Working with Adaptive Populations: Service Standards, Case Management and Treatment

Amy Karn, Psy.D., Licensed Psychologist - Wisconsin DOC

Jake Schuldies, LCSW – Forward Counseling, Sand Ridge Secure Treatment Center, UW Madison

Who’s in the Room?

What is your primary role?

How often do you work directly with this population?

What brought you here today?

Why This Matters (Objectives)

- Traditional assessment tools often overestimate the risk for adaptive individuals.
- A new study published indicated that adaptive individuals' risk is better measured through staff report as opposed to a record review.
  - It looked at 15 studies that examined the predictive validity of 6 different assessment tools.
  - Regarding the ARMIDILO-S, 2 of the 4 studies had to be eliminated from the meta-analysis
  - Due to outliers in the data. The remaining two showed strong predictive validity; however, this also limited the authors' confidence in their findings.
- Due to their cognitive limitations, traditional treatment approaches are less effective.
- Adaptive individuals often require external support to help them manage their risk.

Setting the Foundation

- How to make sense of behaviors within the broader context of the individuals' lives?
  - Different viewpoints shape our perceptions
    - "Their behavior is because of their disability."
    - "The person wouldn't have offended if he hadn't been a victim himself."
    - "They are intending to harm someone because of their criminal lifestyle."
  - Needs underlie their choices and behaviors, both healthy and unhealthy
    - The individual's behaviors are seen as **communication that can be interpreted** to understand their unmet needs

The Role of Trauma History

The role of trauma history, abuse, and environmental factors

- 9% of children /w IDD: 1+ traumatic experience, mean of 2.8/14 (Scotti, Stevens, et al., 2012).
- Increased risk of out-of-home placements (Vervoort-Schel et al., 2018).
- Significantly higher numbers of ACEs in those who had offended sexually (Levenson, Willis and Prescott, 2014).
- ACE scores unrelated to risk but were related to mental health conditions that interfere with treatment (Kahn, et al., 2021).

A trauma-informed approach changes how we see and respond to behavior

- Collaborative case management and service coordination
  - Therapist(s), behavior specialist, and residential care
- Highlight how the long-term effects of ACEs impact adult relationships and a range of dynamic risk factors are to be addressed.
- Recognizing the traumagenic nature of the person's upbringing
- Considering how current interactions can be modified to avoid triggering trauma-reactive behaviors
- How to be honest, caring, considerate, and collaborative to bring about desired positive results that help the client have a better life.

Case A: Institutional Setting

Mr. B is a 33-year-old male currently serving time for two counts of Second Degree Sexual Assault of a Child. He has a conduct report from 2022 for consensual sexual behavior with a male resident. He participated in special education classes throughout school and testing from his childhood showed difficulties with language processing, comprehension and expressive language. Testing completed in 2024 showed he was low average in both processing speed and working memory.

He has lengthy mental health history with significant self-harm behavior via cutting. Between 2014 and 2017, he had numerous observation placements due to cutting himself and punching walls. He showed improvements with regular contact with psychological services, and there was a brief resurgence of self-harm behaviors when he was transferred to a larger institution and could not meet with psychological services as frequently. His current diagnoses are Persistent Depressive Disorder and Borderline Personality Disorder.

He had been involved in the high-risk sex offender program at Oshkosh Correctional Institution since 1/13/25. He showed significant difficulties managing his emotions and developing relationships with group members. His behavior could be disruptive as he yelled at others, slammed doors and argued frequently with others. His motivation for treatment was poor. He received additional assignments to work on these behaviors and showed significant improvements in his ability to manage his emotions. Recently, he reported difficulties managing his urges to touch the person's chest when he interacted with a transgender female. He is able to identify the risks involved in the situation, but shows significant reluctance to limit his contact with the individual. The situation has negatively affected his motivation although he reports that he has reduced the amount of time he spends with the transgender female.

Case B: Community Setting

Marcus, 56 | Supported Housing | Supervised Release

Marcus is a 56-year-old African American man currently residing in a supported housing setting under supervised release. He attended special education classes and did not complete high school; formal cognitive testing reflects a Full Scale IQ of 75, consistent with mild intellectual disability. Marcus was first diagnosed with schizophrenia at age 20, and his adult life has been spent largely in group home environments. Over the course of his placement history, he has engaged in sexual assaultive behaviors directed toward female group home staff, with incidents typically occurring during periods of psychiatric decompensation. His psychiatric history is notable for command hallucinations and sexualized delusions involving adult females. He is currently prescribed clozapine, with good symptomatic response and no recent behavioral incidents. Marcus also carries diagnoses of obesity and poorly-managed Type 2 diabetes, which present ongoing challenges to his overall health and functioning. His care is coordinated through a Managed Care Organization (MCO).

Marcus expresses a genuine desire to pursue discharge from his current level of supervision and move toward greater independence. He speaks about this goal with cautious optimism, though he also voices real uncertainty about whether enough support would be in place. His natural support system is limited: his mother is living but in poor health and unable to provide substantive assistance, and his brother — though present in his life — carries his own significant history of incarceration and substance use.

What We Know: The Evidence Base

- Lack of research literature regarding persons with IDPSB

  And…

- Individuals with intellectual disabilities can learn to manage their sexual behavior problems and deserve appropriate assessment, treatment, and post-release supervision
- Numbers (e.g., FSIQ) are important, but providing adequate care and support is more important, particularly when a failure to provide responsive care may result in further instances of sexually offensive conduct.
- Possible confusion about “sexual deviance” and how well it fits with our understanding of diminished cognitive capacity.
- Using tools that have been developed or adapted with this population in mind (Abel–Becker Cognition Scale, ARMIDILO-S) when available.
  - Caution or avoid using non-adapted tools (especially when this is explicitly stated by the tool)
- Avoiding 'one-size-fits-all' treatment and interventions
- (Hanson, et. al., 2026)
  - ARMIDILO-S demonstrated the highest predictive accuracy
  - Staff reports of recidivism should be privileged over official records (for research purposes)

Assessment: Understanding What's Happening

- Useful tools and instruments: ARMIDILO-S
  - The **A**ssessment of **R**isk and **M**anageability of **I**ndividuals with **D**evelopmental and **I**ntellectual **L**imitations who **O**ffend **S**exually (ARMIDILO-S)
  - Developed in 2013 on a community sample of offenders
  - Manual and scoring sheet are in the public domain www.armidilo.net
  - Structured Professional Judgement (SPJ) measure that focuses on both stable and acute dynamic factors
  - Static-99R used as a baseline for risk
  - Measures both client and environmental factors and scoring is based on self-report, staff observations and record.
  - In addition to identifying risk factors, it also identifies protective factors
  - Scoring:
    - N = Not present
    - S = Somewhat present
    - Y = Definitely present

Assessment: Client Factors

Stable Client Factors (6 months to a year prior to the assessment)

- Supervision compliance
- Treatment compliance
- Sexual deviance
- Sexual preoccupation/sex drive
- Offense management
- Emotional coping ability
- Relationships
- Impulsivity
- Substance abuse
- Mental health

Acute Client Factors (2 to 3 months prior to the assessment)

- Changes in compliance with supervision or treatment
- Changes in sexual preoccupation/sex drive
- Changes in victim related behaviors
- Changes in emotional coping ability
- Changes in coping strategies

Assessment: Environmental Factors

Stable Environmental Factors

- Attitude toward client
- Communication among support people
- Client specific knowledge by support people
- Consistency of supervision/intervention

Acute Environmental Factors

- Changes in social relationships
- Changes in monitoring or intervention
- Situational changes
- Changes in victim access

Assessment: Understanding What's Happening

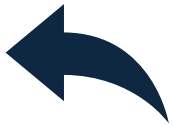
ARMIDILO-S Pros

- Normed on an adaptive population
- Addresses both risk and protective factors in the same instrument
- The items are easy for clients to understand
- It is good at identifying areas of focus for treatment

ARMIDILO-S Cons

- Subjectivity in scoring since it is not an actuarial instrument
- Since it's creation in 2013, there have been no updates on the scoring criteria
- It can be tricky to score some of the items for incarcerated persons

🗣️ Activity: Assessment in Practice



Return to Case A

Small groups (3-4 people), 4 minutes:

What assumptions might you be making?

Brief whole-group share-out: What came up?

Case A: Institutional Setting

Mr. B is a 33-year-old male currently serving time for two counts of Second Degree Sexual Assault of a Child. He has a conduct report from 2022 for consensual sexual behavior with a male resident. He participated in special education classes throughout school and testing from his childhood showed difficulties with language processing, comprehension and expressive language. Testing completed in 2024 showed he was low average in both processing speed and working memory.

He has lengthy mental health history with significant self-harm behavior via cutting. Between 2014 and 2017, he had numerous observation placements due to cutting himself and punching walls. He showed improvements with regular contact with psychological services, and there was a brief resurgence of self-harm behaviors when he was transferred to a larger institution and could not meet with psychological services as frequently. His current diagnoses are Persistent Depressive Disorder and Borderline Personality Disorder.

He had been involved in the high-risk sex offender program at Oshkosh Correctional Institution since 1/13/25. He showed significant difficulties managing his emotions and developing relationships with group members. His behavior could be disruptive as he yelled at others, slammed doors and argued frequently with others. His motivation for treatment was poor. He received additional assignments to work on these behaviors and showed significant improvements in his ability to manage his emotions. Recently, he reported difficulties managing his urges to touch the person's chest when he interacted with a transgender female. He is able to identify the risks involved in the situation, but shows significant reluctance to limit his contact with the individual. The situation has negatively affected his motivation although he reports that he has reduced the amount of time he spends with the transgender female.

Treatment & Intervention Strategies

Risk-Needs-Responsivity

- Providing information in a way that is accessible to everyone
- Skills that account for individual's cognitive needs, personal history, communication style, strengths, and motivation

Positive Psychological Approaches (e.g., Good Lives)

Positive Behavioral Supports (Increasing capacity to meet basic needs safely)

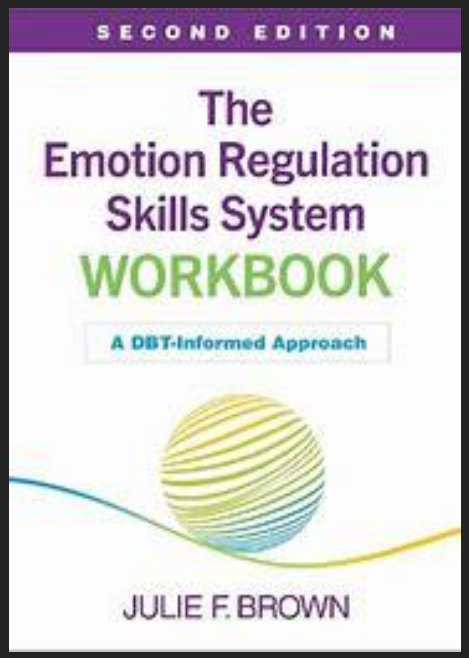
Concrete concepts (e.g., Old Me/New Me, Stop and Think, Skills System by Julie Brown)

Trauma-informed treatment: safety, trustworthiness, peer support, empowerment, cultural humility

Setting meaningful goals — with the person, not for them

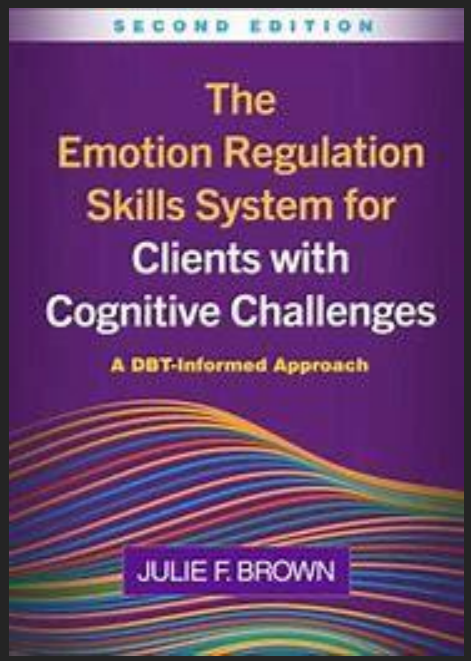
What success looks like:

- Management of risk
- Development of protective factors
- A meaningful life worth living as defined by the person



Evidenced-based Treatment for Skill Building

Example: The Skills System by Julie Brown



Skills System

- When you purchase the book, you receive a PDF files of all the handouts. The author gives you permission to copy them as long as you are using them for treatment purposes.
- There is also the option to use resources provided on The Skills System website: skillssystem.com
- There are E-learning modules to help staff who will be teaching The Skills System and there is an option to give clients access to E-learning modules. It costs about $20 per individual.
- Most recently, they introduced a Skills System app that clients can use.

Skills System

Toolbox of Downloadable Resources

Download the Skills System App on Apple and Android --->

Skills Posters	Skills Map	123 Wise Mind Worksheet
Skills Coaching Checklist	Skills Song	Skills Song Lyrics
Skills Card Sort Game	Implementation Guide	Implementation Worksheet
Course 1 Skills Test	Course 2 Skills Coaching Test	

🗣 Activity: Treatment Planning

Return to Case B

- Small groups, 4 minutes:
  - What adaptations would this person need?
  - How would you involve the person in developing the plan?
- Brief whole-group share-out

Case B: Community Setting

Marcus, 56 | Supported Housing | Supervised Release

Marcus is a 56-year-old African American man currently residing in a supported housing setting under supervised release. He attended special education classes and did not complete high school; formal cognitive testing reflects a Full Scale IQ of 75, consistent with mild intellectual disability. Marcus was first diagnosed with schizophrenia at age 20, and his adult life has been spent largely in group home environments. Over the course of his placement history, he has engaged in sexual assaultive behaviors directed toward female group home staff, with incidents typically occurring during periods of psychiatric decompensation. His psychiatric history is notable for command hallucinations and sexualized delusions involving adult females. He is currently prescribed clozapine, with good symptomatic response and no recent behavioral incidents. Marcus also carries diagnoses of obesity and poorly-managed Type 2 diabetes, which present ongoing challenges to his overall health and functioning. His care is coordinated through a Managed Care Organization (MCO).

Marcus expresses a genuine desire to pursue discharge from his current level of supervision and move toward greater independence. He speaks about this goal with cautious optimism, though he also voices real uncertainty about whether enough support would be in place. His natural support system is limited: his mother is living but in poor health and unable to provide substantive assistance, and his brother — though present in his life — carries his own significant history of incarceration and substance use.

The Collaboration Imperative

- The gap between treatment planning and implementation is where plans fail
- Why it happens: siloed roles, inconsistent communication, different training and experience
- Direct care staff ARE the treatment — they implement the plan in every interaction
- Treatment staff cannot succeed without meaningful partnership with direct care staff and case management
- Trauma-informed collaboration: consistency and predictability are themselves the intervention

The Risk Management Circle (adapted from Blasingame, 2016)

What Each Role Needs to Succeed

Direct Care and Case Management staff:	SOT staff:	Both:
• Clear, jargon-free plans • Timely support • Permission to ask questions to know the 'why'	• Honest feedback • Access to daily observations and concerns • Trust built over time	• Shared language • Regular communication touchpoints • A culture that values the relationship • Members that allow each other to be influenced by the other members' experience and ideas

🗣️ Activity: Collaboration in Practice

Where do things typically break down?

What are some structural supports that help?

Open Questions & Discussion

Resources & Contact Info

- Amy Karn: Amy.Karn@wisconsin.gov
- Jake Schuldies: jschuldies@forward-counseling.com

- Old ATSA guidelines: https://shorturl.at/h7uQR
- New guidelines coming “soon"