In the authors’ experience, there is some confusion on the definition of offenders with intellectual and developmental disability (IDD) and who is included in this category. A variety of terms are used for the individuals to whom we will refer in the current chapter. In the UK and Ireland, we tend to use the term ‘learning disability’ while in the United States and many English-speaking countries the term ‘mental retardation’ was used for decades until recently when it was replaced by intellectual and developmental disability. In the UK we occasionally refer to ‘learning difficulty’, which can also be synonymous with IDDs. In a somewhat confusing categorisation, in some secure settings such as prison systems, the distinction between general or mainstream offenders and offenders with IDD has been different from the various diagnostic guidelines across the world. For example, in the English prison system offenders with lower intellectual functioning are defined by an IQ less than 80 and these individuals are often referred to as having ‘learning disability’ but, as we shall explain, this does not conform to international classifications. This is an important distinction because the international definition of IDD includes psychometrically assessed cognitive function indicating an IQ less than 70 and this alteration in the definition makes a significant difference to both prevalence and individuals concerned. In this chapter we will use the term IDD since it has gained international recognition.

The three most influential organisations in the world include three core criteria for IDD: ICD-10 (World Health Organization, 1992), DSM 5 (American Psychiatric Association, 2013), and the American Association on Intellectual and Developmental Disabilities (AAIDD, 2013). The first of these is ‘significant impairment of intellectual functioning’. Assessment of intellectual functioning should be obtained using an individually administered, reliable and valid standardised test, such as the Wechsler Adult Intelligence Scale (WAIS-IV UK: Wechsler, 2010). ‘Significant impairment’ is conventionally understood to be a score more than two standard deviations below the population mean, i.e., an IQ less than 70. Around 2–3% of the population fall into this category of intellectual functioning but, crucially, if it is redefined to an IQ of less than 80, the percentage of the population increases to 9% or 10%. Clearly this will have a significant impact on prevalence. One should be
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cautious about using shorter, less time-consuming assessments of cognitive functioning that estimate or screen for intellectual ability. Screening measures are designed to be over-inclusive in relation to the population and although they will generally have a high correlation with a more comprehensive measure of intellectual ability such as the WAIS, where there are errors they should be overwhelmingly in one direction. Therefore, they are more likely to misclassify individuals without IDD as falling within the population.

The second diagnostic criterion is significant associated impairment of adaptive or social functioning. Adaptive functioning is a broad concept that is concerned with an individual's ability to cope with the day-to-day demands of their environment. It will include the skills necessary for independent functioning, domestic tasks, self-care skills in addition to a range of community integration abilities such as the use of public transport, shopping skills and the ability to use services such as banking, social services, leisure services and health services.

The third criterion is age of onset within the developmental period before adulthood. There is general international consensus that the ‘age of onset’ criterion means the developmental period during childhood. The assessor should partial out intellectual deterioration that might be caused by traumatic injury or disease, which has occurred in adulthood. Therefore, an assessment of IDD is not confined to current abilities but is also concerned with developmental experience and developmental skills.

Prevalence of offenders with intellectual and developmental disabilities

There are several methodological difficulties resulting in disparity across various prevalence studies (Lindsay, Hastings, Griffiths & Hayes, 2007a). First, studies have been conducted in a variety of settings including prisons (MacEachron, 1979), high secure hospitals (Walker & McCabe, 1973), appearance at court (Messinger & Apfelberg, 1961), probation services (Mason & Murphy, 2002) and appearance at police stations (Lyall et al., 1995). In some settings, it has been reported that particular types of offences are over-represented among offenders with IDD. For example, in their classic study of secure hospitals in England, Walker and McCabe (1973) reviewed 331 men with IDD and found high rates of fire raising (15%) and sexual offences (28%) when compared with other groups in their secure hospital sample. In a more recent study, Hogue et al. (2006) reviewed a number of characteristics of offenders with IDD across community, medium/low secure and high secure settings. They found that rates of arson in the index offence depended on the setting, with low rates in the community setting (2.9%) and higher rates in the medium/low secure setting (21.4%). This is a clear example of the fact that the setting in which the data is collected is very likely to influence the results and subsequent conclusions about the population.

MacEachron (1979) reviewed the literature for prevalence of offenders with IDD in prisons and found a range of 2.6% to 39.6%. She noted that these previous studies had used a variety of methods to identify and measure intellectual disability and concluded that the methodological variation between studies might produce the highly diverse prevalence rates. A third source of variation is inclusion criteria, particularly if those considered to be functioning in the borderline intelligence range are included. Hayes (1991) reviewed studies that revealed that approximately 2% of the prison population in New South Wales had a measured IQ lower than 70. She also noted that approximately 10% of prisoners were placed in the borderline range of IQ between 70 and 80. Clearly, the inclusion of individuals with borderline intelligence significantly increases the prevalence rates and, as was mentioned earlier, several studies have used an IQ of 80 or even 85 as a cut-off for intellectual disability (Noble & Conley, 1992).
The influence of social policy changes was demonstrated by Lund (1990) who reported a doubling of the incidence of sex offending when comparing sentencing in 1973 to 1983 and suggested that this rise might have been a result of policies of deinstitutionalisation whereby people with IDD are no longer detained in hospital for indeterminate lengths of time. He concluded that those with propensities towards offending would be more likely to be living in the community and, as a result, were likely to be subject to normal legal processes should they engage in offending behaviour. Lindsay, Haut and Steptoe (2011a) found that while forensic IDD services received around 30% of cases from criminal justice services from 1990 to 1996, this rose to 80% from 2003 to 2008. Again this indicates a significant change in societal policies. The methodological differences between studies continue and in a variety of settings differences in prevalence have been reported: probation services (Mason & Murphy, 2002; prevalence 4.8%), pre-trial assessment (Vinkers, 2013; prevalence 4.4%), appearances at court (Vanny, Levy, Greenberg & Hayes, 2009; prevalence 10%), and prison settings (Holland & Persson, 2011; prevalence 1.3%; Murphy, Harrold, Carey & Mulrooney, 2000; prevalence 28.8%).

Studies of recidivism rates for offenders with IDD suffer from the same methodological and social policy influences and, due to a lack of controlled studies involving IDD and mainstream offenders, it is difficult to make direct comparisons of recidivism rates. However, it would appear that recidivism rates for offenders with IDD are consistent with those for populations of mainstream offenders. In one recent study, Gray et al. (2007) conducted a two-year follow-up of 145 offenders with IDD and 996 offenders without IDD all discharged from independent sector hospitals in the UK. The IDD group had a lower rate of reconviction for violent offences after two years (4.8%) than the non-IDD group (11.2%). This trend also held true for general offences (9.7% for the IDD group and 18.7% for the non-IDD group).

**Assessment of risk for future sexual and violent offences**

Significant progress has been made in the assessment of risk for future offending in criminal and forensic psychiatric populations. Quinsey, Harris, Rice and Cormier (2005) constructed the Violence Risk Appraisal Guide (VRAG), and this and the Static-99 (Hanson & Thornton 1999) have become standard static risk assessments for violent and sexual recidivism, respectively, in mainstream offender populations. These assessments depend wholly on historical, unchangeable variables for inclusion. Contiguous with the development of actuarial risk assessments, risk assessments based on structured clinical judgement related to the same variables as those used in actuarial assessment were also being developed. The first and most important of these was the Historical Clinical Risk-20 Items (HCR-20; Webster, Eaves, Douglas & Wintrup, 1995), which has been researched in many settings for mainstream offenders in correctional and mental health facilities.

A number of studies have been conducted using risk assessments on offenders with IDD. Quinsey, Book and Skilling (2004) investigated the predictive validity of the VRAG in 58 men with IDD with serious histories of antisocial and aggressive behaviour followed up for an average of 16 months. They found a significant AUC with a medium effect size of .69. Gray et al. (2007) assessed the predictive accuracy of the HCR-20, the VRAG and other assessments. They assessed 118 men and 27 women with IDD discharged from hospital following admission for a criminal offence. This IDD group was compared with a similar control group who were mentally ill offenders without IDD. Following up these individuals for five years, Gray et al. (2007) found that all the instruments predicted violent recidivism with medium to large effect sizes (AUCs = .64 to .81). These predictive values were better
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for the IDD group than those found with the non-IDD group. They concluded that these risk assessment instruments were comparable in predicting future violence for offenders with IDD and the control population.

Fitzgerald et al. (2011) tested both the VRAG and HCR-20 on two samples of offenders with and without IDD over a period of six months. For the group with IDD the VRAG had an AUC for any aggressive incidents of .87 and for the HCR-20, an AUC of 0.77 (both large effect sizes). Both results were superior to those found with the mentally disordered offenders without IDD. Lindsay et al. (2008) tested the predictive abilities of the VRAG and the HCR-20 in a sample of 212 forensic psychiatric patients with IDD in high security, medium/low security and community forensic services. After follow-up of one year, the predictive levels for these tests were AUCs of .71 and .72, respectively.

For sexual offenders with IDD, similar results have been found for risk assessments. Lindsay et al. (2008) investigated the accuracy of the Static-99 with the sex offenders in their sample and found it to have an AUC of .71. Wilcox, Beech, Markall and Blacker (2009) used the Static-99 on a smaller sample of 27 sex offenders with IDD and found an AUC of .64, a small to medium effect size. Lofthouse et al. (2013) also investigated the predictive value of the Static-99 with 64 adult male sex offenders with IDD and found an AUC of .75. In a small meta-analysis with sex offenders with IDD on the Static-99, Hanson, Sheahan and VanZuylen (2013) found that studies converged around an AUC of .69 to .79, which is consistent with research from mainstream groups.

While static risk assessments are promising, caution should be considered for decisions made on offenders with IDD in relation to their risk. Lindsay et al. (2011b) correlated assessed risk and level of security. They graded forensic IDD services from generic community services, through community forensic services to low, medium and maximum secure services. There were significant correlations between level of security and VRAG score (r = 0.24) and Static-99 (r = 0.32), representing small to medium effect sizes. This suggests that there were likely to be individuals in secure settings who were assessed as being a low risk and a number in community settings assessed as being a high risk and, given the extensive decision making in relation to these individuals, it seems a somewhat disappointing result. Therefore, a number of factors are likely to account for treatment decisions other than assessed levels of risk.

The role of dynamic risk assessment in the management of offenders with IDD

Dynamic risk assessments contrast with static risk assessment in that the variables can be changed through treatment and management of the individual. Therefore, these variables can be incorporated into effective risk management plans for offenders with IDD. Studies investigating the predictive value of dynamic variables have suggested that they are as good as static variables in predicting future offences. Lindsay, Elliot and Astell (2004a) found that dynamic indicators of risk, such as poor treatment compliance and antisocial attitudes, correlated with reoffending with a value as high or higher than static variables such as childhood behavioural and attachment problems. Quinsey et al. (2004) found that in addition to the static variables on the VRAG, antisocial attitude (a dynamic indicator) also had a significant relationship with reoffending. McMillan, Hastings and Coldwell (2004) reported that a clinical rating of risk made by the multi-disciplinary team was as good a predictor of future violence as previous violent incidents.

Lindsay et al. (2004b) and Steptoe, Lindsay, Murphy and Young (2008) developed the Dynamic Risk Assessment and Management System (DRAMS), including ratings of mood, antisocial behaviour, self-regulation, compliance and other clinical items. They found that
the total score predicted violence over the ensuing two days with an AUC of .73. This was a particularly powerful result since the occurrence or absence of the incident was so proximal. In relation to sexual incidents, Boer, Tough and Haaven (2004) developed a dynamic assessment and management system (the ARMIDILLO). The predictive value of this was assessed by Blacker, Beech, Wilcox and Boer (2011) and with special needs offenders (a mix of IQ < 80 and organic difficulties), the ARMIDILLO predicted incidents with AUCs between .73 and .76 and with the small sub-group of offenders with IDD (N = 10) it predicted incidents with AUCs between .75 and .86. In the study by Lofthouse et al. (2013) on 64 sex offenders with IDD over a period of six years, predictive values for different sections of the ARMIDILLO ranged between AUC .79 and .90 with an AUC of .92 for total score. These studies certainly suggest that the dynamic risk assessment might be a potent addition to risk management in this client group.

These developments could have significant implications for the assessment and management of risk for violent and sexual incidents in people with IDD. The findings that proximal indicators are as predictive as static indicators could have an important impact on procedures and practice in helping offenders with IDD to access better services. It is a familiar experience for those working in the field to be restricted in our recommendations because static risk assessment (which by definition will never change) places the person in the category of high risk despite the fact that they might not have perpetrated any incident for several years. With the advent of these new assessments, this position could gradually become eroded. The crucial aspect is for further studies to be conducted in this area.

**Assessment for criminogenic need**

For clients with IDD there are two issues for assessment. To ensure comprehension all assessments must be suitably adapted to simplify the language and concepts employed. Lack of understanding is likely to lead to unreliable responding. Second, because of literacy deficits, all material will have to be read and explained to respondents. Therefore, both the item and the response categories need to be explained. The consequence is that assessments take much longer because the assessor has to read the item and explain the responses in the form of a structured interview. The adaptations required for assessment of offenders with IDD are extensive and it is extremely important that the psychometric properties of the assessment remain intact with the integrity of the process maintained.

In relation to anger and aggression, earlier studies by Benson and Ivins (1992) and Rose and West (1999) have indicated that a modified self-assessment measure of anger reactivity (‘the anger inventory’) has some limited reliability and validity with people with IDD. Novaco and Taylor (2004) evaluated the reliability and validity of the Novaco Anger Scale (NAS: Novaco, 2003), the Spielberger State-Trait Anger Expression Inventory (STAXI: Spielberger, 1996), both self-report measures of anger disposition, and the Provocation Inventory (PI: Novaco, 2003), a self-report anger reactivity scale. The STAXI and NAS showed substantial intercorrelation providing evidence for the concurrent validity of these instruments. The NAS was found to be significantly predictive of whether the patient has physically assaulted others following admission to hospital and total number of physical assaults carried out. Alder and Lindsay (2007) also produced a Provocation Inventory (Dundee Provocation Inventory, DPI) which is easily accessible and easy to use. The DPI correlated significantly with the NAS and highly significantly with the PI, indicating that the DPI and PI have good convergence. They also found a five-factor structure consisting of threat to self-esteem, external locus of control, disappointment, frustration and resentment.
Willner, Brace and Phillips (2005) developed the Profile of Anger Coping Skills (PACS) to assess the use by people with IDD of specific skills in managing angry situations. Informants are asked to rate client’s use of eight anger management strategies in specific anger coping situations salient to that individual. The strategies assessed include use of relaxation skills, counting to 10, walking away calmly, requesting help, use of distraction activities, cognitive reframing and being assertive. The PACS was found to have acceptable test, re-test and inter-rater reliability coefficients and was sensitive to change following anger intervention.

For sexual offenders some work has been completed on knowledge and beliefs in relation to social interaction. With this client group, it is important not only to review cognitive distortions but also to consider the level of sexual knowledge an individual might have. Indeed, one of the first hypotheses put forward to account for inappropriate sexual behaviour in this group was that lack of sexual knowledge could lead the individual to attempt inappropriate sexual contact precisely because they are unaware of the means to establish appropriate interpersonal and sexual relationships. This hypothesis of ‘counterfeit deviance’ was first mentioned by Hingsburger, Griffiths and Quinsey (1991) and has been reviewed and revised to account for more recent research findings by Lindsay (2009). There have now been tests of this hypothesis and in every case the sexual offenders with IDD have been found to have greater levels of sexual knowledge than non-offenders (Lockhart, Guerin, Shanahan, & Coyle, 2010; Lunsky, Frijters, Griffiths, Watson & Williston, 2007; Michie, Lindsay, Martin & Grieve, 2006; Talbot & Langdon, 2006). However, although the sexual knowledge of the offenders has been greater, it has still been relatively poor compared to ‘normally’ able individuals. Therefore, sexual knowledge should always be considered in sex offenders with IDD.

Keeling, Rose and Beech (2007a) investigated the psychometric properties of adapted versions of a number of assessments relevant to sex offenders. They found that the Social Intimacy Scale, the Criminal Sentiment Scale and the Victim Empathy Distortion Scale broadly retained their psychometric integrity after adaptation and simplification. Their least successful adaptation was in the Relationship Scale Questionnaire which had low internal consistency. Test re-test reliability was high and there were good correlations between the original and adapted versions, especially for the Social Intimacy Scale and the Victim Empathy Scale. Williams, Wakeling and Webster (2007) also assessed the psychometric properties of six self-report measures with sex offenders with IDD. Their population was 211 men who had undertaken an HM Prison Services (England and Wales) adapted sex offender treatment programme. Average IQ was 71.9 and they accepted participants who had an IQ up to 80, well outside the range of IDD. However, the literacy skills seem similar in that they were required to read all the questionnaires to participants and aid them with their answers. Three assessments had good internal consistency and the other three were reasonable. Factor analyses revealed interesting structures but accounted for a low 30% to 40% of the common variance. Unfortunately, because of time constraints, test re-test reliability was not conducted.

Lindsay, Whitefield and Carson (2007b) reported on the development of the Questionnaire on Attitudes Consistent with Sexual Offences (QACSO), which is designed to be suitable for offenders with IDD. The QACSO contains a series of offence scales including rape and attitudes to women, voyeurism, exhibitionism, dating abuse, homosexual assault, offences against children and stalking. They found that six of the seven scales in the QACSO were valid and reliable measures of cognitive distortions held by sex offenders with IDD (the exception was homosexual assault), and that all scales differentiated between sex offenders and controls, all with IDD, with large effect sizes. Therefore, it would appear that cognitive distortions in sex
offenders with IDD can be assessed with some reliability and validity. The QACSO has been validated by a number of authors (Craig, Stringer & Sanders, 2012; Langdon & Talbot, 2006; Lindsay, Michie, Haut, Steptoe & Moore, 2011c; Murphy et al., 2010; Rose, Anderson, Hawkins & Rose, 2012; Rose, Jenkins, O’Connor, Jones & Felce, 2002).

There are relatively few published studies concerning the assessment and treatment of adult fire setters with IDD. Murphy and Clare (1996) interviewed ten fire setters with IDD concerning their cognitions and feelings prior to, and after setting fires using a newly developed Fire Setting Assessment Schedule (FSAS). The most frequently endorsed antecedents were anger, followed by being ignored and then feelings of depression. Taylor, Thorne, Robertson and Avery (2002b) used the FSAS in 14 fire setters with IDD to review the effectiveness of a fire setting programme for this client group. Taylor, Novaco, Gillmer and Thorne (2002a) also found that anger, being ignored and depression were the most frequently endorsed items on the FSAS in terms of antecedents to and consequences of participants’ fire setting behaviour. In a further study on women with IDD who had set fires, Taylor, Robertson, Thorne, Belshaw and Watson (2005b) also found that anger and depression were the most frequently endorsed items in participants prior to fire raising incidents.

**Treatment and management for offenders with IDD**

The principal treatments that have been developed are those for violence and sexual offending but there are also new approaches for criminal thinking and alcohol-related violence. It is often difficult to separate out treatment and management in offenders with IDD. To state the obvious, in treatment individuals attend a course of therapy and the effects can be evaluated over months and years, both in terms of improvement in personal characteristics such as a propensity towards aggression, and outcomes such as the number of violent incidents. Management implies that carers and significant others in the person’s life monitor and control that individual so that any propensities towards aggression are identified and prevented, irrespective of the person’s self-regulation. With offenders with IDD, the two are often confounded in a way that would not occur with offenders without mental impairment. The difficulties in evaluation are placed into focus in a treatment study on six sex offenders with IDD reported by Craig, Stringer and Moss (2006). They completed a seven-month programme incorporating sex education, addressing cognitive distortions and promoting relapse prevention in participants but found no significant improvements in proximal measures including the assessment of sexual knowledge. However, they also reported no further incidents of sexual offending during a 12-month follow-up. In the description of individual participants, they wrote that all six received 24-hour supervision and so, presumably, had little or no opportunity to reoffend.

In a series of evaluations of a comprehensive in-patient forensic service (the MIETS unit), Clare and Murphy (1993) and Xenitidis, Henry, Russell, Ward and Murphy (1999) followed up six and 64 patients, respectively. Clare and Murphy (1993) noted that all patients were living in less restrictive environments but did not report reoffending. Xenitidis et al. (1999) reported that while only 18% of referrals had been admitted from community facilities, 84% were discharged to the community and that there was a significant reduction in challenging and offending behaviour. In a 12-year follow-up study from a medium secure unit, Alexander, Crouch, Halstead and Piachaud (2006) when following up 64 patients discharged from medium secure services found that while only 11% had been reconvicted, 58% had shown offending-like behaviour that had no legal consequence. The presence of personality disorder, previous theft and young age increased the likelihood of reconviction.
Lindsay and colleagues (Lindsay et al., 2004c, 2006, 2013) have followed up offenders accepted into a community forensic IDD service. In their most recent evaluation (Lindsay et al., 2013) they reported on 309 participants followed up for up to 20 years. They consisted of 156 sex offenders, 126 non-sexual male offenders and 27 women. During the study period, 16% of the male sexual offenders, 43% of the non-sexual male offenders and 23% of the women committed at least one further offence. All but 15 of the 309 participants continued to have unrestricted access to the community throughout the follow-up period. Analysis of the number of incidents following referral, in comparison to the number two years prior to referral, revealed that there was a 90–95% reduction, representing a significant amount of harm reduction.

Service evaluation of services for offenders with IDD has been conducted regularly over the last 50 or 60 years. Results suggest that at least half of the offenders are likely to commit another incident during the follow-up period. Sex offenders are less likely to reoffend than non-sexual offenders who commit predominantly violent and acquisitive offences. However, there is also evidence to suggest that those individuals who commit further offences are likely to commit significantly fewer and less serious offences than they did prior to treatment (Gray et al., 2007; McGrath, Livingston & Falk, 2007).

### Treatment for specific criminogenic needs

#### Treatment for aggression

Taylor et al. (2002a), Taylor, Novaco, Guinan and Street (2004) and Taylor, Novaco, Gillmer, Robertson and Thorne (2005a) have evaluated individual cognitive behavioural anger treatment with detained male patients with mild to borderline IDD and significant violent, sexual and fire raising histories in a series of waiting list controlled studies. The 18-session treatment package included a six-session broadly psycho-educational and motivational preparatory phase, followed by a 12-session treatment phase based on individual formulation of each participant’s anger problems and needs, that follows the classical cognitive behavioural stages of cognitive preparation, skills acquisition, skills rehearsal and then practice in vivo. These studies showed significant improvements on self-reported measures of anger disposition, anger reactivity and behavioural reaction indices following intervention in the treatment groups compared with scores for the control groups, and these differences were maintained for up to four months following treatment. Staff ratings of study participants’ anger disposition conferred with patients’ reports but did not reach statistical significance.

There have been a number of treatment trials that have shown the effectiveness of group cognitive behavioural anger treatment over waiting list/no treatment control conditions with clients with IDD living in community settings (Rose, West & Clifford, 2000; Willner et al., 2005; Willner, Jones, Tams & Green, 2002). Lindsay et al. (2004d) reported a controlled study of cognitive behavioural anger treatment for individuals living in the community and referred by the court or criminal justice services. There were significant improvements in anger control on all measures following treatment, with significant differences between the treatment and control groups. In addition, the treatment group recorded significantly fewer incidents of assault and violence at the post-treatment assessment point (14% v. 45%). These controlled evaluations mean that anger management as a treatment programme is the best evaluated treatment in the field of offenders with IDD.
A major recent development in the use of psychological treatment for sex offenders with IDD has been the employment of cognitive and problem solving techniques within therapy. These methods have been developed to a sophisticated degree with mainstream offenders. Hanson et al. (2002) reported in a meta-analytic study that those treatments that employed cognitive techniques showed greater reductions in recidivism rates compared to treatments employing other techniques, including behavioural treatments. Support for the centrality of cognitive distortions in the offence process came from a qualitative study of nine male sex offenders with IDD by Courtney, Rose and Mason (2006), using grounded theory techniques. In the analysis of interviews with participants they concluded that all aspects of the offence process were linked to offender attitudes and beliefs such as denial of the offence, blaming others and seeing themselves as the victim.

There have been a number of small scale uncontrolled studies that have demonstrated no reoffending or low reoffending rates for at least a year following treatment (Craig et al., 2012; Keeling, Rose & Beech, 2007b; Lindsay et al., 2011c; Rose et al., 2002, 2012). One important aspect of these reports is that all participants were either living in or released into the community without daily supervision. Lindsay and Smith (1998) compared seven individuals who had been in treatment for two or more years with another group of seven clients who had been in treatment for less than one year. The group that had been in treatment for less than one year showed significantly poorer progress and were more likely to reoffend than those treated for at least two years. Therefore, it seemed that shorter treatment periods might be of limited value for this client group.

A number of larger scale studies have been published reviewing the outcome of sex offender treatment programmes. Unfortunately, the main treatment comparison studies have a number of serious limitations. The first is that they have not used a waiting list or no treatment control group. Most of the reports have employed comparisons of convenience such as other types of offenders or sex offenders without IDD. The second limitation is that in at least one of the studies (McGrath et al., 2007) most of the participants continued to be supervised and monitored at all times. The third difficulty is that in some of the studies the numbers are very small (e.g. Lindsay & Smith, 1998; Keeling et al., 2007b).

In a larger scale study, McGrath et al. (2007) evaluated the effect on sex offenders of a total deinstitutionalisation programme in Vermont, USA. They reviewed the treatment and management regimes of 103 adult sex offenders with IDD, all of whom lived in staffed or private homes with paid care givers. In an 11-year follow-up period, with an average of 5.8 years follow-up, they reported 10.2% reoffending. As a comparison, they reported on male sexual offenders without IDD and 21.3% were charged with a new sexual offence. One of the difficulties with the McGrath et al. (2007) evaluation was that 62% of participants received 24-hour supervision that presumably limited access to potential victims. Importantly, they also reported a considerable amount of harm reduction in that 83% of the participants were classified as contact sexual offenders while only 45% of the re-offences were contact offences.

Murphy et al. (2010) conducted a treatment study on 46 sex offenders with IDD who were living in community settings. Treatment groups ran over a period of one year and assessments included several attitudinal measures. They found that sexual knowledge, victim empathy and cognitive distortions had improved significantly and maintained at six-month follow-up. They also reported that 8.7% of their sample reoffended after the treatment programme. Heaton and Murphy (2013) have demonstrated further effectiveness in a follow-up study over one year for these participants. In a 20-year follow-up of the community
forensic IDD service, Lindsay et al. (2013) followed up 156 treated sexual offenders and found that 16% reoffended in this lengthy follow-up period. These authors also calculated the amount of harm reduction that occurred when comparing the number of offences prior to the referral and up to 20 years after referral. They found that there was over 95% harm reduction in this comparison.

In all of the treatment evaluations there have been no suitable control comparisons. While all the studies had at least 12 months and up to 20 years follow-up, and some are uncontaminated by constant supervision, they did not have alternative treatment conditions. Despite that, there is an undoubted weight of evidence that would support the use of sex offender treatment within a forensic IDD setting.

**Interventions for other offence related problems**

A number of case studies have been reported on the treatment of fire setters with IDD. Clare, Murphy, Cox and Chaplin (1992) reported a case study involving a man with mild IDD who had been admitted to a secure hospital following convictions for two offences of arson. He had a prior history of arson and for making hoax calls to the fire service. Using a comprehensive treatment package, including social skills and assertiveness training, significant clinical improvements were observed in targeted areas. The client was discharged to a community setting and had not engaged in any fire related offending behaviour at 30 months follow-up. Taylor, Thorne and Slavkin (2004) reported a case series of four detained men with IDD and convictions for arson offences. They received a cognitive behavioural, 40-session group-based intervention that involved work on offence cycles, education about the costs associated with setting fires, training skills to enhance future coping with emotional problems associated with previous fire setting behaviour and work on personalised plans to prevent relapse. All participants completed the programme and recorded improved attitudes with regard to personal responsibility, victim issues and awareness of risk factors associated with their fire setting behaviour. In a further series of case studies on six women with mild–borderline IDD and histories of fire setting, Taylor et al. (2005b) also employed a group intervention. The intervention successfully engaged participants in the therapy process, all completed the programme and scores on measures related to fire treatment targets generally improved following the intervention. The results of these small but methodologically weak pilot studies do provide some limited encouragement and guidance to practitioners concerning the utility of group-based, cognitive behavioural interventions for fire setting behaviour in people with IDD.

Several criminal thinking programmes have emerged in the forensic literature and, given the difficulties that offenders with IDD are likely to have with intellectual and moral development, it is surprising that these programmes have not spread to this field other than some pilot investigations. Lindsay et al. (2011d) have conducted a study reviewing the effectiveness of an adapted cognitive skills programme for offenders with IDD. The programme is based on the theoretical work of D’Zurilla and Nezu (1999), drawing heavily on the ‘Stop and Think’ programme (McMurran, Fyffe, McCarthy, Duggan & Latham, 2001), which is an offence-related problem-solving programme for offenders with personality disorder. In an evaluation of ten participants who had completed the programme, they found reductions in measured impulsiveness and increases in positive style and orientation towards social problem solving. Therefore, there was some limited evidence that assessment and treatment of criminal thinking styles might be a suitable addition to general work on offenders with IDD.
Summary and conclusions

As can be seen from this brief review, there have been a number of important advances and developments in the assessment and treatment of offenders with IDD. Assessments have been for risk of reoffending and have been directed at criminogenic need. Treatment methods have been based on cognitive behaviour therapy and have also employed specific methods to adapt procedures for the client group. The main areas of progress have been for anger, aggression and sexual offending, and there have also been promising advances in the fields of fire raising and criminal thinking, with increased advances hoped for over the forthcoming years.

References


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