Community Management of People Who Have Sexually Abused
and the Challenges of working with Special-Needs Clients

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Realities of Sexual Offending

- ≈95% of persons who sexually offend are male (3% police reports, 11% victimization surveys)
- The largest age cohort of people who sexually offend is boys aged 13-15
- People who sexually offend have more than three times the number of adverse childhood experiences
  - They have complex needs
- As many as 95% of people coming into the system for sexual offending are first time caught

Realities of Sexual Offending

- Reoffense rates are lower than most people think
- Meta-analytic studies show that about 15% will reoffend within 5-7 years post-release (dated)
- Most States and the Federal government (BJS) now report lower rates (e.g., 10% in 10 years)
- People on supervision are more likely to be returned to prison because of technical violations than because they committed a new "crime"
  - Reiterating that they have complex needs
- Initiatives need to address complex needs

Tips to Increase the Efficacy of Community-based Risk Management

- Follow the RNR principles
- Be data driven
- Consider those data when setting policy and practice guidelines
  - Evidence-based decision-making, not decision-based evidence-making
- Collaborate with others (in your work and advocacy)
- Engage in knowledge transfer whenever possible
- Involve the community-at-large, they can do it

Sexual offending is NOT new

1984

nobody knew what a "sex offender" was…

2023

…everybody knows what a "sex offender" is

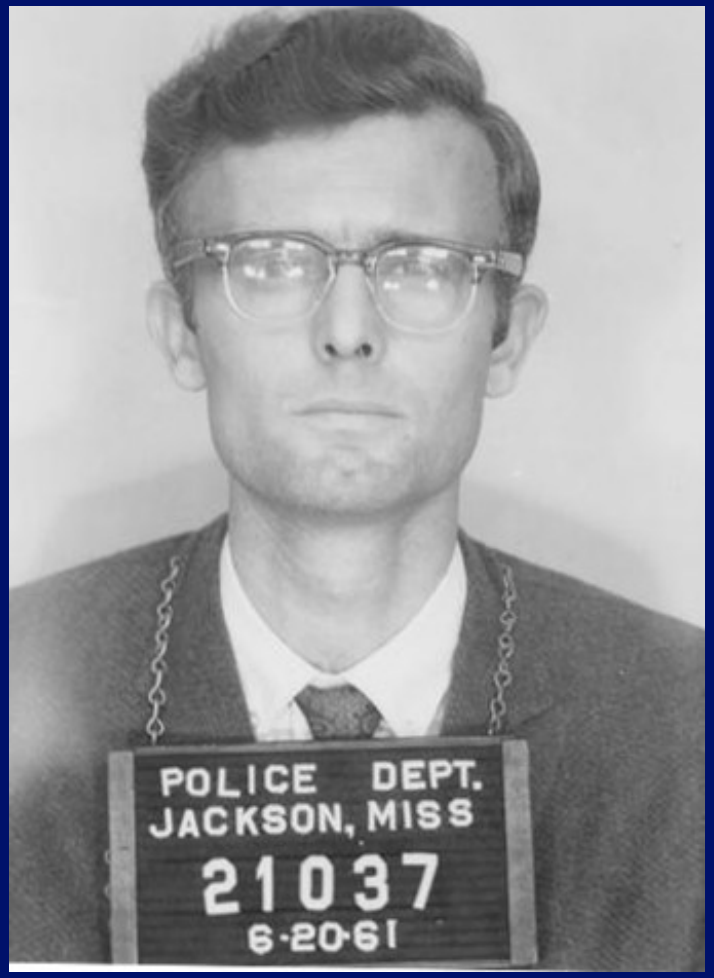
Or do they?

Effective Interventions

Nothing Works?

Martinson (1974)

- Large-scale study of correctional intervention outcomes
- Found no clear evidence that efforts to rehabilitate clients were "working"
- Led to considerable research into aspects of treatment/counseling/ interventions that would lead to lower recidivism



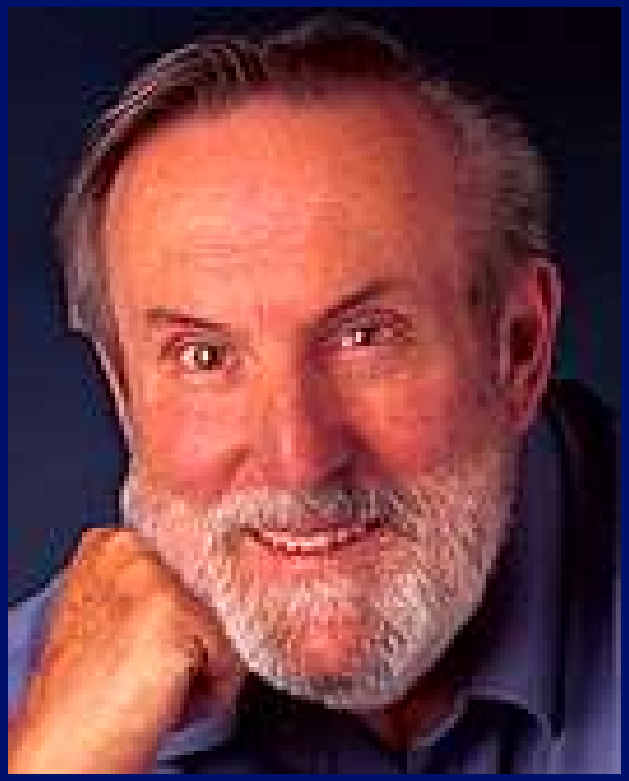
Nothing works?

Furby, Weinrott, & Blackshaw (1989)

- Found essentially the same thing to be true of programming for sexual violence
- There were no statistical elegant studies showing that rehabilitation efforts were having any measurable effect
- In nearly 35 years, not much has changed re: RCT designs, but meta-analyses consistently show a significant degree of change via treatment

Andrews, Bonta, Gendreau

What Works?



Sanction vs. Human Service

Several very large-scale meta-analyses

- Smith, Goggin, & Gendreau (2002; N = 442,471)
- Aos, Miller, & Drake (2006; 571 studies)
- Lipsey & Cullen (2007)

All arrived at the same conclusion:

- Punishment alone will not reduce bad behavior

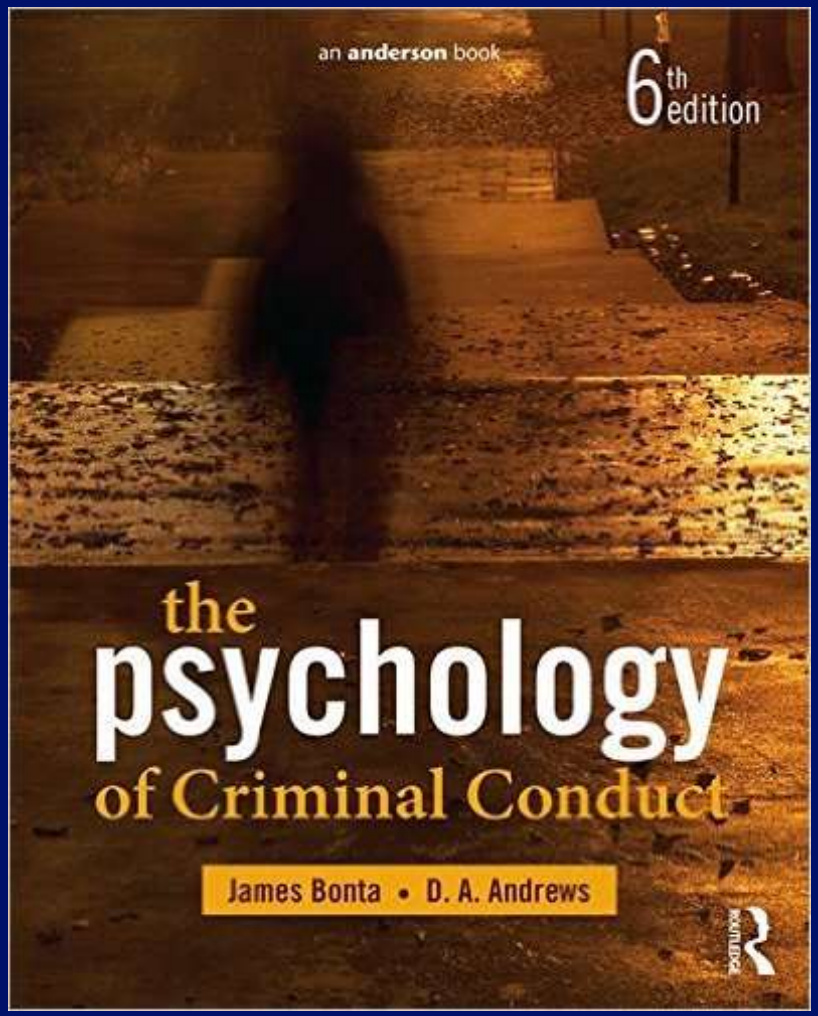
An answered question?

We are confident that, no matter how many studies are subsequently found, sanction studies will not produce results indicative of even modest suppression effects or results remotely approximating outcomes reported for certain types of treatment programs.

Smith et al. 2002, p.19

Bonta & Andrews (2017)

Psychology of Criminal Conduct



Assessment

- The primary purpose of psychological assessment and diagnosis is to provide an understanding that informs a practical plan of action.
- Assessment aspects emerge over time, and the process is ongoing
- Assessment should include an identification of strengths and competencies, in addition to areas of concern.

Effective Programs

- Pre-treatment assessment
- Assessment-driven treatment
- Specific focus:
  - What risks are there (e.g., violence, suicide)?
  - What treatment needs exist that are related to these risks?
  - What factors should we consider for tailoring treatment so our clients will "get it"?

Andrews & Bonta (2010) – "Big 4"

Through meta-analytic research designed to help better predict success in correctional / rehabilitative treatment, Andrews and Bonta determined that 4 major factors contribute to most re-engagement in bad behavior:

- Antisocial personality structure
- Antisocial values and attitudes
- Antisocial peer affiliation
- Antisocial behavior

Overarching Risk Factors
(Andrews & Bonta, 2010)

Added to these were 4 additional factors to comprise the Central-8 risk domains:

- Antisocial behavior
- Antisocial personality structure
- Antisocial values and attitudes
- Antisocial associations
- Family/marital factors
- Poor school/work performance
- Few leisure/recreational activities
- Substance abuse

Overarching Risk Factors

There are two over-arching risk factors in the literature about risk for sexual violence

- **Sexual deviance**
  - Which may include some aspect of hypersexuality, either as a distinct or contributing factor
- **Antisociality**
  - Which may include some aspect of youthful nonsexual violence, either as a distinct or contributing factor

Not associated with risk

- Denial/disclosure
- Empathy deficits
- Psychological maladjustment
- Many personality features
- Most biographical features

RNR Principles

Bonta & Andrews, 2017

Through exhaustive research, Bonta & Andrews identified simple principles that, when followed, dramatically increase the potential for client success on community release.

Effective Interventions

RISK Principle

- Effective Interventions match the level of intervention intensity to the level of risk posed by the persons with behavior problems
- high risk = high intensity
- mismatching can result in increased risk

Risk

environmental/situational elements

+

personal elements

=

RISK

Static, Stable, & Acute Risk Factors Definitions

- **Static** – Non-changeable life factors that relate to risk for sexual reoffending, generally historical in nature
- **Stable** – Personality characteristics, skill deficits, and learned behaviors that relate to risk for sexual reoffending that may be changed through intervention
- **Acute** – Risk factors of short or unstable duration that can change rapidly, generally as a result of environmental or conditions related to the person

Static Risk Factors

- Age
- Ever lived with a lover
- Current non-sexual violence
- Prior non-sexual violence
- Prior sexual offenses
- 4+ sentencing dates
- Non-contact sexual offenses
- Unrelated victims
- Stranger victims
- Male victims

Effective Interventions

NEED Principle

- Effective Interventions target identified dynamic factors (criminogenic needs)
- Persons with behavior problems require treatment programming individualized and specific to their needs
- Other programs may result in some ancillary gain, but risk for additional misconduct likely will not be reduced

Need Principle

- Criminal interests
- Criminal attitudes/beliefs
- Criminal schemas
- Criminal associates/significant others
- Self-regulation/management
  - Problem-solving skills
  - Coping skills
  - Interoception

Stable Dynamic Risk Factors

Significant Social Influences

Intimacy Deficits

- Lovers and intimate partners
- Emotional identification with children
- Hostility towards women
- General social rejection/loneliness
- Lack of concern for others

Sexual Self-Regulation

- Sexual drive/pre-occupation
- Sex as coping
- Deviant sexual interest

General Self-Regulation

- Impulsive acts
- Poor cognitive problem solving
- Negative emotionality/hostility

Cooperation with Supervision

Acute Dynamic Risk Factors

Sex/Violence Recidivism

- Victim Access
- Hostility
- Sexual Pre-occupation
- Rejection of Supervision
- Emotional Collapse
- Change in Social Supports
- Substance Abuse

Treatment Focus

Treatment has standard components addressing raising awareness and building skills in key areas of risk:

- Case-specific elements (sex, violence, substance abuse, etc.)
- Antisocial orientation
- General self-regulation
- Sexual self-regulation
- Attitudes/schemas supportive of misbehavior
- Significant social influences
- Intimacy deficits
- Emotion regulation

Effective Interventions

RESPONSIVITY principle

- Effective interventions are those which are responsive to client characteristics
  - cognitive abilities
  - maturity
  - motivation
  - mode of intervention
  - scheduling concerns

Argh…The Clients

- Righteous anger?
- Inequities in incarceration and release
- Entrenched antisociality
- Grievance thinking and increased litigation
- Institutionalization
- Hopelessness and pathological anomie

Responsivity

- Do we even know what this is?
  - I honestly wonder sometimes.
- I've come to be suspicious whenever someone says their program "adheres to RNR," especially when citing Responsivity.

Responsivity Assessment

Big Question: What gets in the way of accessing the services we have to offer?

- Intellect and/or disability status
- Trauma
- Stages of change
- Motivation
- And ???

Paradoxes

- You need to be more motivated to change
- You put yourself in this situation; we will decide when you're out of it
- We can challenge you, but you can't challenge us
- You must participate in treatment regimens that we professionals can't agree on ourselves
- Treatment holds the promise of a "good life"
- Treatment must proceed according to our timetable.

Agents of Change

As clinicians and other concerned practitioners, our goal is to assist all clients in treatment in the development of a:

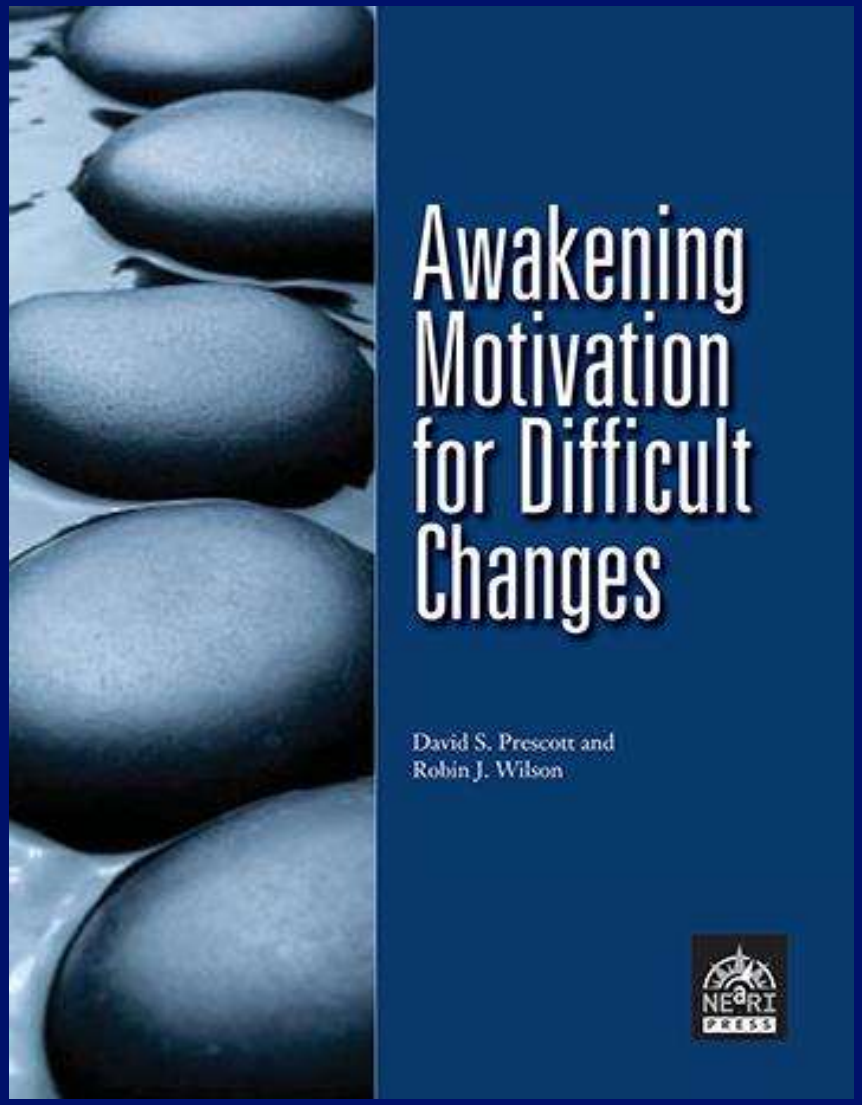
balanced, self-determined lifestyle

Contemporary research in our field suggests that learning to live a "good life" is inconsistent with antisocial behavior.

Motivation to Change

- Motivation cannot be adequately measured by self-report
- Behavioral reference point must be the source of information, that is, we must look at what they do, in order to tease out what might be motivating them
  - Functional behavioral analysis can help

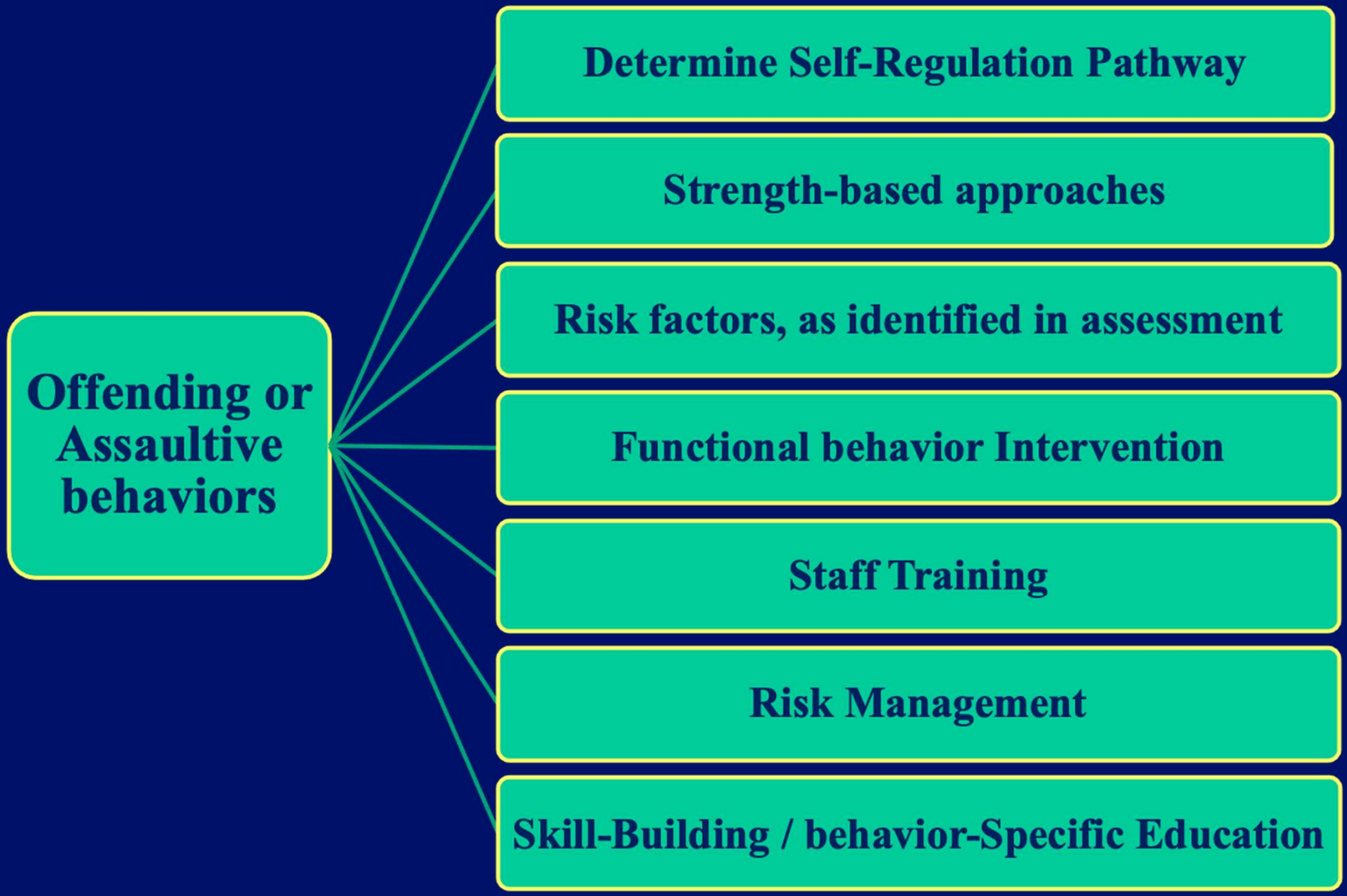
Prescott & Wilson (2013)



Stages of Change
(Prochaska & DiClemente, 1983)

Phase	Presentation	Level of Motivation	Tips for Clinicians
Precontemplation	No acknowledgement of problem's existence	Defensive/unmotivated	Create dissonance; raise doubts
Contemplation	Acknowledgement that problem "might" exist	Vacillation between minimization and acknowledgement of the problem	Tip the decisional balance; evoke reasons for change (pros/cons); support change
Preparation	Recognition of the problem	Appearance of motivation	Explore best course of action
Action	Active engagement with the process of change	Good motivation	Take steps toward change
Maintenance	Maintenance of change through application of effective coping strategies	Good motivation	Identify and use adaptive coping strategies

Treatment Programs



Program Delivery

Treatment Components

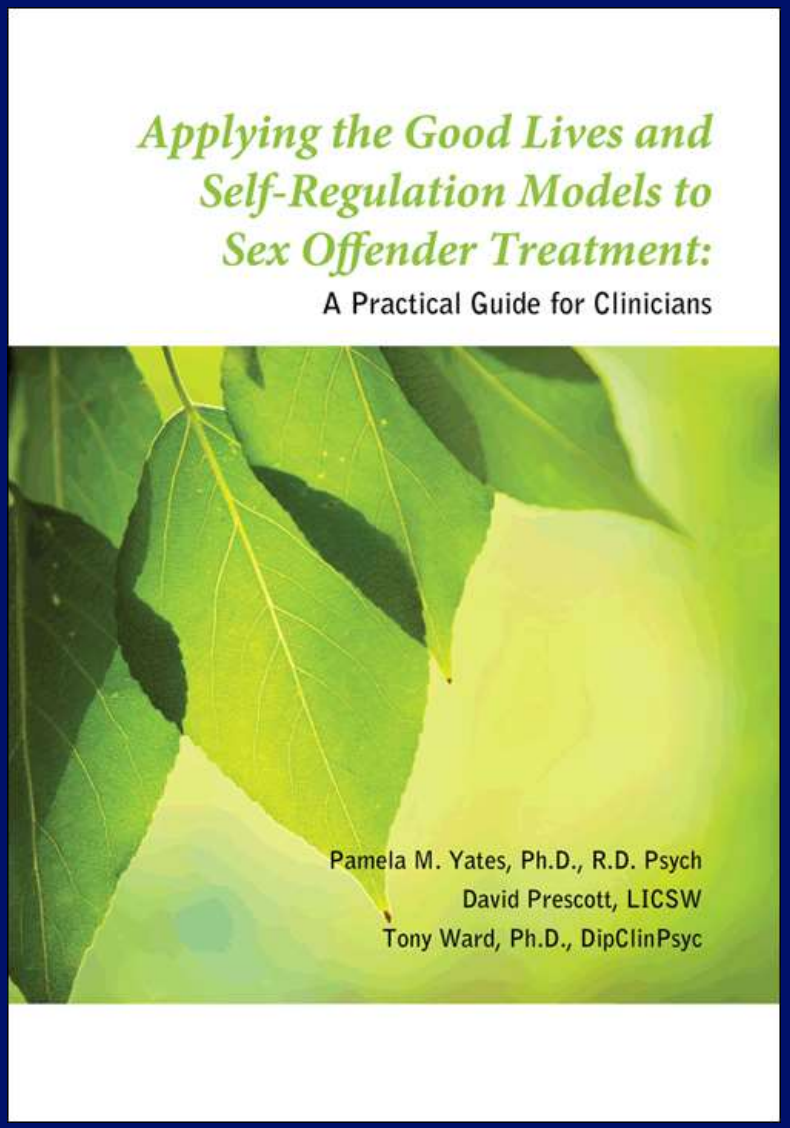
- Sex Education
- Public vs. Private
- Social Skills
- Age Discrimination
- Relationship Training
- Social Responsibility
- Anger Management
- Problem Solving
- Self Regulation
- Risk Management Plans
- Supervision
- Community Access

Rise of Strength-based Approaches

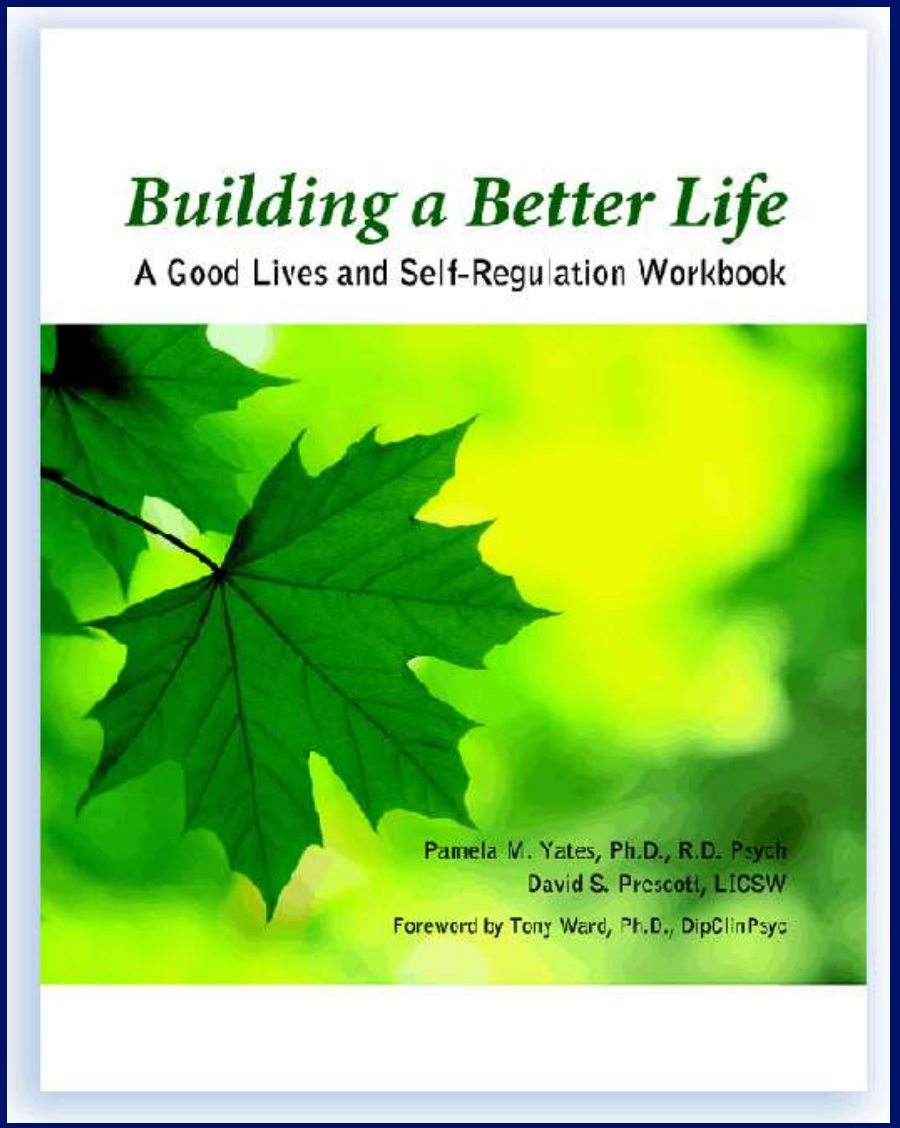
- Traditionally, our work with clients has focused on what's going **wrong** and how likely it is that bad behaviors will **persist**.
- We're currently seeing a shift – influenced by positive psychology and strength-based approaches – that calls on us to identify what's going **right** and how likely it is that clients will **desist** if we provide them with support, resources, and meaningful accountability frameworks

Self-Regulation Model (SRM) of Sexual Offending

- Outgrowth of self psychology
- Focus is on how people regulate internal and external processes as they engage in goal-directed actions
- Proposed in response to shortcomings identified in relapse prevention model
  - Acknowledgment that there is more than one pathway to offending
- Proposes four pathways of offending based on offense-related goals and strategies



Yates, Prescott, & Ward (2010)



Yates & Prescott, (2011)

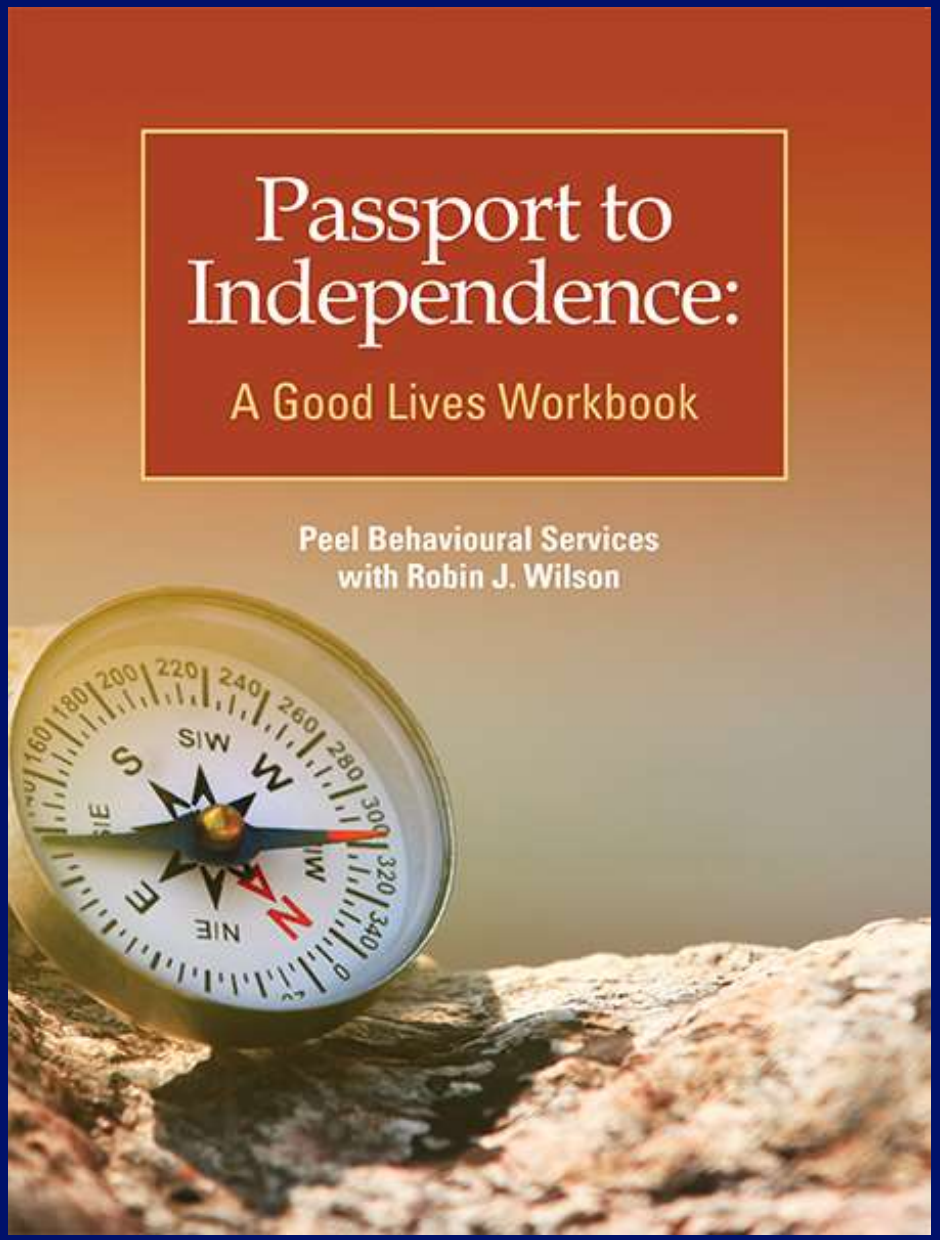
Good Lives Model (GLM)

- Many contemporary programs identify with "self-regulation" and "good lives" models of treatment.
- The basic premise of the Good Lives Model is the development of a "balanced, self-determined lifestyle".
  - Borrows from self psychology and Life Skills model
  - Treatment approaches are multi-modal and holistic
- The GLM suggests that successfully-treated individuals strive to lead lives that are healthy, productive, and free of risk as a natural consequence of the stability that comes with leading a "good life".

Primary Human Goods

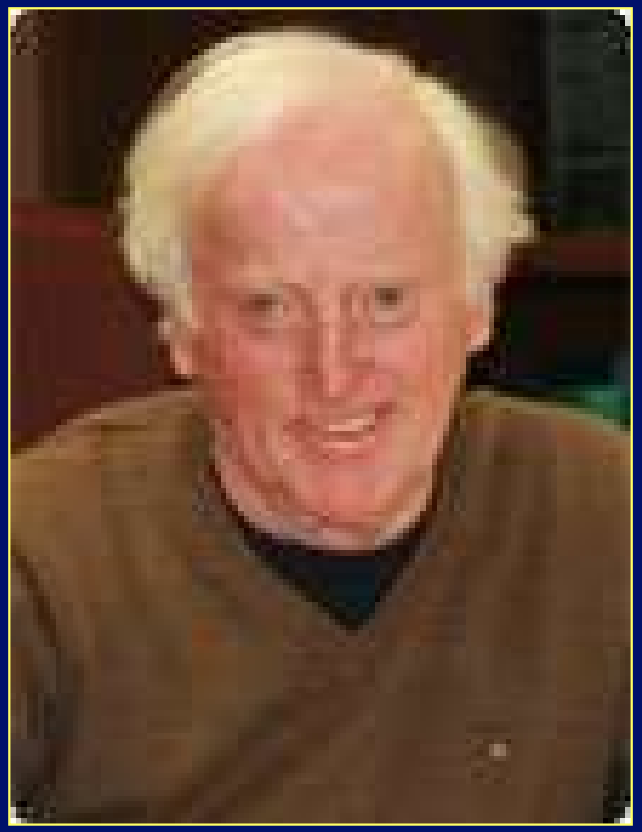
- Life (including healthy living and functioning)
- Knowledge (how well informed one feels about things that are important to them)
- Excellence in play (hobbies and recreational pursuits)*
- Excellence in work (including mastery experiences)*
- Excellence in agency (autonomy, power and self-directedness)
- Inner peace (freedom from emotional turmoil and stress)
- Relatedness (intimate, romantic, and familial relationships)
- Community (connection to wider social groups)
- Spirituality (broad sense of finding meaning and purpose in life)
- Pleasure (feeling good in the here and now)
- Creativity (expressing oneself through alternative forms)

Peel Behavioural Services & Wilson (2017)



Marshall, 2005

- Warm
- Empathic
- Rewarding
- Directive



Problem: Many people think they have these qualities, but actually don't.

Features that Enhance and Reduce Effectiveness

Features that Enhance Effectiveness

- Empathy
- Warmth
- Respect
- Genuineness
- Supportive
- Directive
- Flexible
- Encourages Participation
- Rewarding
- Attentive
- Trustworthy
- Use of humor
- Emotionally Responsive

Features that Reduce Effectiveness

- Aggressive Confrontation
- Rejection
- Manipulative/Lack of boundaries
- Lack of interest
- Critical
- Sarcastic
- Hostile/Angry/Rigid
- Cold/Unresponsive
- Dishonest
- Judgmental
- Authoritarian
- Defensive
- Nervous/Uncomfortable

What does the research tell us about treatment?

- Holistic approaches are better than "sex-offender-specific" approaches
- Confrontation is less effective than therapeutic engagement
- Models of citizen engagement in community risk management – as a treatment adjunct – are showing promise
- Most treatment outcome studies show positive results, suggesting that treatment is leading to greater reintegration potential and greater community safety

What does the research tell us about treatment?

- Recent study in the UK suggested that treatment for persons who sexually offended in the UK was NOT working
- Subsequent meta-analytic research was more favorable:
  - "Recidivism was 13.4% for treated individuals and 19.4% for untreated comparisons over an average follow up of 66.1 months."
  - "Relative reductions in offense specific recidivism were 32.6% for sexual offense programs, 36.0% for domestic violence programs, and 24.3% for general violence programs."

Managing Risk in the Community

Sexual Violence is a Community Issue

- The community lives in fear of sexual violence and responses to dealing with this fear are varied throughout history
- At the end of the day, reduced recidivism is everyone's business
  - People who have offended, people who were victimized, and the community-at-large

Today's Situation

- Upon release, many persons who have sexually offended are subject to public notification, vilification and, sometimes, vigilantism.
- As a result, some are eventually driven out of one community into another and, often, go "underground".

This does not help.

Official Control

There are several "official" means by which to control individuals released to the community …

- Court Diversion
- Probation & Parole
- Court Orders / Orders of Prohibition
- Specialized Peace Bonds
- Community Notification
- Sex Offender Registries
- 1000/2000/2500 feet rules
- Electronic/GPS Monitoring
- Long Term Supervision Orders / Lifetime probation
- 3 Strikes / Civil Commitment

Paying Attention to RNR

- I won't tell you that each and every one of these measures is inappropriate all the time.
- Clearly, some individuals under supervision need special attention, using specialized tools and risk management options.
- However, we consistently fail to apply risk and need considerations when implementing risk management measures, potentially washing out any potential gains.

Registration & Community Notification

- Based on the notion that knowing where people under supervision are will increase risk management prospects.
- Police may release information about an individual, depending on an evaluation by the Police Service, with or without consultation with the community.

Why Registration / Notification?

"Sex Offender Registries" and notification schemes are based on the belief that…

- People who have sexually offended are "predatory prowlers"
- Reoffense rates are high
- Nothing else will work

Truth in Advertising

Are people who sexually offend "predatory"?

- As many as 95% of individuals coming into the system because of a sexual offense are first time caught – and are, therefore, not registered
- Predators vs. Farmers?

Are reoffense rates high?

- Under-reporting is an important consideration
- Rates vary by risk level, but meta-analytic data say overall average is about 5% in five years, approximately 10% in 10.

Is there really nothing else we can do?

What bang for our buck?

- Overall, little evidence exists that community notification, residency restrictions, or maintaining SORs reduce reoffending
- There are, however, unintended consequences for many individuals under supervision, including residence and job instability, along with difficulties establishing social contacts
- The literature on dynamic risk management tells us that problems in these areas increases risk

Risk Management Strategies

Containment, MAPPA, CASOM, & CoSA

Custody & Release

- Levels of incarceration and restrictions of freedom start high and are, under normal conditions, gradually decreased over course of sentence

Prison (max>med>min) → Halfway House → Community

- Generally believed that facilitated community reintegration reduces risk of reoffense
- However, many individuals at higher relative risk are released at sentence completion with no ***official*** community reintegration process

Risk Management

Players include:

- Case management / supervisory staff
- Programs staff
- Psychologists and other mental health professionals
- Agency staff and counselors
- Students and volunteers
- Law enforcement
- Victims' advocacy groups
- Community

Risk Management

- Treatment providers, case managers, and clients need to be vigilant in examining attitudes, motivation, and quality of participation
- Peer review is critical, and is a primary reason why treatment for persons who have sexually offended is done in groups
  - Case-conferencing is a must – multi-disciplinary
- Avoid complacency
  - Just because the client seems to be doing okay doesn't necessarily mean he actually is

Containment

- Colorado, beginning in late 1990s
  - English, 1998
- Popular approach across USA
- Specially trained supervising agents
  - Smaller caseloads
  - In instances where supervising agents are few, law enforcement becomes involved through registration and ensuring compliance with conditions
- Coordination with treatment providers
- Polygraph examinations
- Enhanced community monitoring (e.g., GPS)

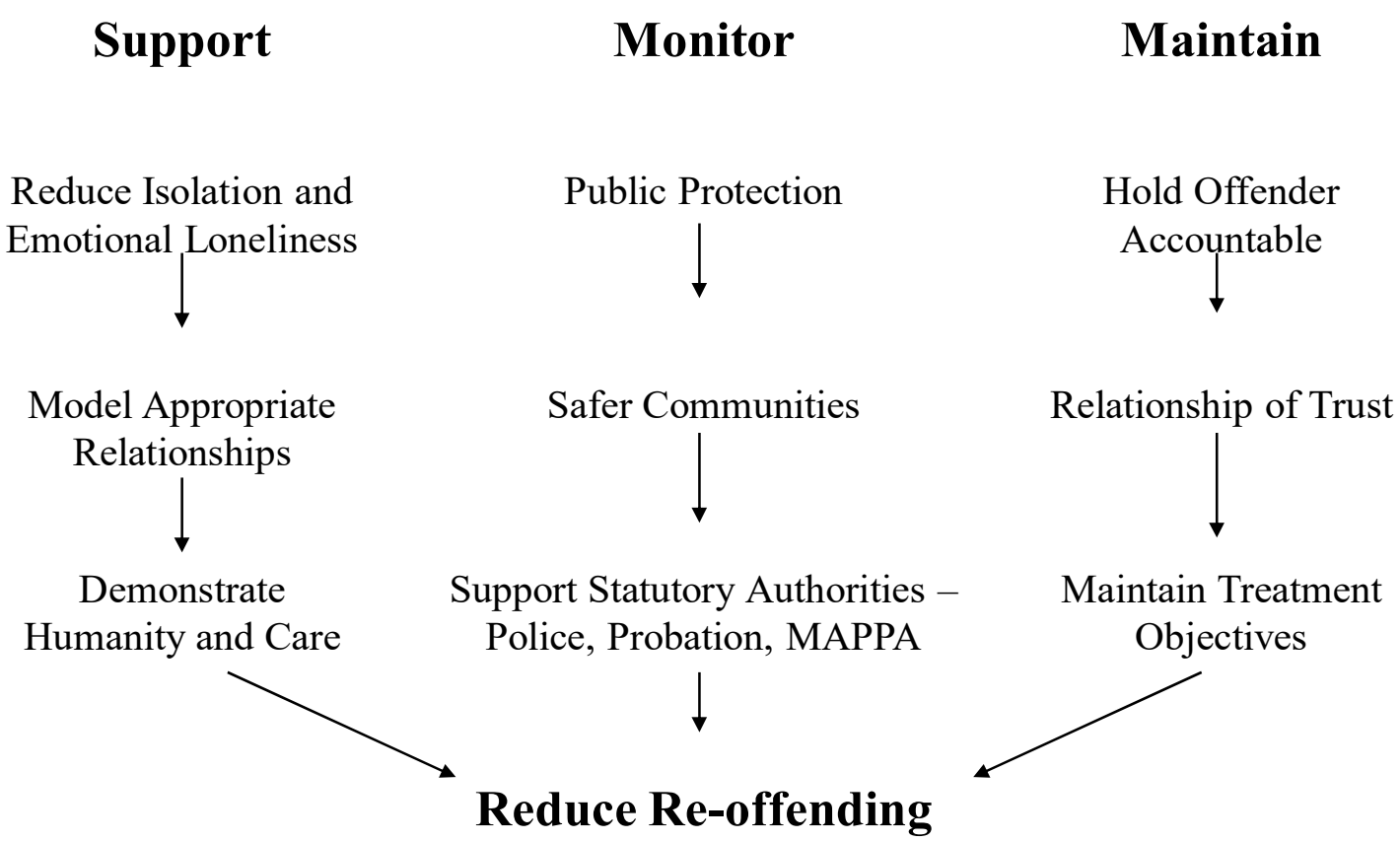
MAPPA

(https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance)

In the UK, Multi-Agency Public Protection Arrangements help to manage a partnership of statutory agencies and community groups tasked with increasing public safety

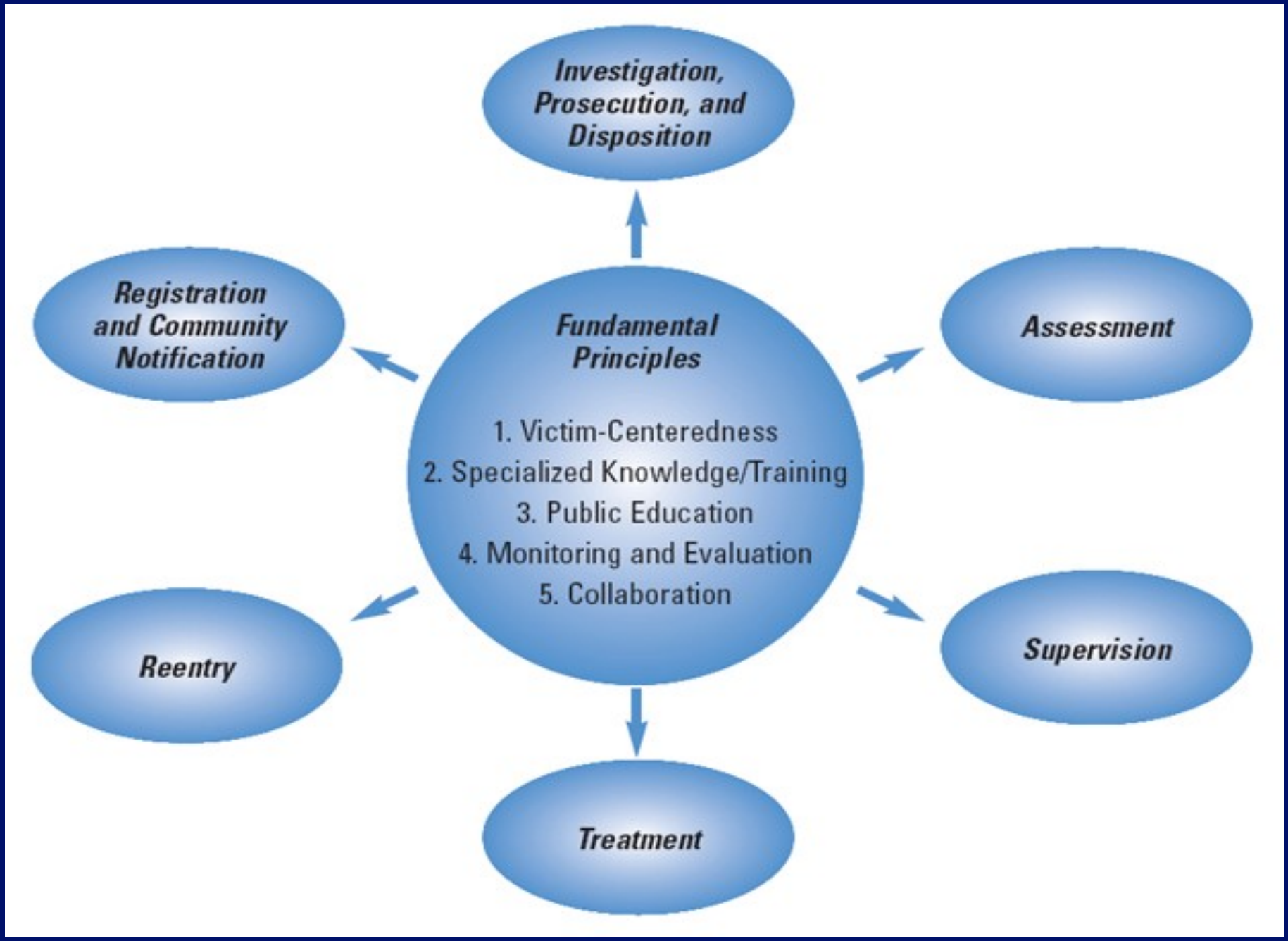
- Police, Probation, Social Services
- Circles-UK has become an important part of the MAPPA process, in addition to other community groups

The Three Key Principles



CASOM
Comprehensive Approaches to Sex Offender Management

- Training and funding agenda sponsored by SMART Office
- Recognizes that comprehensive approaches are the most effective way to manage clients with sexual offense histories ***within*** communities
  - Aim is to develop effective public policies and practices that will promote public safety and to respond effectively to the needs of persons who were sexually victimized
  - Best and promising practices are currently being investigated and promoted
  - https://www.atsa.com/pdfs/Policy/CSOM_SOManagement.pdf



https://www.atsa.com/pdfs/Policy/CSOM_SOManagement.pdf

CASOM Partners

- Law enforcement
- Treatment
- Probation/Parole
- Victim Services
- Courts
- Prosecution
- Schools
- Housing
- Community programs
- Faith Communities

NB: ***Most collaborative models now include greater representation of all pertinent stakeholders.***

Containment, MAPPA, CASOM

- What are the potential drawbacks to approaches like these?
- Are all concerned parties at the table?
- What happens when something goes wrong?

Are individuals at high-risk high-risk forever?

from Hanson et al. (2014)

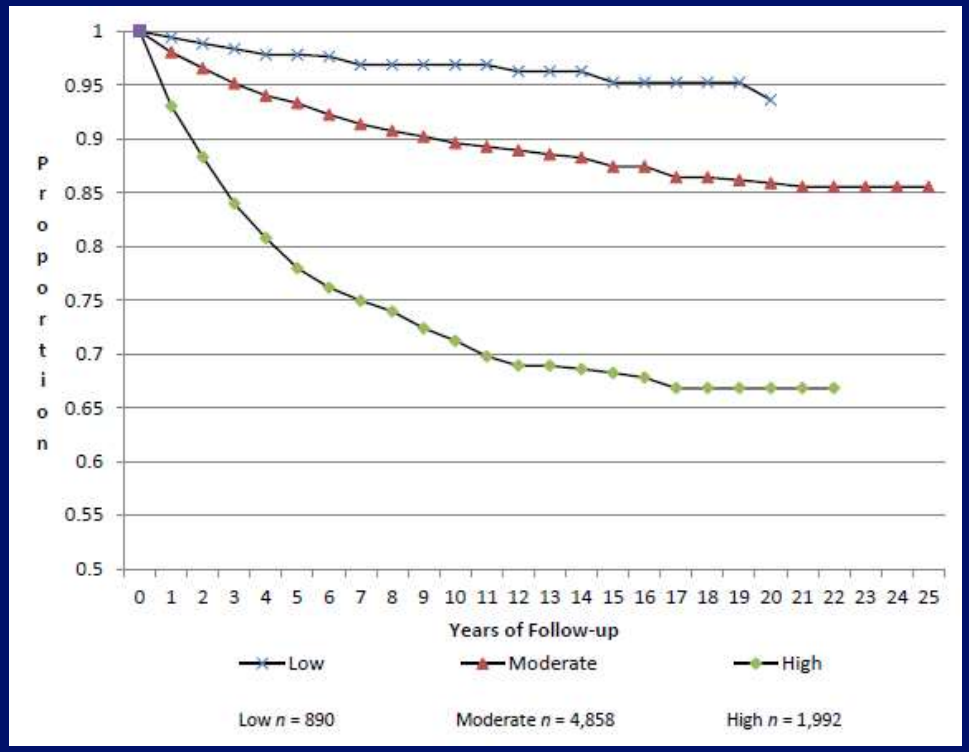
- All estimates of reoffending are confounded by under-reporting.
- Approximately 70% of persons who sexually offended are at low to low-moderate risk to reoffend.
- Approximately 10% are at high risk to reoffend.

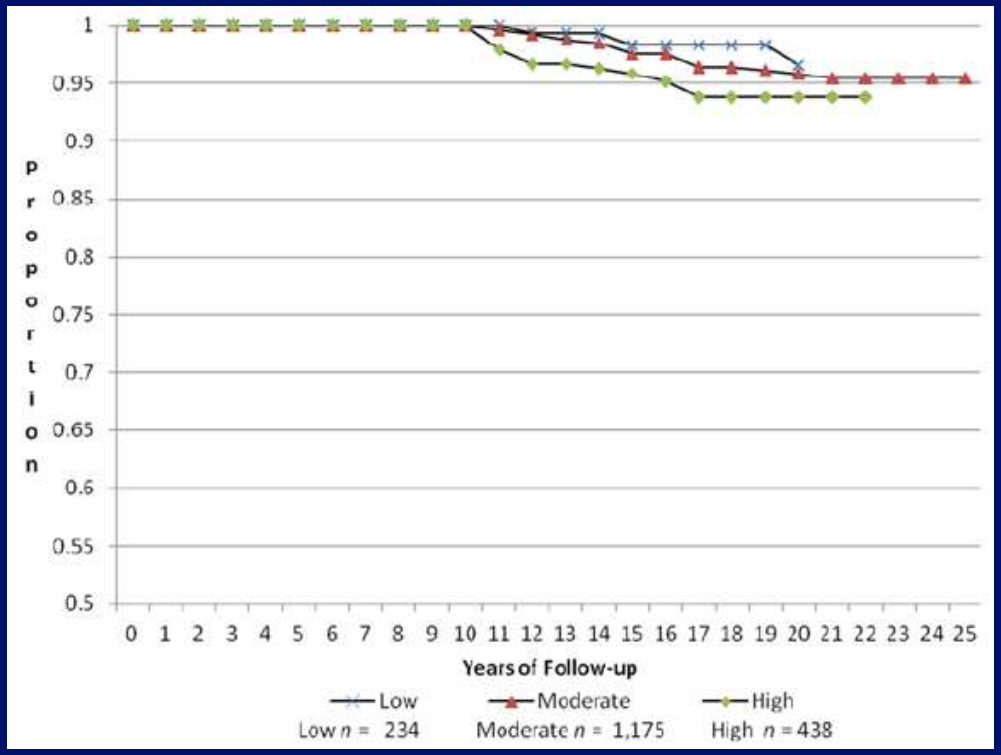
Are individuals at high-risk high-risk forever?
(Hanson et al., 2014)

- If they are going to, most persons with sexual offense histories will reoffend within 5 years post-release.
- The longer they remain offense-free in the community, the more likely it is that they will continue to be offense-free.
- The effect is most pronounced with higher risk individuals.

Are individuals at high-risk high-risk forever?

(Hanson et al., 2014)





Years to Desistance According to Initial Risk Levels (Hanson et al., 2014)

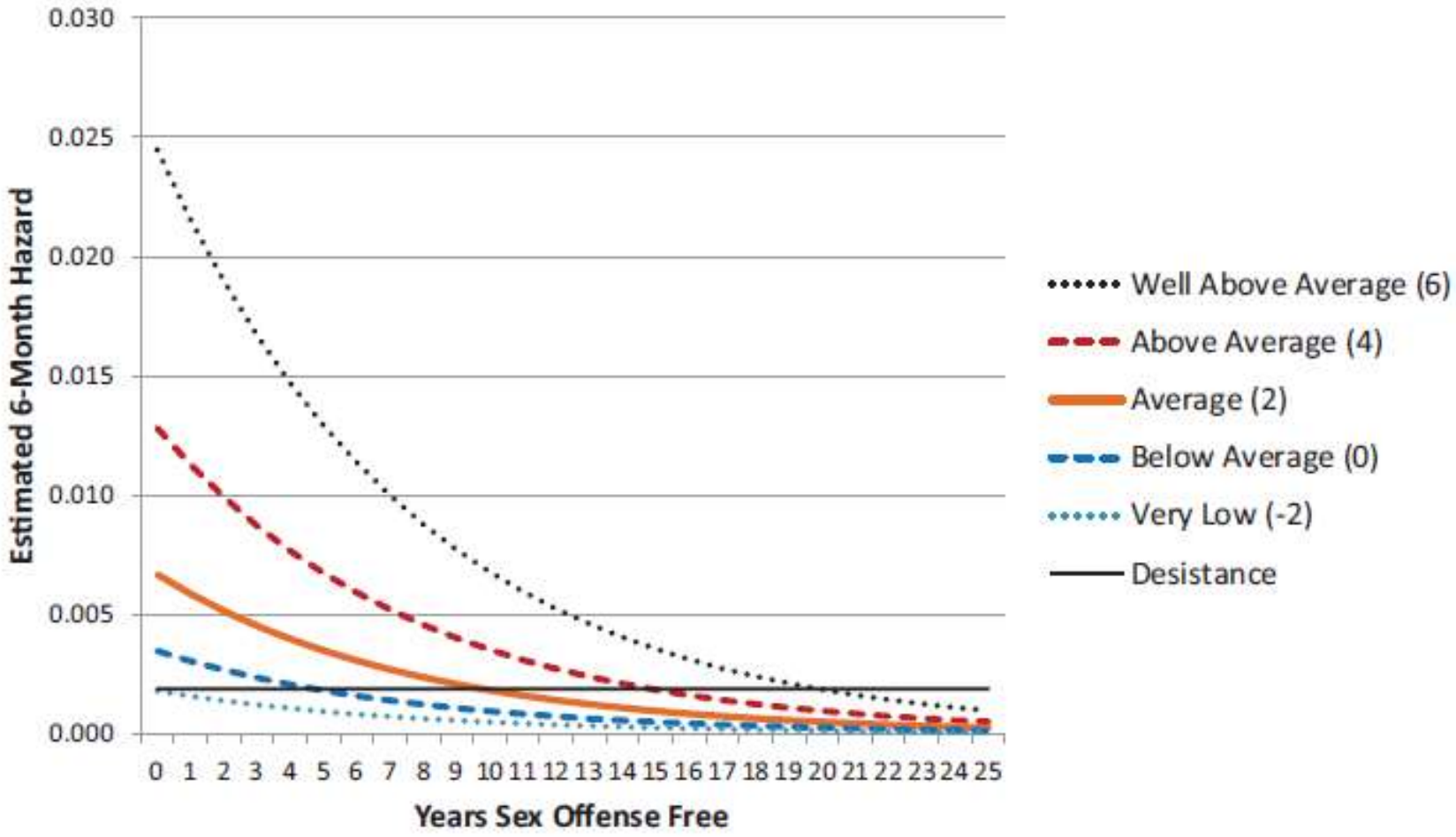


Figure 2. Years to desistance according to initial risk level based on selected Static-99R scores. Estimated hazard rates based on Model 5 (n = 7,225) for routine/complete samples. See the online article for the color version of this figure.

Citizen Engagement & Partnerships

We're all in this together…

Sir Robert Peel

- Prime Minister of the UK in early 1800s
- Generally acknowledged as the "father" of modern policing
- Famous quote:

"The police are the public and the public are the police."

Jane Jacobs (1961)

The Death and Life of Great American Cities

The first thing to understand is that the public peace—the sidewalk and street peace—is not kept primarily by the police, necessary as police are. It is kept primarily by an intricate, almost unconscious, network of voluntary controls and standards among the people themselves and enforced by the people themselves. No amount of police can enforce Civilization where the normal causal enforcement of it has broken down.

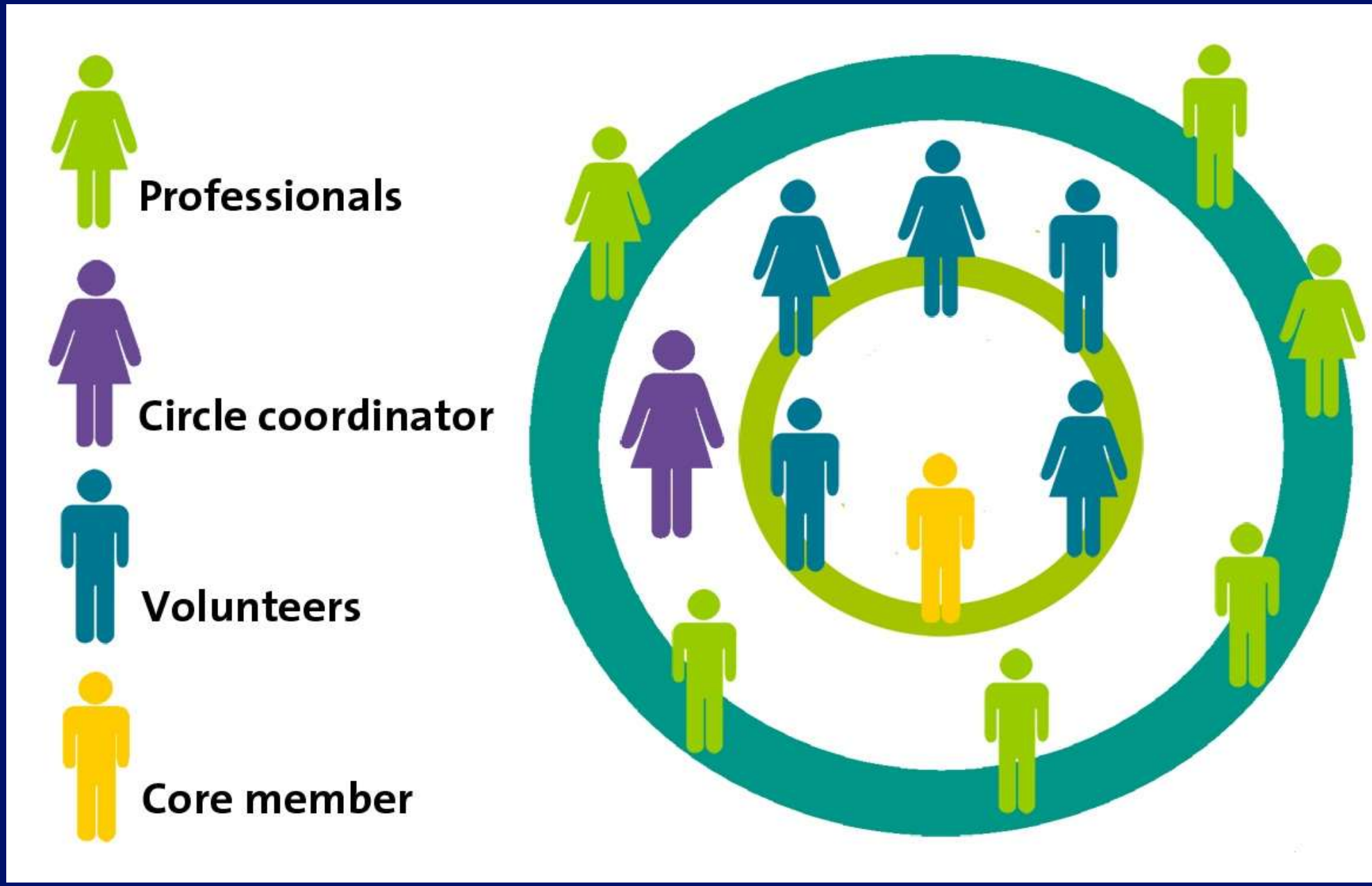
The Shadow Cast by Formal Justice

Community is made from conflict as much as from cooperation; the capacity to solve conflict is what gives social relations their sinew. Professionalizing justice "steals the conflicts," robbing the community of its ability to face trouble and restore peace. Communities lose their confidence, their capacity, and, finally, their inclination to preserve their own order. They instead become consumers of police and court "services" with the consequence that they largely cease to be communities.

Nils Christie (1977). Conflicts as Property. *British Journal of Criminology*.

Circles of Support & Accountability
The Model

- Based on "wrap-around care"
- Late 1960s to 1970s: early precedents:
  - Native American/Canadian traditions
  - Canadian Brownsdale (Larch) programs
  - Kaleidoscope, Chicago
  - 1985: Alaska Youth Initiative or AYI
- Current model started in Canada in 1994



Core Principles

- No one is disposable
- No one does this alone
- No more victims
- Community is responsible for people who were victimized **and** those who offended against them

Do Circles Work?

Do Circles Work?

Social Support

Persons with sexual offense histories released to the community who have positive, pro-social support are at less risk of re-offending than those who have no such support, or whose supports are anti-social in nature.

Core member experience

Without my Circle, I may have …

- Had difficulty adjusting
- Had difficulty in relationships with others
- Become isolated and lonely
- Turned to drugs or alcohol
- Reoffended

Outcome Studies

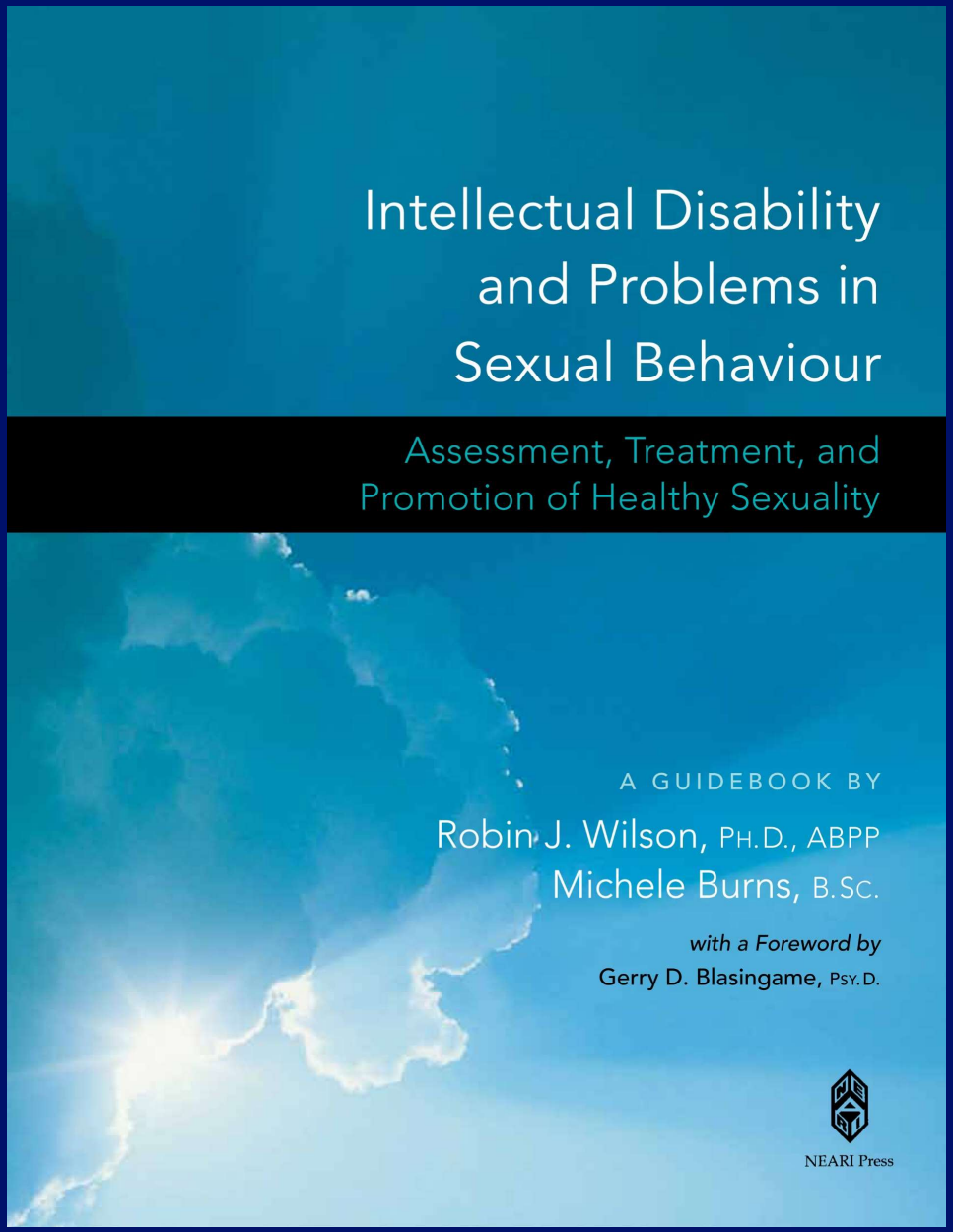
- Wilson, Picheca, & Prinzo (2007a and 2007b) – Canada
  - Matched comparison (N = 60); 70% less SO
- Wilson, Cortoni, & McWhinnie (2009) – Canada
  - Matched comparison (N = 44); 83% less SO
- Bates, Wilson, Williams, & Wilson (2013) – UK
  - Matched comparison (N = 71); 75% less SO+V
- Duwe (2013) – Minnesota
  - RCT design (N = 30); 62% fewer rearrests, 72% fewer technical revocations, and 84% fewer reincarcerations
- Duwe (2018) – Minnesota
  - Extension of the 2012 RTC project (N = 50); 88% less SO, 49% to 57% reductions in all other recidivism domains
- Wilson, Fox, & Kurmin (2017) – Vermont
  - Matched comparison (N = 34); 75% less SO

CoSA Research Interpreted

- To date, there have been five evaluations of the CoSA model
  - 2 from Canada, 1 from UK, 3 from USA (1 in process)
- All studies show the same basic findings
  - CoSAs can contribute to lower reoffending and better community reintegration
- However, it is important to note that, so far, these are but 6 studies with small samples and short follow-up – more research is necessary

Working with Individuals with Special Needs

Wilson & Burns, 2011



Who are we talking about?

"Special Needs" in the context of this presentation is a broad category that can include many different clinical presentations (or a combination thereof):

- Acquired Brain Injury
- Autism Spectrum Disorders (including Asperger's)
- Fetal Alcohol Spectrum Disorders
- Intellectual Development Disorder (and Borderline Intellectual Functioning)
- Severe Mental Illness
- Others with impaired cognitive ability due to a variety of reasons

Judge Trueman

The cognitively challenged are before our courts in unknown numbers. We prosecute them again and again and again. We sentence them again and again and again. We imprison them again and again and again. They commit crimes again and again and again. We wonder why they do not change. The wonder of it all is that we do not change.

(https://canliiconnects.org/content/documents/34634)

Special Needs and Crime

- It is tragically well known that persons with mental health difficulties are increasingly being found in criminal justice settings
- It is reasonable to assume that at least some of those with special needs are not adequately identified by the courts
- Those who look different or who have special needs are more likely to be incarcerated and incarcerated for longer than average

Special Needs and Sexual Offending

A judge in Canada observed:

Herein lies the problem relating to the commission of sexual offenses. Having a mature body beyond his intellect, he has urges for sexual gratification which leads to impulsiveness and unpremeditated behavior without using caution and with risk taking. This is followed by non-comprehension that the behavior was inappropriate.

Assessment

Behavioral Difficulties

- Children with special needs tend to be impulsive, uninhibited, overly friendly, inquisitive, demanding of affection and physical contact, intrusive, insensitive to social cues, and have poor social skills.
- It's not hard to see how some of these could ultimately lead to problems in later life.

Difficulties for our clients

People with special needs and behavior problems often experience significant limitations leading to difficulties in many or all of the following domains:

- Communication
- Home living
- Community use
- Self-direction
- Functional academics
- Sexuality
- Self-care
- Social skills and relationships
- Health and safety
- Leisure and work

Individualized Safety Plan

Wallet-Sized Safety Card for the Community

I have a responsibility to:

a) Think safe and healthy thoughts

b) Stay focused, aware, and alert

c) Keep potentially vulnerable persons safe at all times

d) Respect everyone's personal boundaries

e) Speak appropriately

f) Plan only safe outings

g) Stay with safe person at all times

h) Stay with peer group my own age

i) Buy only items that are suitable

j) If I feel uncomfortable—leave

Emergency contact number: _____

Areas of Focus

History of Abuse

- Any history of physical, emotional, or sexual abuse?
- Role of Adverse Childhood Experiences (ACEs)

Relationships and Sexual Behavior

- In what kinds of sexual behavior (if any) have they engaged, other than the offense or referring problem?
- Is there any appropriate sexual behavior?

Attention/Hyperactivity/Perseveration

- Does the client have issues with focus?

Areas of Focus

Behavioral

- behavior to get attention?
- To avoid a task?
- Control?
- Communication?
- Learned?

Socio-Sexual And Social Skills

- Inappropriate courtship skills, social skills, interactional skills?

Partner Selection

- Do they have access to appropriate partners
  - (e.g., same age peers vs. staff or children)?

Areas of Focus

Sexual Knowledge

- What do they know about healthy sexuality?
- Where/How did they learn about sex?
- From whom did they learn about sex?
- What did they learn about sex?

Learning History

- What consequences have their behaviors led to?
- Punishment, aversive stimulus, etc.?
- Myths about SN.

Areas of Focus

Structure

- Does the client have privacy – a space of their own?
- Is appropriate self-expression allowed/encouraged?
- Attitude of staff and parents/family?
- Policies of supporting agency, group home, or residence.

Modeling

- Has the client learned about social distance, boundaries, private talk?

Medical and Psychiatric Issues

Medical

- Any medical or physical condition to explain behavior?
  - infection, allergies, clothing too tight, hypersensitivities

Medication

- Side effects from medications?
  - decrease in sex energy, sex drive, ability to focus

Psychiatric

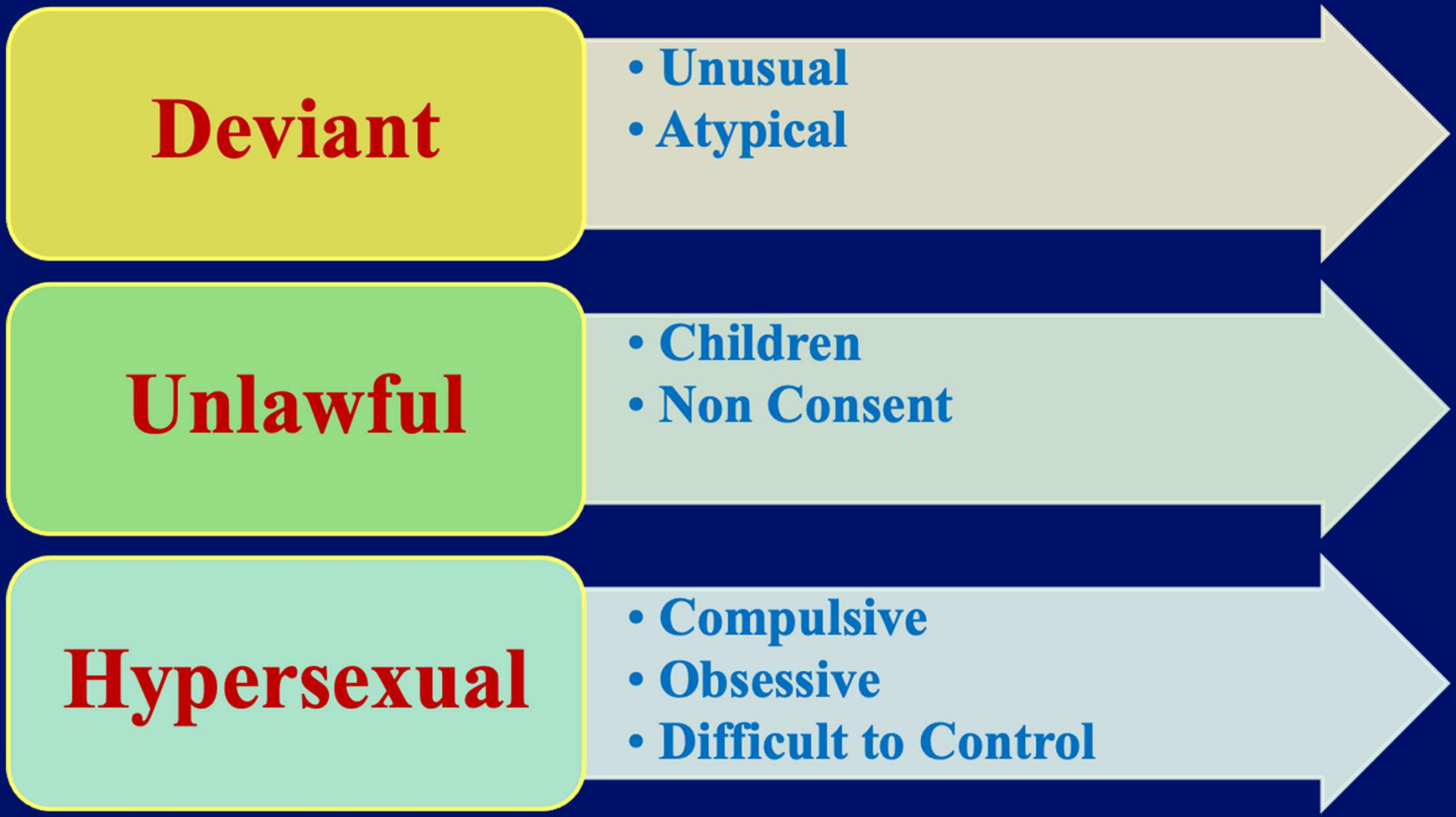
- Dual Diagnosis?
  - substance abuse, PTSD, re-enactment of behavior

Hypersexuality

- Excessive sex drive

Sexual Offending and Deviance

Conceptualizations



Inconsistency

- A lack of clarity remains regarding definitions for "inappropriate" sexual interests, preferences, and behaviors.
- One of the greatest hurdles to defining sexual deviance is a lack of clarity as to what actually constitutes offensive sexual behavior.
- What do you consider to be sexually offensive?

Consent

A particularly important concept to consider when looking at sexual offending is that of consent.

- What constitutes consent?
- Who can give it?
- Under what circumstances?
- Are there personal or situational variables that would impinge on consent?
  - Disability? Cognitive status?

More Inconsistency

In treatment, we tell people who have offended that it is not okay to fantasize about or have sexual relations with minors

Yet we, as a society, appear to be okay with…

- Young persons being sexually active
- Depicting minors in a sexually-charged manner

Many of our clients with special needs have a harder time with age discrimination

Counterfeit Deviance
(Griffiths et al, 2013)

Counterfeit Deviance is observed in some people with SN, in which the behavior looks "deviant," but may not be when you consider the circumstances.

– Dave Hingsburger

(Makes a great argument for employing Applied Behavioral Analysis)

Consequential Learning

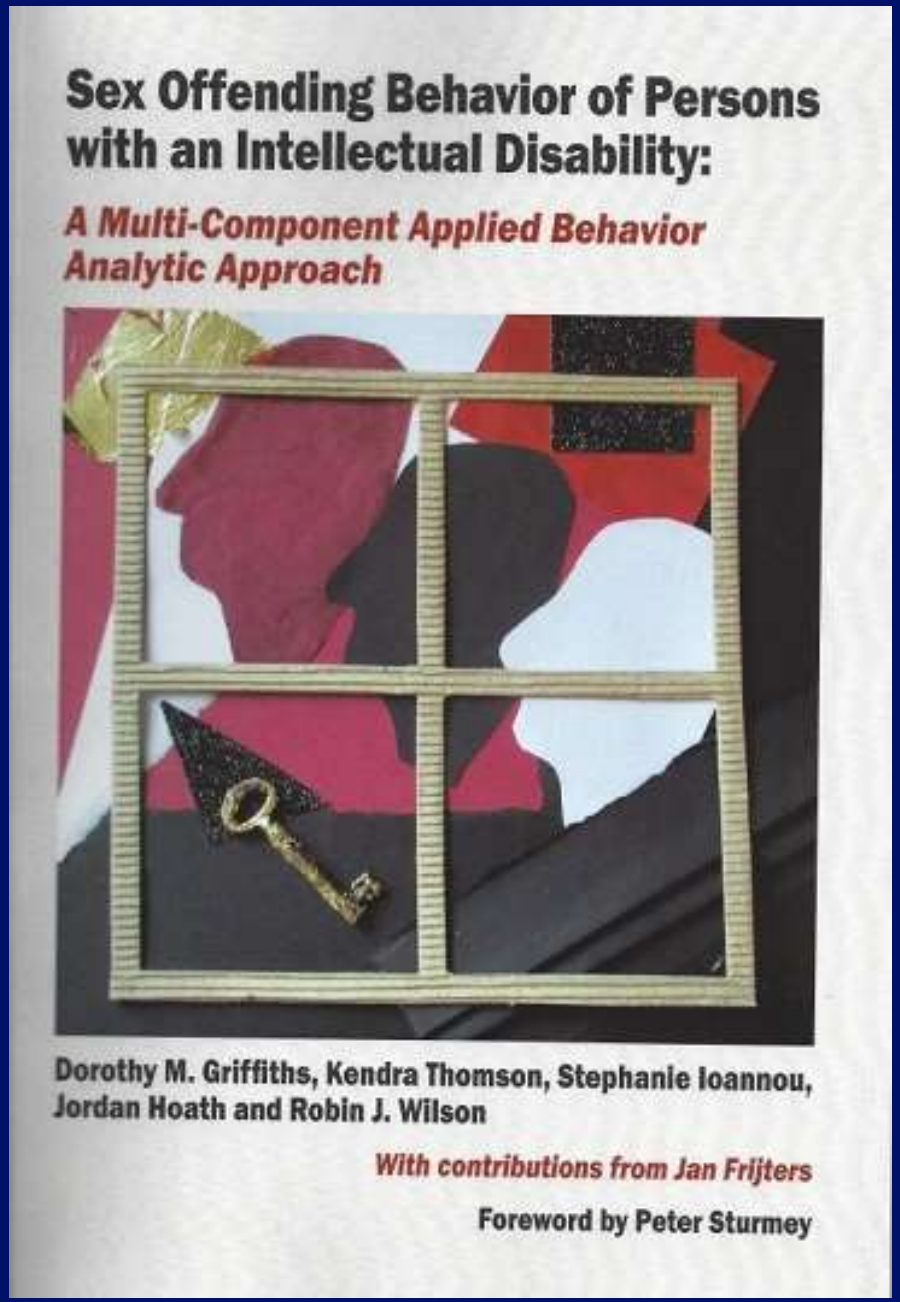
- Persons with special needs have often gotten a "free pass" from the criminal justice system
  - Officers have been reluctant to lay charges
  - Courts have been reluctant to convict
- Consequently, some persons with special needs and behavior problems never truly learn that their conduct is unacceptable.

Applied Behavioral Analysis

We certainly don't want to "excuse" inappropriate behavior in a person with special needs, but it is important to acknowledge that exploring the manifestations of sexual violence and other aggression in our clients requires a different approach.

- ABA approach to understanding misbehavior in SN clients is gaining favor

Griffiths et al., 2019)



Morning Routine — Visual Schedule

The following is an example of a morning routine — visual schedule. Visual schedules must be modified to address the specific needs of the individual being supported.

Week Of : _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Wake Up (6:45 am) 					
Take Meds 					
Take Shower 					
Eat Breakfast 					
Use Washroom 					
Brush Teeth 					
Get Dressed for work 					
Go to Work 					
REWARD EARNED?					

Outing Journal

Part 1

To be completed before going on the outing:

1. What are your plans for today? What will you do? Where will you go?

2. What are the risks? Will there be any dangerous situations?

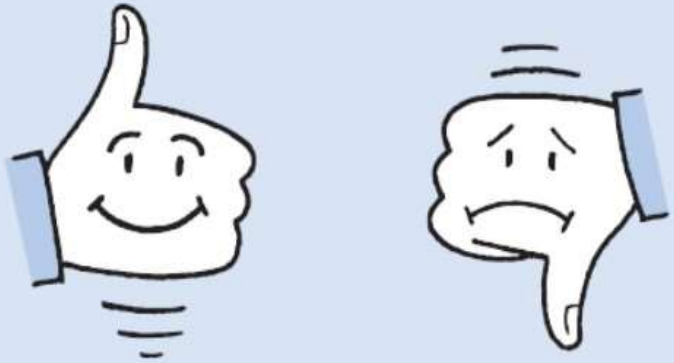
3. How will you use SRT (Self-Regulation Techniques) to make sure everyone is safe?

Part 2

To be completed upon return from the outing:

4. How did your day go? Did you follow your Safety Plan? Did you use any SRT strategies, and if yes, which ones?

5. Circle the picture that best represents your outing today.



Individual's signature: _____

Safe Person's signature: _____

Formal Risk Assessment

- Includes consideration of static (historical) and dynamic (day-to-day) variables
- Facilitated by use of actuarial risk assessment instruments like Static-99R, LSI-R
  - Augmented by formal consideration of dynamic risk factors or "criminogenic needs" using specialized tools, including actuarial instruments and structured professional judgment

Dynamic Risk & ID

Clearly, many persons with special needs and behavior problems are at a disadvantage in regard to many dynamic risk variables (e.g., relationship histories, emotional congruence, same sex victims)

- Differential diagnosis and individualized case planning can be difficult
- Recent research suggests that many standardized tools are of questionable validity

ARMIDILO-S

Assessment of **R**isk and **M**anageability
of **I**ntellectually **D**isabled **I**ndividua**L**s
who **O**ffend **S**exually

www.armidilo.net

With whom can we use this?

- The ARMIDILO-S is an example of a risk assessment tool designed specifically for Special Needs clients.
- It is intended for male adults who have committed sexual offenses and are either in the borderline region of intellectual functioning or are intellectually disabled.
- Sexually offensive behavior is defined as any sexual actions on the part of the individual that have been formally or informally sanctioned due to their inappropriate or illegal nature.

Stable Client Items
1. Supervision Compliance
2. Treatment Compliance
3. Sexual Deviance
4. Sexual Preoccupation/Sexual Drive
5. Offence Management
6. Emotional Coping Ability
7. Relationships
8. Impulsivity
9. Substance Abuse
10. Mental Health
11. Unique Considerations - Personal and Lifestyle (e.g., neglect, physical or sexual abuse, antisocial tendencies)

Stable Environmental Items
1. Attitude Towards ID Client
2. Communication Among Support Persons
3. Client Specific Knowledge by Support Persons
4. Consistency of Supervision/Intervention
5. Unique Considerations (e.g., level of supervision, behaviour reinforced, staff modelling)

Acute Client Items
1. Changes in Compliance with Supervision or Treatment
2. Changes in Sexual Preoccupation/Sexual Drive
3. Changes in Victim-Related Behaviours
4. Changes in Emotional Coping Ability
5. Changes in Use of Coping Strategies
6. Changes to Unique Considerations (e.g., mental health symptoms, medication changes)

Acute Environmental Items
1. Changes in Social Relationships
2. Changes in Monitoring
3. Situational Changes
4. Changes in Victim Access
5. Unique Considerations (e.g., access to intoxicants, a new room-mate)

Treatment & Supervision

How do we Ensure Rights in a Culture of Risk while Managing Risk in a Culture of Rights…*

**…without making our clients batty and losing our own minds in the process?*

Rights

There has been much talk recently about "rights for persons with disabilities"

I agree…

…but would note that these rights include:

- A right to competent and individualized risk assessment
- A right to evidence-based treatment and risk management
- A right to safe and secure social interaction
- A right to live offense-free

Points to Consider

- Treatment for persons with behavior problems has a long history of confrontational and punitive approaches
- Studies also show that confrontational style results in poorer treatment outcome
- Research shows that failure to complete treatment not only predicts future problems, but can elevate level of risk
- Can some program attributes be both implicitly confrontational and pro-noncompletion – leading to decreased overall treatment responsivity? (we'll come back to this issue)

Agents of Change

As clinicians and other concerned practitioners, our goal is to assist all clients in the development of a

balanced, self-determined* lifestyle.

Contemporary research in our field suggests that learning to live a "good life" is inconsistent with continued engagement in antisocial behavior.

**within reason, and always with safety in mind*

Responsivity

- Program materials must be presented in a manner that is simplified, concrete, and redundant
- Frequent review of topics covered is important, as is sufficient time for practice and repetition
- Given the increasing diversity of our clientele, programs must be culturally relevant, holistic, and community-based

Treatment & Special Needs

Tough (2001)

- People with disabilities are often exempted from treatment due to their disability
- Impact of inappropriate environments, insufficient teaching, and inadequate support often not recognized
- Post-treatment reoffense rates are often quite similar – SN vs. non-SN
- People with intellectual disabilities **are** amenable to treatment

The intent of treatment and supervision

First and foremost, we want to increase public safety. But, in order to do so, we are increasingly aware that we also have to increase client quality of life and understanding:

- Treatment programs must be created to reflect individual client needs.
- Knowledge and skills are developed for application to many domains – such as social, leisure, and work.

Treatment of Persons with behavior Problems

- Historically, many types of interventions were applied to persons with sexual behavior problems
  - Some were quite aggressive and confrontational
- Current effective practice requires…
  - Adherence to principles of risk, need, responsivity
  - Assessment of risk factors/criminogenic needs
  - Cognitive(?)-behavioral interventions
  - Treatment that specifically addresses identified risk factors/criminogenic needs
  - Post-treatment maintenance/follow-up programming
  - A focus on wellness

Treatment & Supervision

- Clients with special needs will require interventions that are mindful of the RNR principles
- Structure, intensity, and targeted and individualized service are of paramount importance

And, I can't emphasize this enough:

Responsivity, Responsivity, Responsivity

Generalized Safety Plan

1. Before every outing in the community, I will read, understand, and accept the details of my Safety Plan. I will do this in front of the staff or other support person(s).
2. Before I go into the community, I will make sure that I am in a good/positive mood. If I am not in a good mood I will do something relaxing and calming before I go out.

   I MUST BE CALM AND POSITIVE BEFORE I GO OUT!
3. I have already completed the first part of my outing journal for this outing and have discussed my plans with staff. I will complete the rest when I get back.
4. An adult who is aware of my safety strategies will accompany me in the community to help me practice my SRT (Self-Regulation Therapy) and to help me stay safe.
5. When I go into the community, I will choose appropriate and safe places where there will be very few or no PVPs (Potentially Vulnerable Persons).
6. It is **my responsibility** to use as many of the following strategies as I can to stay safe in the community:
   - Stay focused on my task.
   - Choose places that are safe for me to attend.
   - Discuss my feelings or strategies with staff when it is safe to do so.
   - Keep a safe distance from PVPs.
   - Make sure the environment is safe before entering.
   - Walk away from any problem area(s).
   - Look away from area(s) where there are PVPs.
   - Leave the environment altogether if I am feeling uncomfortable or if there are too many PVPs to stay safe.
7. It is **my job** to remember to use my SRT (Self-Regulation Therapy) strategies in the community without being reminded.
8. Staff are there to help me stay safe, so it is best for me to follow their direction when on an outing.

By following the items above, I will make sure that I have a safe and fun outing. With practice, I will get even better at making safe choices by using my SRT strategies in the community.

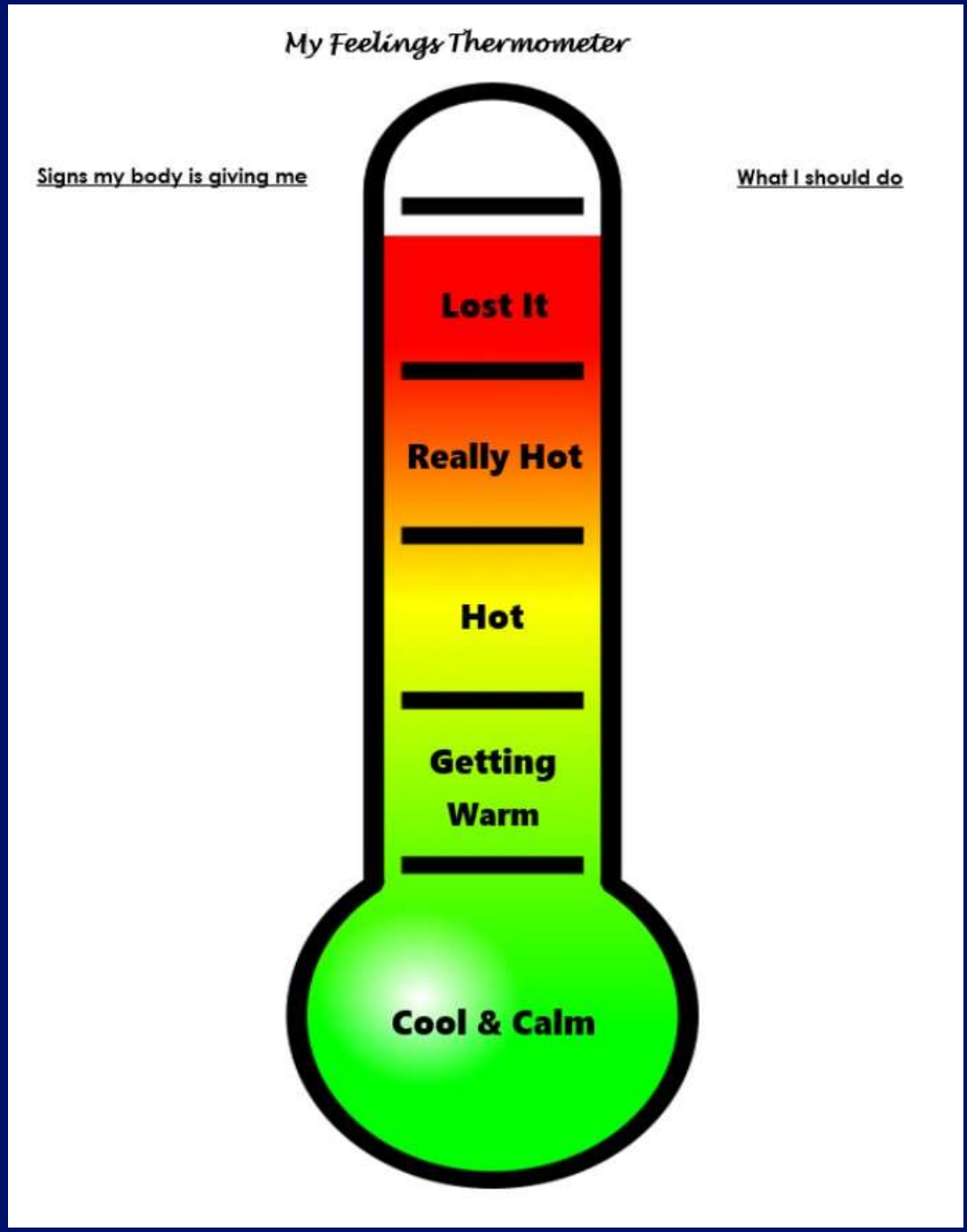
_____ _____

Signature Date

Modifying Interventions

Treatment modifications include:

- Reduced reliance on verbal materials
- Increased use of visuals and modeling
- Increased use of practice
- Sexual education
- Increased supervision and structure
- Emphasis on predictability, clarity
- Use active teaching/explicit instruction
- Medication may be necessary
- Focus on rules and consequences



Treatment & Supervision

- For many clients with special needs and behavior problems, a structured and supportive living environment will be required
- Group homes can be helpful, especially when 24/7 supervision is necessary
- Some clients may be able to function in assisted or semi-independent living environments, but proper assessments are required to identify appropriate clients

Treatment & Supervision

Responsivity

- Program materials must be presented in a manner that is simplified, concrete, and redundant
- Frequent review of topics covered is important, as is sufficient time for practice and repetition
- Given the increasingly multi-cultural nature of our clients, programs must be culturally relevant, holistic, and (where possible) community-based

A little more behavioral than cognitive?

- Often, we have to consider the extent to which the "special need" interferes with the clients ability to function in the cognitive realm
- Some clients will require a behavioral focus, including applied behavioral analysis
  - Requires development of a structured plan and collection of data
  - Attempt to gain better understanding of the function of the behavior

Strength-based Approaches

The basic premise is the development of a "balanced, self-determined lifestyle".

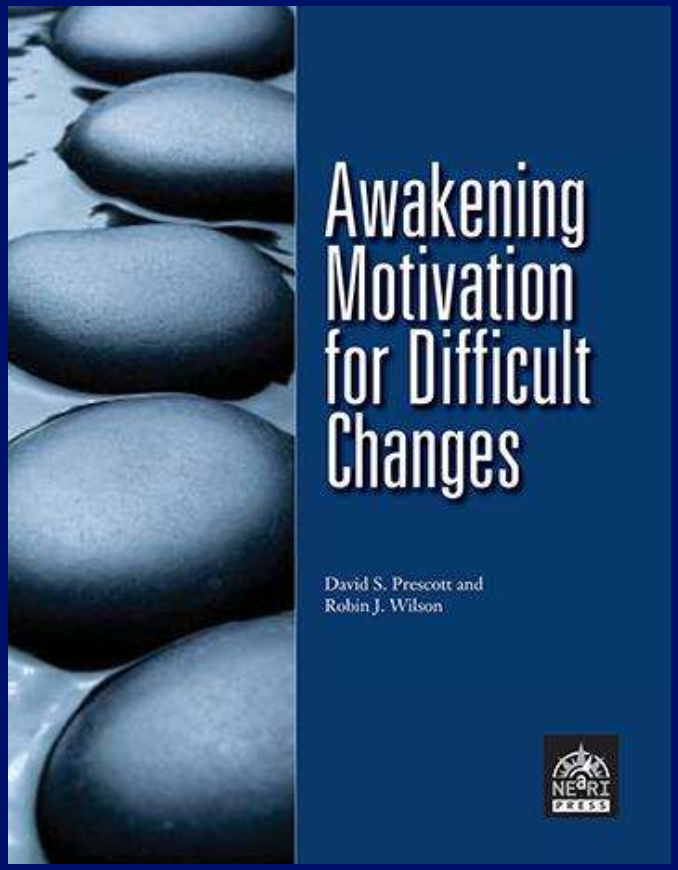
- Borrows from self-psychology and Life Skills model
- Treatment approaches are multi-modal and holistic

Such approaches assert that successfully treated clients strive to lead lives that are healthy, productive, and free of risk as a natural consequence of the stability that comes with leading a "good life."

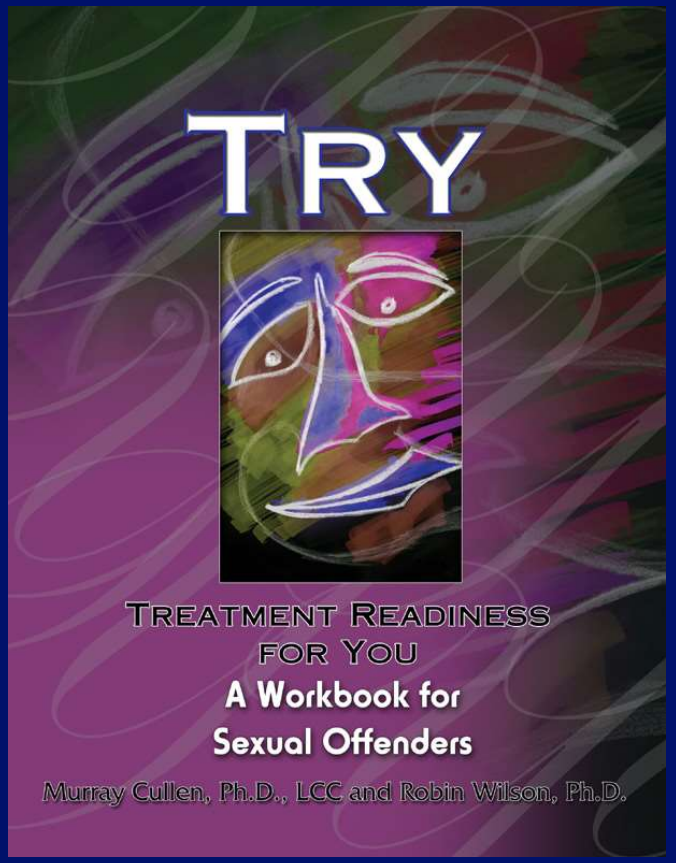
- What is a good life, and how will our clients with special needs know what it is when they see it?

Treatment Readiness

Many programs fail to appreciate the depth of resistance put up by many clients referred for treatment.

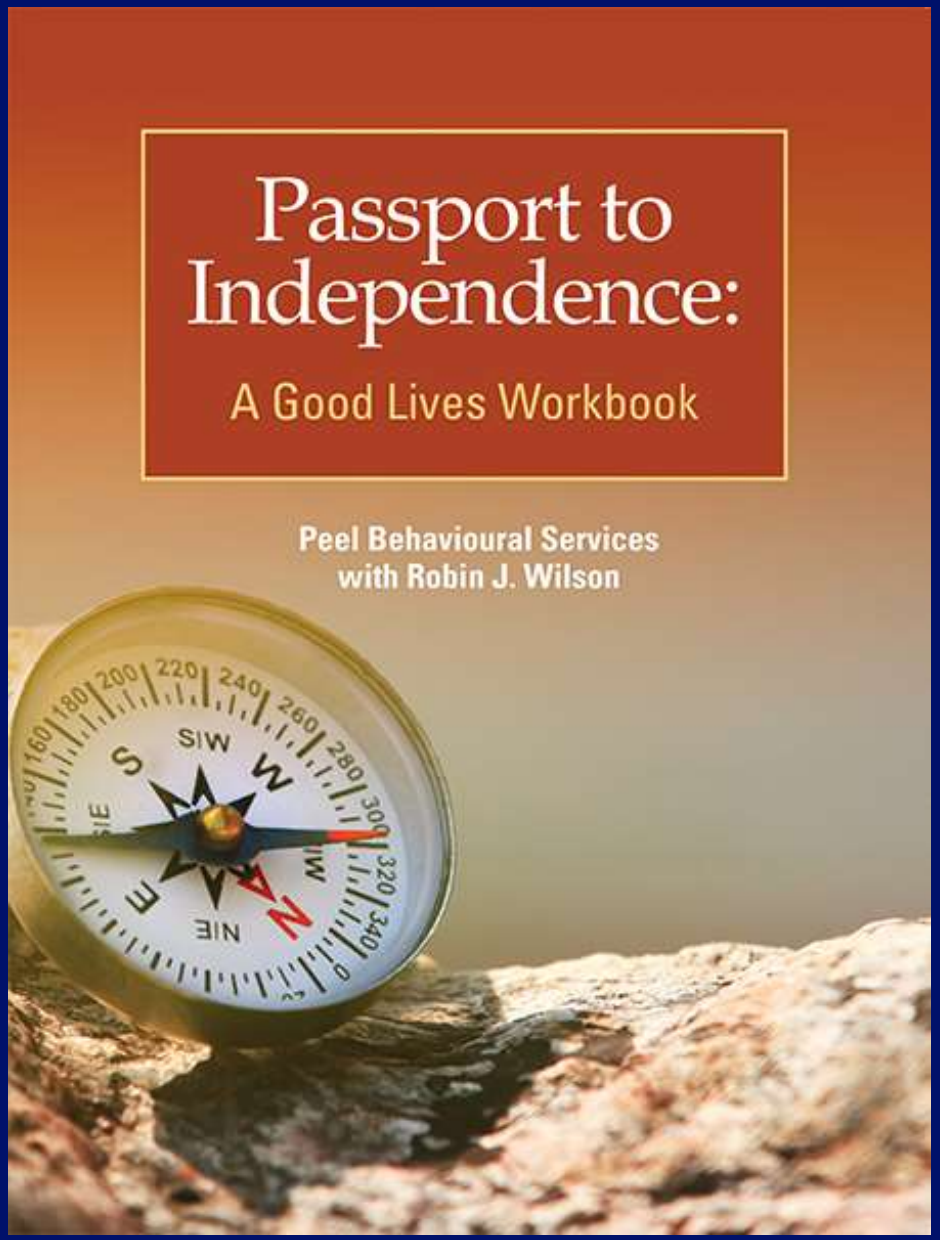


Prescott & Wilson (2013)



Cullen & Wilson (2003)

Peel Behavioural Services & Wilson (2017)



Roadblocks (Problems)	What are these roadblocks or problems?
Ways to meet goal (Means) 	This problem is about the way people try to meet their goals – what they actually do that either doesn't work or that causes problems.
Too Narrow or Too Broad a Good Life Plan (Scope) 	This problem happens when people don't have enough goals in their lives, or when they have too many or their goals are too general. Their Good Life Plan is too narrow and focused on short-term happiness or too broad and unfocused.
Conflict between goals 	This problem happens when different goals in life don't complement one another, or when meeting one goal means that other goals can't be met.
Lack of Skills 	This problem happens when people don't have the skills or strategies to meet their goals.
Lack of opportunities 	This problem happens when people don't have the opportunities to meet their goals because outside factors stop them from doing so.

Prevention — The other side

- We have focused on clients with special needs who have become offenders
- We should not forget that an alarmingly high percentage of persons with special needs were also victimized (Hingsburger* said 90% for ID; Sobsey & Doe [1991] say 4.5 times as often as their peers without disabilities)
- Many traits/scenarios that increase risk for **victimizing** also increase risk for **victimization**, and *vice versa*
- These two positions will interact with one another, especially regarding modeling
- *https://www.nearbycafe.com/loveandlust/davidsteinberg/1996/01/30/differences-sex-and-power-an-interview-with-dave-hingsburger/

Prevention — The other side

- As we noted, many clients with special needs didn't just offend, they were likely also victimized
- Trauma is pervasive in this group
- Trauma causes people to "blunt" their lives
- Treatment of clients with special needs and sexual behavior issues will also require attention to that trauma (responsivity, responsivity, responsivity!!)
- Isolation – either social or geographic – is also something to be considered

Challenges

Promoting healthy sexuality while maintaining safety

Meeting Sexual Needs

Individuals with intellectual disabilities may lack certain social and relationship skills; however, they all have the same desire for social comfort, personal relationships, and meeting of sexual needs in appropriate ways.

– Gerry Blasingame

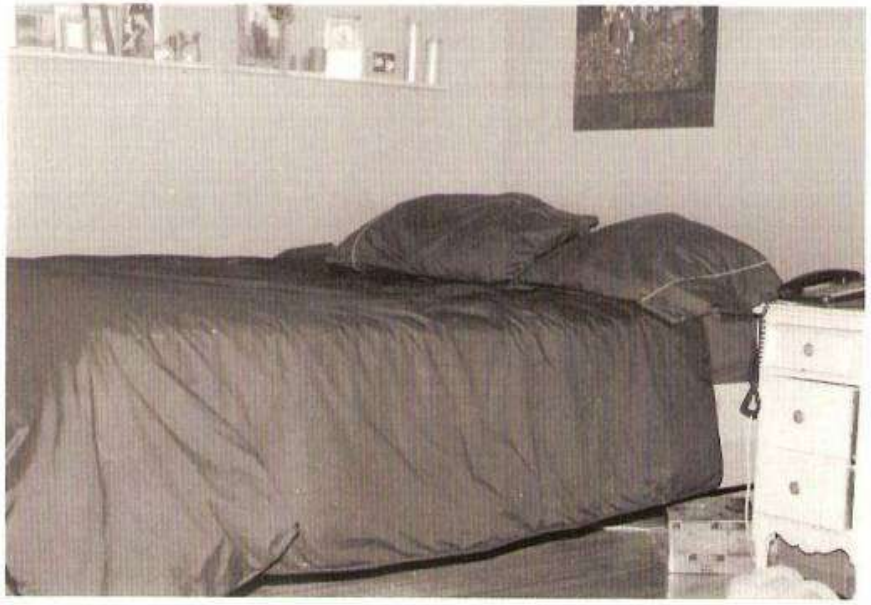
Promoting Healthy Sexuality

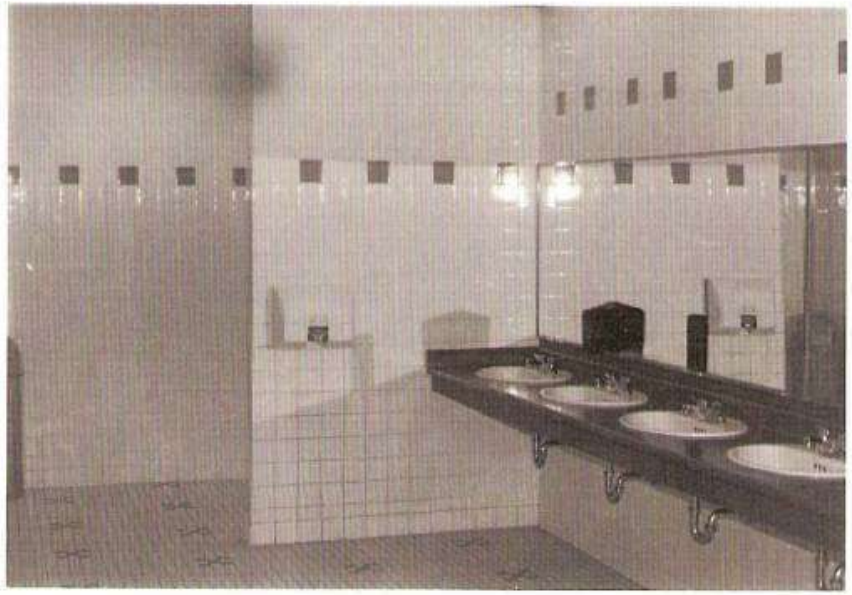
- Attitudes of professionals can greatly influence persons in care
- This may lead to unhealthy ideas and beliefs about sexuality and their bodies
- Harsh words and consequences are common forms of overt pressures from staff
- Subtle expressions of disapproval such as facial expressions, body posture, etc.
- Persons in care pick up on these subtle gestures and begin to develop their own beliefs about sexuality

Challenges

- Persons with IDD often have fewer opportunities for privacy or for finding a meaningful intimate relationship
- Few individuals are taught the difference between appropriate and inappropriate sexual behavior
- Many agencies institute policies prohibiting ***any*** sexual expression within their program

Location Laminate D





Pornography

- Pornography vs. Erotica
- Appropriate vs. inappropriate imagery
- “Sexy Pictures”
- Healthy masturbation (including videos)

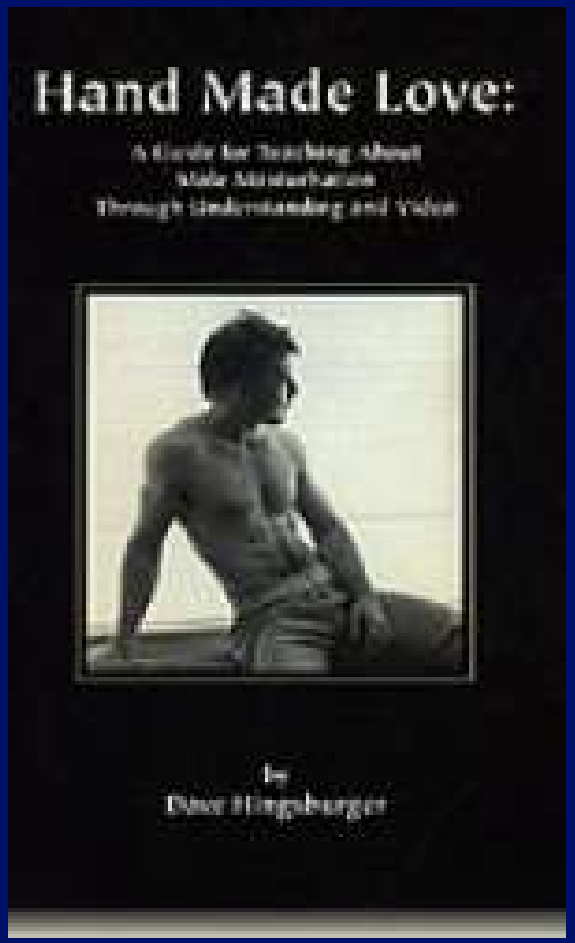
Healthy Masturbation Protocol

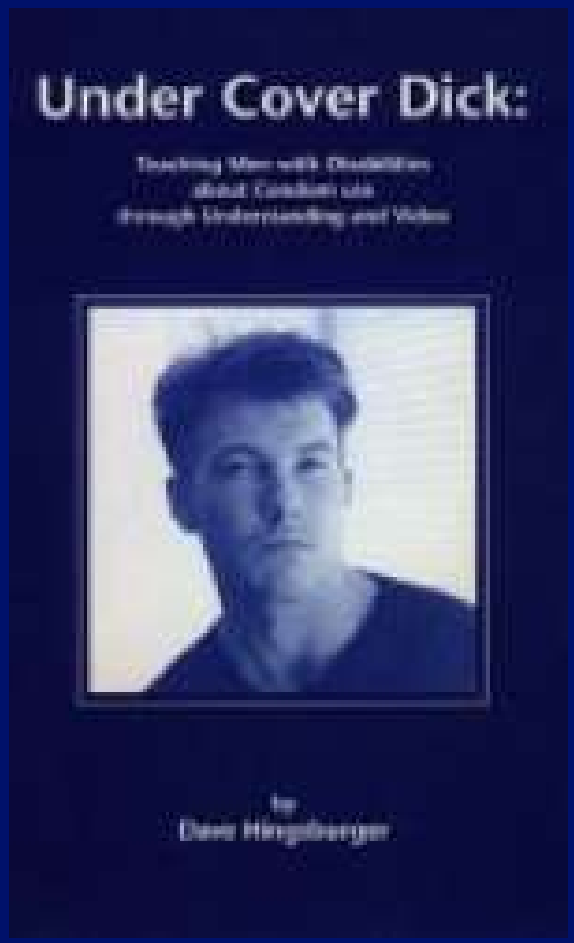
1. All of my pictures must be legal. I cannot have pictures that are against the law.
2. My pictures are provided by (*Name of Agency or therapist*) and they meet the following rules. They do not contain any of the following:
   a. Objectifying the body (makes the person non-human)
   b. Violence of any kind
   c. Rape, sex with children, or any other illegal behaviour
   d. Anybody who looks like safe persons or others that I work with
   e. More than one person
3. All of my pictures will be of age-appropriate men or women.
4. I will not show my pictures to anyone. I will not show the pictures to anyone in my home, or to guests. If I have any questions about the pictures, I will only speak to (*name those who have provided the pictures*).
5. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private. They are to remain in my room and to never be taken out of the home.
6. I will keep my pictures in an envelope/folder. I will keep all my supplies (pictures, Healthy Masturbation Protocol, lubrication, Fantasy Starter [optional], data sheets, and wet wipes) in a safe place where no one else can find them. They will be put safely away after I use them, so that no one coming into my room can see them.
7. If I show my pictures to anyone I will lose them for a period of time, which will be determined by (*name of person setting up protocol*). If I share them a second time, then they may be removed altogether.
8. I will only fantasize to the individuals on the pictures (or to my Fantasy Starter) while I am masturbating.
9. Should I want different pictures in the future, I will speak to (*name of person setting up protocol*).
10. I will be very careful with my hygiene:
    a. I will make sure that I wash my hands before I masturbate.
    b. I will use wet wipes or tissues to clean my hands.
    c. I will clean off the pictures with a fresh wet wipe.
    d. I will use sanitizing wipes to clean any part of my room that I have touched.
    e. I will use sanitizer for my hands before leaving my room, and then I will go and wash my hands thoroughly in the washroom.
    f. Should I feel that a shower would be best to clean myself thoroughly, I will do so.
11. If I abuse my genital area in any way or violate any of the above agreements, my kit may be removed.
12. Self-reporting—it is a good idea to write about masturbation activity on a calendar. I will try to write about 1) Successful Ejaculation, and 2) Type of thoughts and fantasies involved. I will keep this data private in my kit. Being honest and open with those directly involved in my treatment about my fantasies and masturbation practices is an important part of my ongoing treatment.

_____	_____	_____
(*Client*)	(*Person establishing protocol*)	Date

Dave Hingsburger

Diverse City Press





Media Contracts

- All forms of media must be reviewed for appropriate content dependent on the needs of the person in care
- TV, internet, video games, books, magazines, newspapers, catalogues, Play Station 3, Wii systems, iPods, etc.
- TV programs need to be monitored for type of individuals in the media, (e.g., children, women), amount of nudity, amount of violence—what is fine for one person is another person's pornography—for example, diaper commercials

Computer, Laptop, and Wireless Device Safety Agreement

The following is a contract, which outlines _____ (individual's name)'s obligation to use his/her computer (laptop) and all wireless-capable devices in a safe and responsible manner. This agreement also applies to the Wii wireless game system and any other wireless- or Internet-capable device in any location. This includes all gaming devices, watches with memory storage, cell phones, MP3 players, cameras and digital picture frames.

1. Administrative changes to the computer are limited to _____ (designated safe persons) who have a special password, which is required to add, remove, or change programs. The administrator has disabled capacities to burn CDs and connect to the Internet.
2. Any removable data storage devices such as memory cards, memory-sticks, CDs, DVDs, CDRWs, including rewritable game cartridges, are not permitted.
3. _____ (the user) is expected to use the computer in a safe and responsible manner and must have all viewable (non-recordable) media i.e., VCDs, CDs, or DVDs screened by _____ (designated safe person) before purchasing and/or viewing. The user is also accountable for all content that they have written in word processing programs to be of an appropriate nature.
4. _____ has agreed that it is not safe to take her/his computer or any wireless-capable device on home visits or anywhere outside the home unless special permission is obtained from _____ (designated safe person).
5. _____ (designated safe person) reserves the opportunity to do a computer or wireless device spot check and view the device's contents to ensure that it contains appropriate content and that it has been used appropriately and safely.
6. (If applicable) All provisions set forth in the media agreement for the house also apply to computers and wireless devices. This means that the lending, borrowing, trading, giving, selling, or acquiring any data or data storage device from anyone is **not permitted**. This includes all data files such as pictures, video, music, etc. Purchasing music/data from online stores or approved sources will be supervised by a designated safe person.
7. The individual is aware that any violation of this contract will result in the suspension of computer/device privileges for an amount of time determined by the safe person/ support team.

_____ _____

Individual Safe Person

Dated: _____

Rules for Keeping My Pictures

1. All of my pictures must be legal. I cannot have pictures that are against the law.
2. I cannot have pictures that:
   a. objectify the body (make the person non-human),
   b. show pain or hurting,
   c. show rape, sex with children, or any other illegal behaviour,
   d. resemble staff or others that I work with, or
   e. have more than one person in them.
3. All of my pictures will be of age-appropriate men or women.
4. I will not show my pictures to anyone. I will not show my pictures to anyone in my home or to guests. I will not show my pictures to anyone at work. If I have questions about my pictures, I will speak only to _____ [support person].
5. _____ [support person] must approve my pictures.
6. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private.
7. I will keep my pictures in the following safe place: _____, where nobody else can find them. I will put my pictures back in the safe place after I finish using them, so that nobody coming into my room will see them.
8. If I show my pictures to anyone, I will lose them for a period of time to be determined by _____ [support person]. If I show them a second time, they may be removed altogether.
9. If I am practising inappropriate masturbation in my bedroom with my pictures (for example, if I am urinating or harming myself), I will lose them for a period of time to be determined by _____ [support person]. If I inappropriately masturbate a second time, I may lose my pictures altogether.
10. I will fantasize about the individuals in the pictures only while I am masturbating.
11. If I want different pictures in the future, I will speak to _____ [support person].

_____ Client

_____ Support Person

_____ Date

_____ Support Person

Challenges

What if the sexual practices of the person in care are ***unusual*** or ***abnormal***?

An incredibly brief summary …

Tips to Maximize Case Management Efficacy

- Follow the RNR principles
- Be data driven and remember those data when setting policy and practice guidelines
  - Evidence-based decision-making, not decision-based evidence-making
- Collaborate (in your work and advocacy)
- Involve the community-at-large; they can help
- Engage in knowledge transfer whenever possible
- **Responsivity, Responsivity, Responsivity**

The Bottom Line

Science-based Risk Assessment

+ Effective Treatment
+ RNR-based Re-entry
+ Emphasis on Responsivity
+ Collaboration efforts

= Effective practices and safer communities

The safest "offender" ...

Gwen Willis

- Has a place to live
- Is connected to support people to whom he or she is accountable
- Has work
- Has everything to lose by engaging in a new offending behavior

Closing Thoughts

Research has clearly shown that a collaborative approach which includes representation from all stakeholders can assist considerably in enhancing public safety, client abilities, and accountability for all. Working together, we can manage the risk.

Teamwork is the key,
and the community has an integral role
to play in public safety!!

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