey, Mooney, Hogue, Lindsay, & Taylor, 2007).

MEASURES OF DYNAMIC RISK/CRIMINOGENIC NEED The field of risk management for persons who have sexually offended has seen a recent surge in the popularity of measures of dynamic risk potential. Whereas static actuarial scales measure risk markers that are largely historical in nature (i.e., what the client *has done*), dynamic scales focus on predictors based largely on personality, values and attitudes, and other changeable lifestyle elements (i.e., who the client *is*). Contemporary research suggests that comprehensive risk assessment protocols are more accurate when they consider both these aspects (see Harris & Tough, 2004; Mann et al., 2010). For non-intellectually disabled clients, the SRA-FV (Thornton, 2002), VRS-SO (Olver et al., 2007), and *Stable-2007* and *Acute-2007* (Hanson et al., 2007) enjoy relative degrees of favor, depending on jurisdiction.

Currently, research is ongoing as to how to conduct useful dynamic assessments with the IDPSB population. Boer, Haaven, and associates (2012; see also Boer, McVilly, & Lambick, 2007; Boer, Tough, & Haaven, 2004) have been working to establish the ARMIDILO-S as a useful structured professional judgment tool for measuring dynamic risk specifically in persons with intellectual disabilities. Additionally, the *Treatment Intervention and Progress Scale for Sexual Abusers with Intellectual Disability* (TIPS-ID—see McGrath, Livingston, & Falk, 2007) is similar to the ARMIDILO-S in terms of the risk factors considered, and both instruments serve as a structured approach when evaluating dynamic, changeable characteristics within the individuals' psychosocial and contextual environment (Blasingame, in press). Recently, McGrath has suggested that a separate dynamic risk assessment tool designed specifically for persons with IDPSB may be unnecessary due to overlap between factors for persons with and without ID, but the use of the TIPS-ID is recommended for case management decisions (Blasingame, in press).

Of the measures of dynamic risk noted above specific to clients with intellectual disabilities, the ARMIDILO-S has been subject to recent investigation as to its predictive and clinical utility. This instrument follows the dynamic risk framework suggested by Hanson and Harris (2001), and many of the items are similar in concept to those included in the *Stable-2007* and *Acute-2007* (Hanson et al., 2007). The ARMIDILO-S employs structured professional judgment to rate dynamic risk, and it incorporates a static actuarial risk rating (i.e., scored externally and separately to the ARMIDILO-S, such as the Static-99R). It includes several items grouped in four categories of risk factors (client-stable, client-acute, environment-stable, and environment-acute). Of particular assistance, these factors may be considered as being either risk enhancing or protective.

The ARMIDILO-S has demonstrated predictive accuracy ratings ranging from moderate to good (see Blacker, Beech, Wilcox, & Boer, 2011; Lofthouse et al., 2013). Lofthouse et al. (2013) suggested that the ARMIDILO-S outperformed both the Static-99 and VRAG in ability to predict sexual recidivism, whereas Blacker and associates (Blacker et al., 2011) suggested that it also outperformed the RRASOR (Hanson, 1997) and the RM-2000-V (Thornton et al., 2003). However, it is important to note that these studies (Lofthouse et al. [2013] and Blacker et al. [2011]) have particularly small sample sizes, which calls into question current perspectives on the overall stability and predictive utility of the ARMIDILO-S. More research is required before anything definitive may be said about the potential utility of this tool over existing ARAI measures.

SUMMARY AND RECOMMENDATIONS Before using specialized testing, it is critical to identify whether the client being assessed is intellectually disabled. Failure to identify a client as a person with ID may result in that person receiving inadequate or inappropriate services, not benefitting from the treatment received, and not appropriately managing whatever risks the client poses or experiences. In addition, practitioners will need to remember a few important points:

1. Evaluators will need to consider the intellectual challenges faced by clients, specifically:
 - a. General and functional illiteracy
 - b. Problems with memory
 - c. Problems with receptive and expressive language
 - d. Diminished social abilities (especially for those with issues on the autism spectrum).

2. It is important to reduce reliance on verbal materials and processes.
 - a. The use of diagrams and pictures can be helpful.
 - b. Where verbal materials are unavoidable, information is best acquired using processes that are simplified, concrete, and repetitive.
3. Persons with intellectual disabilities typically have much less knowledge and education regarding many aspects of life, including sexuality. Therefore, education in this area is important.
4. External/environmental factors exert greater influence on persons in care settings (e.g., hospitals, group homes, etc.)

Best practice in risk assessment is to be as comprehensive and holistic as possible. Evaluators must also take care to use tools validated on or specifically produced for use with the client population being assessed. Given the nascent status of the research literature regarding persons with IDPSB, this has been something of a challenge to both evaluators and clinicians. Nonetheless, much like their neurotypical peers, persons with intellectual disabilities can learn to manage their sexual behavior problems and, as such, they deserve appropriate assessment, treatment, and post-release supervision—all of which require tools and processes specific to their clinical and risk management needs.

TREATMENT

HISTORY During the “deinstitutionalization” movement of the 1950s and 1960s in the United States, there was increased attention to persons with IDPSB. The first article outlining advanced practices in addressing persons with IDPSB was by Murphy and colleagues (Murphy, Coleman, & Haynes, 1983). Two programs starting in the late 1970s—one in Canada (Griffiths, Quinsey, & Hingsburger, 1989) and one in the United States (Haaven et al., 1990)—outlined the first programming descriptions for persons with IDPSB. These early programs relied heavily on research and intervention strategies developed for non-intellectually disabled male adults who had sexually offended. Although it may have been expedient to borrow from this existing literature, the ultimate answer to addressing this issue lies in a comprehensive understanding of the characteristics and nature of persons with IDPSB. Over the past 20 years, there has been a significant increase in the body of research on this subject. Two books (Lindsay, 2009; Lindsay, Taylor & Sturmey, 2004) provide a comprehensive collection of research on this topic.

TREATMENT PRINCIPLES AND MODELS There is no single treatment model that addresses all of the unique characteristics of this population. With respect to persons with IDPSB, there is a consensus in the field that best practice approaches are drawn from a variety of principles and theoretical models. Two books in particular (Lindsay, 2009; Wilson & Burns, 2011) provide useful descriptions and overviews of various theories and models of treatment for both non-intellectually disabled clients and persons with IDPSB.

In the 1980s, the Relapse Prevention model (RP—Pithers, Marques, Gibat, & Marlatt, 1983) became the predominant treatment model for persons who had sexually offended. RP is a self-management, skill-based approach to preventing risky behavior from escalating to a criminal sexual offense. In the

past, most programs for persons with IDPSB used the RP model as a framework for treatment, even though there were limitations to its use with this population. Persons with IDPSB have been observed to experience difficulty in identifying subtleties of risk situations, in addition to learning sequential chains of events (Haaven, 2006). Over time, RP has been used less frequently as an overarching model of change in sexual abuse treatment. However, the central concepts of identifying precursors to risk and implementing corresponding avoidance strategies continue to be helpful components in comprehensive approaches to treatment. The RP model provides a useful framework for staff to develop external supports around a person with IDPSB's pattern of risk situations, and it serves as a tool for staff intervention in the community.

Counterfeit deviance (Hingsburger, Griffiths, & Quinsey, 1991) is one of a number of hypotheses that attempt to explain the origin and manifestation of problematic sexual behaviors in persons with ID. The central hypothesis is that sexual behavior in some persons with IDPSB may seem as if it may be driven by deviant interests (which may also be unlawful) or arousal but, when all the circumstances are considered, the reason for the behavior is less deviant. In this regard, it is important to distinguish between paraphilic (i.e., sexually deviant) behaviors and unlawful behaviors. For example, many persons with IDPSB live in environments where there is little opportunity for privacy, including when engaging in personal sexual behavior. Some individuals in these circumstances engage in "public masturbation"; however, this behavior may be more a function of the situational restrictions than being indicative of sexually deviant intentions (e.g., exhibitionism). Although several studies have questioned the validity of the counterfeit deviance hypothesis (Lunsky et al., 2007; Michie, Lindsay, Martin, & Grieve, 2006; Talbot & Langdon, 2006), it does bring attention to a couple of important points. First, persons with IDPSB may lack an awareness of the extent to which their acts are socially unacceptable (Lindsay, 2009) and, second, it is important to address environmental factors, especially regarding the degree to which they may increase risk for sexual offending.

The Risk/Need/Responsivity model The Risk/Need/Responsivity model (RNR—Andrews & Bonta, 2010) of effective interventions integrates a psychology of criminal conduct into an understanding of how to reduce recidivism while increasing clients' prosocial capacities. This model has been applied to persons with IDPSB, although no research has been conducted specific to this population. The three core principles are as follows:

- *Risk*: Intensity of services provided should be matched to the level of risk posed by the client.
- *Need*: Treatment targets should be clearly linked by research to reoffending, and treatment planning should be individualized to the specific criminogenic profile of the client.
- *Responsivity*: Use of effective methods (e.g., primarily those that are cognitive-behavioral and skills-based) ensures that treatment is adjusted to the learning style and clinical presentation and unique qualities of the individual, thereby maximizing the therapeutic alliance between client and treatment provider and resulting in increased motivation.

The Old Me/New Me model The Old Me/New Me model (Haaven, 2006; Haaven & Coleman, 2000) identifies six principles that guide treatment for persons with IDPSB: develop a positive self-identity, increase self-efficacy, increase capability to meet basic needs, manage dynamic risk factors, focus on

approach goals, and develop capacity to establish and maintain wrap-around supports in the community. Central to the model is the use of the terms “Old Me” and “New Me.” The labeling of appropriate and inappropriate thoughts and behaviors is a narrative used to describe and discuss the internal struggle that goes on between the “Old Me” and “New Me” when managing risk and life decisions.

The Pathways/Self-Regulation model The Pathways/Self-Regulation model (Ward & Hudson, 1998) is based on self-regulation theory, in which persons with IDPSB engage in goal-directed behavior impacted by internal and external circumstances and events that direct this behavior. Persons with IDPSB may offend by following one of four pathways that have been identified in the model. The pathways represent two types of goals—avoidant and approach—and two types of regulation—passive and active. Two studies (Keeling et al., 2006; Lindsay, Steptoe, & Beech, 2008) suggest that the vast majority of persons with IDPSB use approach pathways versus avoidance pathways, which somewhat limits the utility of the model. As more discrimination of pathways for persons with IDPSB is identified, this model may have increased utility.

The Good Lives Model The Good Lives model (GLM—Yates, Prescott, & Ward, 2010) is a comprehensive extension of the Old Me/New Me model. It focuses on the client developing a balanced, prosocial personal identity and goal-seeking to develop a life that is healthy, self-determined, and free of risk for offending. It is assumed that if clients develop skills, beliefs, and values to prosocially obtain primary human goods or valued outcomes, they are less likely to reoffend as a means of meeting those primary needs (Yates et al., 2010). What makes this model different from others listed here is that it seeks to prescriptively identify prosocial replacement goals and behaviors for the clients’ criminogenic needs that are motivating the offending behavior.

Most professionals view the models above as appropriate for use with persons with IDPSB. The following are common components of “best practice” treatment interventions drawn from the models detailed above:

- Use cognitive-behavioral approaches that are skill-based.
- Match intensity of treatment programming to risk level.
- Ensure that treatment programs principally target the problem areas most related to offending.
- Individualize treatment plans to the specific criminogenic needs of the client.
- Increase motivation through attention to responsivity.
- Intervene in offending patterns.
- Focus on personal identity, increasing self-efficacy and approach goals.
- Develop compensatory strategies specific to offending pathways.
- Address environmental influences and concerns.
- Increase basic skills for community engagement.
- Develop wrap-around risk management supports within the community.

TREATMENT MODIFICATIONS There are more similarities than there are differences in treatment methods used with persons with IDPSB and those used with persons with similar histories who are not intellectually disabled (Coleman & Haaven, 2001). Adjustments are necessary when adapting treatment principles and strategies for persons with IDPSB from models for treating persons without IDPSB, owing to the former's unique developmental issues, vulnerabilities, and skill deficits.

Responsivity has always been a central focus for clinicians working with persons with IDPSB, especially in regard to learning style, cognitive ability, and life circumstances. Group and/or individual therapy is usually required with this population (Haaven, 2006). In group therapy, the facilitator needs to maintain a heightened awareness of information discussed so as not to introduce new or inappropriate imagery. Persons with IDPSB need to be aware of the consequences of their actions, many of which have often been overlooked; however, focusing solely on consequences can have a negative impact on motivation. Clinicians have historically relied on contingency programming (e.g., token, level systems, etc.) and consequential learning to motivate persons with IDPSB in treatment. Motivating persons with IDPSB requires a wide range of strategies, and it is important to maintain attention on the therapeutic alliance and use of motivational interviewing principles (Miller & Rollnick, 2002). Additional useful strategies are increasing attention to the design of positive structured living environments, focusing on strengths before focusing on challenges, providing frequent progress reviews to the client, fostering prosocial group cohesion, making self-disclosure a motivating process, and focusing on developing a prosocial and empowered self-identity (Haaven, 2006).

Many programs focus on identifying and interrupting offending behavior cycles (relapse prevention). In this regard, several interventions have been designed specifically for persons with IDPSB (see descriptions and frameworks in *Developmentally Disabled Persons with Sexual Behavior Problems* by Blasingame [2005], *Footprints: Steps to a Healthy Life* by Hansen and Kahn [2005], *Healthy Choices* by Horton and Frugoli [2001], *The Treatment of Sex Offenders with Developmental Disabilities* by Lindsay [2009], and *Intellectual Disability and Problems in Sexual Behaviour: Assessment, Treatment, and Promotion of Healthy Sexuality* by Wilson and Burns [2011]). Haaven (2006) suggested that, for some individuals, learning about their offending patterns can be useful, but it is not always necessary to teach a specific chain of events (or cycle) to reoffense. Instead, the individual can match specific, behavioral high-risk situations with corresponding interventions. Learning one's "cycle" in a group therapy setting often does not generalize well for application in the community; generalization requires significant rehearsal in various community settings and situations.

Commitment and active engagement in the community (work, play, and personal attachments) and societal norms and values are important treatment focuses for persons with IDPSB. Involvement in the community is reflected in the Old Me/New Me model and GLM, but Lindsay (2005) was the first to elucidate the theoretical importance. The focus needs to be on physical and material surroundings that increase quality of life and, most importantly, on prosocial influences and full community integration (Lindsay, 2009).

Central treatment targets for this population include meeting unmet basic needs and addressing dynamic risk factors (criminogenic needs—see Haaven, 2006; Yates et al., 2010). Common basic skill areas for focus in treatment programming are:

- Communications
- Sexual education (consent, appropriate touch, and healthy expression of sexuality)
- Seeking help
- Moral reasoning (right from wrong)
- Leisure activities
- Other skills identified as important in community integration.

Basic skill training should be presented within the context of relationship development and community integration (Haaven, 2006).

The dynamic risk factors identified for individual persons with IDPSB are the primary focus of treatment, in keeping with the need principle. Common risk factors addressed in treatment are general self-regulation, relationships and intimacy deficits, distorted attitudes, and sexual self-regulation. Self-regulation to manage emotional impulses is addressed primarily by identification and management of feeling states, with additional focus on impulse management strategies, including problem solving. Relationship-building skills should be a central focus throughout the treatment process, with other basic life skills introduced within that context (Blasingame, 2005; Haaven, 2006). Distorted attitudes and deviant sexual self-regulation are addressed primarily by learning avoidance strategies, cognitive restructuring, and implementing appropriate replacement behaviors (e.g., promotion of approach goals). Where there are psychiatric conditions (e.g., paraphilias, hypersexuality) that lead to elevated sexual arousal, pharmacological interventions may be indicated. Behavioral conditioning approaches (aversive conditioning, masturbatory reconditioning, etc.) appear to have limited effect with this population (Wilson & Burns, 2011).

Cognitive restructuring is an area in which significant adaptations often need to be made, as persons with IDPSB may be limited in their ability to mediate cognitions (Wilner & Goodev, 2005). These individuals frequently experience limited ability to recognize feeling states and are even more limited in their ability to introduce new cognitions to change their feeling states and behavior. Other cognitive restructuring options are introducing thought-stopping techniques, correcting distortions (false beliefs), and storytelling to create success imagery (Blasingame, 2005; Haaven, 2006).

Addressing denial is an area in which differing approaches are used with this population. Generally, current practice is to not remove persons with IDPSB who are in denial from treatment (Haaven, 2006). The self-disclosure process ranges from providing specific details of the offending behavior within a group setting to providing very limited details and only doing so within individual counseling.

The focus on positive, prosocial identity is a central component of the Old Me/New Me model and GLM. The Old Me/New Me model emphasizes the importance of taking an active, prescriptive approach in supporting persons with IDPSB in developing identities of their own.

IMPORTANT POINTS TO REMEMBER There are several areas to highlight regarding treatment of persons with IDPSB. Treatment must be relevant to the individual—it must make sense and its goals must be those that clients actually would want to achieve. Treatment approaches should ensure that skills generalize to various settings and conditions. Healthy sexuality and realistic opportunities for sexual expression must be of central focus and not just another skill module offered (Wilson & Burns, 2011). Engagement with the community and connectedness with others need to be central throughout the treatment process. Finally, Blasingame (2005; in press) suggested that treatment effectiveness requires comprehensive, user-friendly risk management systems in the community involving collaboration of all parties including, when applicable, group home staff.

SUPERVISION/CASE MANAGEMENT

Like all other aspects of addressing the special concerns of persons with IDPSB, the designation of appropriate levels of community supervision for this population should be informed by a comprehensive assessment of the individual's particular treatment and risk management needs. These needs must be integrated into a tailored plan of supervision, with support and services designed to minimize the recurrence of problematic sexual behaviors (PSB) while increasing public safety. This is true whether (a) the person with IDPSB has been charged or convicted for a sexual offense and is involved in the criminal justice system, (b) the individual with an ID has engaged in but has never been criminally adjudicated for PSB and is being served in the social service system, or (c) the person with IDPSB is connected to both the correctional and developmental disability service systems.

While it is important to recognize that persons with IDPSB may be both similar to and different from persons without IDPSB in important ways, it is equally if not more important to appreciate how differently they may be viewed by the distinct but necessarily overlapping service agency systems that are tasked with the supervision of persons with IDPSB in the community. For instance, police officers responsible for sexual offender registration and notification duties, or probation and parole officers, may have a general appreciation that persons with IDPSB can be more concrete and slower in their thinking and may need more time to process and respond to information and directions. However, criminal justice professionals providing community supervision services may not fully appreciate essential but more nuanced issues associated with individuals with ID that may impede effective communication and supervision service delivery. These may include, but are by no means limited to the following (see Cumming & Buell, 1997):

- The needs of many persons with IDPSB for specificity and repetition
- The impact of impaired verbal comprehension and reading skills on persons with IDPSB
- Inherent difficulties that persons with IDPSB may have with abstraction and generalization
- A tendency in persons with IDPSB toward an acquiescence bias, and the associated need for professionals to avoid yes/no questioning

- The sensitivity persons with IDPSB can experience regarding criticism
- The often highly circumscribed areas of competence found in persons with IDPSB.

Regarding the final bullet, a law enforcement officer may not recognize the actual low incidence of criminal thinking among the population of persons with ID. As a result, he or she may assign antisocial motives to a deception that is actually generated by fear of disapproval on the part of the individual with ID. This type of miscommunication can result in costly and inappropriate designation of the individual's actions as community supervision violations.

Similarly, well-intending social service and mental health providers who have limited experience with persons with IDPSB often have their own blind spots regarding these types of human service clients (Guidry & Saleh, 2004). Some may tend to infantilize persons with IDPSB, while others may overly pathologize persons with ID, minimizing accountability for their behavior, fostering system dependency, inadvertently colluding with the client's distortions, and ignoring or failing to recognize the client's potential for risk. Still other human service providers respond to persons with IDPSB with the same kind of misguided and uninformed reactivity that the general public has toward the high profile and emotionally evocative cases of sexual offending featured in the news, which support a perspective that all persons who have sexually offended are the same, and that they are all dangerous, untreatable, and at high risk for reoffense. Persons with IDPSB are sometimes erroneously believed to be at even greater risk than other offenders for sexual reoffense and are seen as even more dangerous secondary to their disability, which is assumed to leave them vulnerable to extreme dyscontrol relative to their sexual behavior (Chivers & Mathieson, 2000). As such, social service providers may be prone to under- or over-respond to risk for reoffense in a person with IDPSB. Inaccurately matched responses can result in costly—on many levels—miscalculations of supervisory care needs and misallocation of valuable but limited staff and fiscal resources.

Distinct in their roles, but overlapping in their mandate, the correctional and ID service systems are uniquely bound through their responsibility to appropriately supervise, support, and facilitate the safe management and treatment of persons with IDPSB in the community (Vermont Agency of Human Services, 2005). As such, professionals in both service systems responsible for the development and implementation of adequate community supervision, risk management, and supportive services plans for persons with IDPSB should be fully educated about this special needs population. Training for both sets of professionals should include, but may not be limited to:

- Exposure to the extant evidence-based, basic research regarding what is currently known about persons who have sexually offended, a review of state sexual offender laws and local registration and notification laws and practices, and a review of the role of community supervision (i.e., parole, probation) offices
- Understanding of fundamentals regarding intellectual disabilities, including potential deficits and strengths in cognitive, social, and emotional functioning, the high incidence of abuse and trauma among individuals with ID, the high rate of concurrent psychiatric conditions and traumatic brain injuries (TBI) among individuals with ID, and an explanation of the typical role of ID social service agents providing community care

- Introduction to a growing body of research on persons with IDPSB, including similarities and differences between persons—with or without intellectual disabilities—who have sexually offended and the special considerations in assessment, treatment, and risk management of persons with IDPSB. From this shared base of knowledge, these two typically divergent service systems can work together to collaboratively promote effective supervision and risk management practices for those persons with IDPSB under their watch and care (Vermont Agency of Human Services, 2005).

USE OF THE ARMIDILO-S IN EFFECTIVE SUPERVISION PLANNING As noted, appropriate levels of supervision and accurately targeted safety management plans that match the risk presented by persons with IDPSB are derived from a comprehensive assessment that includes an accurate assessment of risk as observed among persons with IDPSB. As referenced earlier, the ARMIDILO-S is a widely used risk assessment tool specifically designed for use with persons with IDPSB. Recent research has demonstrated a degree of promise regarding use of the ARMIDILO-S in regard to predictive validity (Lofthouse et al., 2013). However, results are preliminary and further research is required before definitive statements can be made regarding relative utility in comparison to other available ARAI tools. In its favor, the ARMIDILO-S includes both stable and dynamic client factors associated with risk for sexual reoffense among persons with IDPSB and allows for consideration of factors as being either risk-increasing or protective, all of which improves case management strategy development.

Additionally and importantly, the ARMIDILO-S represents the first effort of its kind to view persons with IDPSB within the context and influence of the environment within which such clients are embedded. This allows for an empirically based measure and conceptualization of the additional influence of stable and acute environmental factors, particularly the impact of supervisory factors that may function to increase or reduce risk for sexual reoffense in a person with IDPSB. Relevant to the discussion of the effective supervision of persons with IDPSB, the combination of stable and acute client factors with the essential environmental factors provides a particularly helpful template upon which to build an informed and effective supervision and risk management plan.

CHAPERONE TRAINING Another way that effective community supervision of persons with IDPSB can be enhanced is through chaperone training (Center for Sex Offender Management, 2012). These trainings are designed for laypersons, as well as semi-professional and professional staff who are interested in learning effective methods to safely supervise, support, and manage the risk that persons with IDPSB pose in community settings. Participants in these types of training opportunities can include, but are not limited to, non-offending family members and friends, guardians, those who may offer respite to the persons with IDPSB, adult foster care and family home care providers, vocational and recreational support staff, and direct-care residential staff. General goals of chaperone training can include:

- General education regarding persons who have sexually offended and local laws and practices
- Specific training regarding special needs populations, such as persons with IDPSB
- Chaperone training certification
- Ongoing opportunities for support as well as updates to chaperone education and certification.

Chaperones may be included as part of a collaborative team. This approach can serve to widen the invaluable network of supervision and support that surrounds persons with IDPSB as they move throughout the community setting and progress towards increasing safe independence—all of which can serve to enhance the goals of successful community supervision.

SUMMARY & CONCLUSION

In summary, although the area of assessment and treatment for persons with IDPSB is specialized, it is actually relatively commonplace to find such individuals, adjudicated or not, among the clients referred to assessment and treatment specialists working with adult persons who have sexually offended. As is good and ethical practice, if a client is outside of his or her area of expertise, a professional may make a referral to another specialist. However, it is the position of the Association for the Treatment of Sexual Abusers that by being aware of the assessment and treatment options for persons with IDPSB, in conjunction with specialist supervision, effective work may be done with this population to enhance public safety and improve the lives of these clients. It is hoped that this informational packet will provide useful introductory information to this extremely important area of practice.

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