

## Community-Based Supports for Individuals with Developmental Disabilities and a History of Sexual Offense

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## **Community-Based Supports for Individuals with Developmental Disabilities and a History of Sexual Offense**

Suzanne arrived at work at the group home early on a Saturday spring morning. She was looking forward to the day as she was accompanying several people who lived in the group home on a trip to the city zoo. She had worked for the agency for about seven years. They were never able to do enough of these day trips as far as she was concerned. She got to work in plenty of time to help people get ready for the trip. She checked to make sure each person brought a light jacket and had water and snacks for the van ride.

A new person had just moved to the group home. Larry was 28 years old and she knew he was quite independent from the little time she had spent with him. She was looking forward to getting to know him better on the trip to the zoo.



When they all boarded the van, Julie, the residence supervisor got in the driver seat and Suzanne got in the back on the bench seat. Larry sat next to Suzanne. After the vehicle had been going for about 20 minutes, Larry began to seizure. He fell over, hands and arms flailing over her hair, her breasts, her calves. His head hit her first at her shoulder, and slowly followed down her chest and her belly. He ended up quietly resting with his face and chest in her lap.

Suzanne was somewhat concerned about him as he did not respond to her calling his name. She didn't know what to do, as she could not lift him off of her lap. She waited, not knowing what to do with her hands and arms as her instinct told her not to cradle him or touch him further. Eventually he did get up. He never said a word about the event. She turned her body away, with her back to him, as much as she could with her seat belt on, for the rest of the trip. On the return trip, she made sure that he sat alone.

She learned later that he had no medical history of seizures, and he had been accused of sexual offenses. She had just been another one of his victims.

### **Questions for Personal Reflection**

*How would you feel if you were Suzanne?*

*How would you feel if you were Larry?*

*What should Julie, the residential manager have done differently?*

*What should Suzanne have done differently?*

*What do you think about her instincts?*

*What should staff learn about new people before they work with them?*

## Introduction

If you have been in the field of disabilities for a while, you have been trained to respect rights, privacy, choice and self-determination. All of your training has convinced you that consumers of services are people who just happen to have a disability, and we should focus on the abilities, strengths and unique gifts that each person offers. It becomes our job, for some our passion and life's work, to demonstrate to society the value and significance of these people who are not less than, just different than others.

If you are now going to work with people who are, or suspected of being sexual offenders, everything you know is turned upside down. The person's life and plan is no longer focused on rights and self expression. It is focused on the responsibility to society. His rights become secondary. His uniqueness becomes a reason for constant oversight and scrutiny.

This new assignment requires a different mentality with an entirely different approach and response to the person and his behavior. You are now expected to be vigilant in protecting society from this perpetrator with developmental disabilities. Your role becomes one of protecting neighbors, or other persons with disabilities, from becoming a victim of sexual offense.

Communities may be at risk for victimization on various levels and in different ways when individuals with a history of sexual offense live in their neighborhoods. David Hingsburger (2002) recommends that we spend time determining, "Who do we support?" when providing community-based supports to individuals with DD and a history of sexual offense. Hingsburger contends that we are responsible to each of these groups:

- **Neighbors.** The neighborhood has expectations of safety. We need to take our job of protecting neighbors very seriously.
- **All people with disabilities.** An offense by one person with DD, unfortunately reinforces old myths that all people with disabilities are sexual offenders. By protecting community members from sexual offense, you will help ensure that all people with disabilities retain their rightful place in the community. Protecting the community from offense sustains a positive reputation for people with developmental disabilities
- **Agencies who serve people with developmental disabilities.** Offending behavior by individuals served can place the agency at risk. It threatens employment of all employees, and services to all those served.
- **Taxpayers.** Citizens expect us to serve our primary consumer. If people didn't have a disability they wouldn't need any services.
- **Individual with disabilities and history of sexual offense.** Prison is not a proper environment for treatment of a person with a cognitive disability. The person has a right to secure, safe placement, and respectful treatment.



Hingsburger's work provides us with food for thought about the importance of this work, and the responsibility carried by all agency staff.

Some of the skills that it takes to work with these offenders are different than those skills employed with non-offending people with disabilities. Your knowledge base must be expanded so you understand this new challenge and can respond appropriately.

**Note:** As we approach this topic, it is important to keep in mind some individuals with DD and a history of sexual offense actually HAVE NOT committed a deliberate sexual act against a non-consenting victim. Some people have acquired this label due to an inadvertent act that was perceived by others to be a sexual offense, when in fact the person merely lacked social judgment or experience. This note is not meant to diminish the importance of following the recommendations in the training plan for the each individual who has a history of sexual offense. The caution is given to stress the importance of following the individualized treatment plan for each person. Do not assume everyone with the label is treated the same.

## **Feedback Exercise Introduction**

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1. Who do you serve? Explain each of the five categories.

## Chapter 1: Sexuality and Developmental Disabilities

### Myths

Stereotypes, myths and old-wives tales die hard. For years, people with developmental disabilities have been thought of in two extremes, both demeaning and stigmatizing. They have been thought of as innocent ‘children of God’ who needed protection. Or, they have been thought of as perpetrators of unrestrained impulses, violence and criminal behavior from whom society needed to be protected. Neither of these views are realistic, of course. Although, after decades, there are still those who cling to those beliefs.

#### Question for Personal Reflection

*What other myths have you heard about the sexuality of people with developmental disabilities?*

### Reality

The reality is that most people with developmental disabilities have historically not been offered meaningful, understandable sex education. Most have been given little opportunity to develop sexual relationships. They don’t know how to select partners and develop appropriate relationships. They have been deprived of an understanding of ‘courtship behavior’. Many have become used to having staff or family members touch their body to clean, groom, dress and care for them, so they don’t know appropriate touch from inappropriate touch.



Some people with cognitive disabilities have trouble understanding the differences in appropriate social behaviors within various types of relationships. Many people with intellectual disabilities do not get enough training in differentiating the types of relationships and acceptable behaviors within those relationships. For example, acquaintances shake hands, friends may hug, wives and husbands share sexual intimacy. This concept is sometimes referred to as ‘boundary differentiation’.

Deficits can also be seen in general social skills and impulse control. People with intellectual disabilities may also misinterpret the nuances and subtleties of other’s tone of voice, behaviors, facial expressions and body language. Jill Schoen, a therapist from South Dakota Developmental Center, reported that a man she had treated there for sexual offenses “developed a friendship with a mentally retarded female while in a community residence. As soon as she indicated a friendly interest, he fondled her breasts without permission in an inappropriate public setting. He was, as a result, reinstitutionalized.” **Shoen encourages us to question whether, in some cases,**

**the team should focus on training for skill deficits, rather than treat for pathology (i.e., sexual offense).**

This lack of knowledge can be the reason for people with disabilities becoming a victim of sexual perpetrators. It can also be a reason for people with disabilities to be at risk of offending others. Therein lies the difficulty for professionals to determine if the deviant behavior is a sexual offense or simply offensive behavior. The difference lies in the motive or intent. While it is crucial for the treatment team to understand intent in planning the subsequent treatment of the perpetrator or offender, **this differentiation would make no difference to traumatized victims.**

One sexual offense by a person with an intellectual disability will reinforce old myths and prejudices against all people with DD. It could have a neighborhood up in arms and allow them to justify intolerance of all persons with disabilities. So, regardless of the reason for any inappropriate sexual behavior, the public must be protected from further offense from those who have offended. Perhaps the appropriate supports for some individuals would include helping them acquire information or experience that will keep them from getting in trouble again. Here is an example:



*Maybe a person who is arrested for masturbating in the city park, needs to learn that the only place it's permissible to masturbate is in a private place like his own bedroom or bathroom. His offense probably occurred because he didn't know where this behavior was appropriate, NOT because he had a need to be seen masturbating in public. In this case, the appropriate supports would be to teach discrimination skills. While the person is learning these skills however, there would need to be supervision to insure he would not inadvertently re-offend.*

**Question for Personal Reflection**

*Did this information in this chapter shatter any myths you believed?*

## Feedback Exercises

### Chapter 1

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1. It is possible that people are labeled a 'sexual offender' when they have not purposely committed a sexual offense. Explain:
2. What skill deficits can lead to a behavior that might be seen as a sexual offense?
3. What difference, if any, does the behavioral motive or intent make? Why?
4. Explain 'boundary differentiation':
5. What types of behaviors do you think of when you hear "courtship behavior" in relation to sexual offense?

## Chapter 2: Sexual Offense by People with Developmental Disabilities

### Demographics

Various researchers report that up to 10% of those who are incarcerated in prisons, and up to 5% of those who are in state institutions, are mentally retarded. This is substantially higher than the incidence found in the society at large (1-3%) (Arc, 2004). Several factors may contribute to this situation.



Sometimes, a person with an intellectual disability is lured into criminal activity by others and then left to take the blame. Due to cognitive deficits, the person with intellectual disability is often caught while the others involved escape or evade the law. If a person with intellectual disability is scared, intimidated or doesn't want to admit a lack of understanding for fear of looking "stupid", he may not deny accusations. Failure to declare innocence or stand up for oneself may be interpreted as a confession.

By and large, most sexual offenders with developmental disabilities are male who may start offending as early as adolescence. Their level of intellectual disability is usually in the borderline to mild range, although some fall in the moderate range. Developmentally, they are ego-centric, in that they are only able to relate to their own feelings. At this developmental stage they are not able cognitively to empathize with their victims. The lack of ability to understand what others feel is a result of their intellectual disability. People with mild or moderate intellectual disability function at a concrete level – they cannot think abstractly. This has direct effects on the choice of treatment methods, such as victim empathy, commonly used with sexual or criminal offenders of average intelligence.

#### Question for Personal Reflection

*What information above surprised you?*

### Incidence of Multiple Diagnoses



The work done with sexual offenders with intellectual disabilities indicates that they have poor relationships with their peers, a lack of socio-sexual knowledge, deficits in social skills and frequently a history of having been sexually abused themselves. Victims of offenders with intellectual disability may be men or women and children or adults. The highest recidivism (repeat behavior) rate is with men who prefer to sexually aggress against males.

A high percentage of those who sexually offend also have an adjustment disorder. This means they may have hostility to females, low self-esteem, inadequacy and powerlessness, or gender-identity confusion. Many are found to have some mental illness along with intellectual disability, such as borderline personality disorder, depression, schizophrenia or bi-polar disorder. These diagnoses as well as organic or traumatic brain injury can produce inappropriate sexual behaviors. When these additional factors are present in a person with developmental disabilities, treating and supporting them becomes even more complex.

Like any criminal, denial of any unacceptable activity is common. Some do not admit to the behavior at all for up to a year or longer even when in a weekly, specialized therapy group. Even then, they can deny the severity and the frequency of the offensive behavior. Excuses are numerous: “I didn’t think it bothered her.” “I thought she would forget it.” This is called ‘thinking errors’ or ‘criminal thinking’.

It is important to recognize that only a small proportion of people with developmental disabilities commit sexual offenses. These offenders may have other types of or levels of disability that makes their situation and treatment very complex. It is difficult to see much progress during treatment. You are not going to see positive changes in the short term. It will take a long time, probably years, and a lot of support.

### Question for Personal Reflection

*Are you able to wait for years to see success?*

## Types of Offense Patterns

### Predatory

Some offenders are predators who select a victim, watch, observe, stalk, and plan their offense. These individuals are very capable cognitively and can control their impulses. They challenge the limits of authority and are calculating, manipulative, and are the most dangerous. They must be in ‘line of sight’ at all times. Few true sexual predators have developmental disabilities due to the forethought and planning necessary.



### Opportunistic

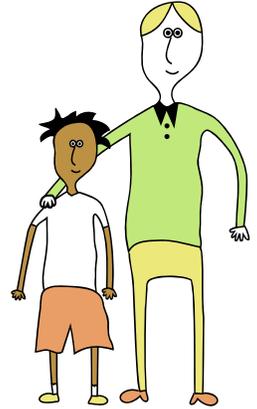
Most offenders seen in ND community programs for individuals with DD offend only when an opportunity presents itself. They look for such an opportunity in which they will not be detected. They usually respond well to treatment and do not offend when they know they are closely supervised. If there is a weak link in supervision, an opportunistic offender will find it and take advantage of it to offend again. **This means staff must control the offenders access to people who may be victimized.**

## Impulsive

Unlike the two patterns above, impulsive offenders have no premeditation in their criminal behavior. They act spontaneously, often on a whim, due to their inability to control their own impulses. Some are so severely impacted they can be diagnosed with impulsivity control disorder.

## Inadvertent (unintentional or accidental)

Some people with poor impulse control have been accused of offending when they may actually have been 'naïve', and as a result become labeled as a sexual offender. An example is a man who affectionately and innocently hugs an unrelated child in public, and is then accused of being sexually aggressive. Although the man's motivation was not sexual, the interpretation of observers was that it was sexual. Fair or unfair, sometimes the connotation is as much or more about the observer's beliefs about the person with a disability as it is the behavior, due to historical misperceptions.



## Types of Offenses

There is a range of sexual behaviors that society does not accept.

### Nuisance

This behavior is not assaultive, but involves non-consenting victims. Nuisance behaviors include public masturbation, indecent exposure, fetishism and verbal descriptions of sexual aggression. Even if some of these behaviors don't cause physical harm to others, they would frighten and alarm most innocent victims. One study found that nuisance behaviors were more likely to be displayed by offenders who were mentally retarded than those who are not.

### Assaultive

Assaultive sexual behavior, includes touching, fondling, penetration or attempted intercourse with a non-consenting partner or a partner too young to give consent.

### Consent To

This includes hetero or homosexual activity with a consenting partner who is considered by society to be **inappropriate** due to age or ability.

Each of these categories would be approached differently in therapy.

### Question for Personal Reflection

*If you know someone accused of sexual offenses, within which category does their behavior fall? How do you feel about their behavior?*

## Feedback Exercises Chapter 2

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1. Why do you think people with intellectual disabilities are caught and accomplices may not be?
  
2. People with intellectual disabilities function at a \_\_\_\_\_ level. This means that:
  
3. Identify three other diagnoses that an offender with retardation may have:
  - 
  - 
  -
  
4. Name and explain the four types of offense patterns:
  - 
  - 
  - 
  -
  
5. What is meant by ego-centric?
  
6. Sexual offenders with intellectual disabilities frequently have a history of having been \_\_\_\_\_ themselves.
  
7. The highest recidivism rate is with \_\_\_\_\_ who prefer to sexually aggress against \_\_\_\_\_.
  
8. Dual diagnosis means \_\_\_\_\_ along with \_\_\_\_\_.
  
9. Denial of any wrongdoing, very common in offenders, is often referred to as \_\_\_\_\_ or \_\_\_\_\_.
  
10. The most dangerous offender has this type of offender pattern: \_\_\_\_\_
  
11. Which of the four types of offenses are more often displayed by people with intellectual disabilities?

## Chapter 3: People with DD and & the Criminal Justice system

The court system can be very confusing, therefore not meaningful for some people with intellectual disabilities. An example of this is the young man who, when asked by an officer of the court to waive his rights, held up his right arm and waved his hand. Today the emphasis is on trying to keep the accused out of the courts, jail, and prison, as many people with cognitive disabilities do not benefit from the traditional criminal justice processes.

### Competency

Common law requires that three criterion must be met to be determined competent to stand trial.

1. The ability to work with an attorney
2. Basic knowledge of the workings of the court
3. Understanding of the possible consequences if found guilty

The evaluation of competency is a complex process, involving both clinical and legal knowledge. Historically, the process of proving “competency to stand trial,” meant that the person could be held in limbo indefinitely, never found to be competent. If a person with an intellectual disability is found competent and sent to trial, the time between accusation and consequence can be several months or years. Because of limitations in the person’s ability to think abstractly, he cannot make a connection between the activity and punishment.



#### Question for Personal Reflection

*Would the people you support be able to pass the competency criterion?*

### Levels of Sexual Offense

Individuals who are convicted of different levels of sexual offense may be served in community treatment programs. There may be some who were found competent, adjudicated (a judgment in court was rendered), imprisoned and paroled. The relatively new Megan’s Law requires anyone convicted of a sexual offense against a child, to register in their town as a sexual offender after they serve their term of incarceration and return to society.

Some situations may have been very high profile in the community and resulted in facility placement, probation or institutionalization. A person may be well known due to an accusation of a sexual offense that received a lot of press and attention. The accusers may have agreed to not file charges if the person was institutionalized, kept from others, tracked, followed and/or treated at the North Dakota Developmental Center.

A person may have been accused of offending and/or terribly frightening someone with nuisance behaviors, and taken into custody. The police, not knowing what to do with the person, and in order to avoid criminal charges, returned him to the community program without any specific restrictions.

**Question for Personal Reflection**

*Have you heard of Megan's law?*

**Over and Under Responses**



It may be difficult to make sense of the legal penalties. You will find that there may be no consistency in the legal actions and the consequences to the people who offended. Because decisions are made at many levels of law enforcement, there is little uniformity to the handling of complaints or charges. Police officers, the district attorney or a judge can determine how a case proceeds. At any point in the criminal justice process, the case might be dismissed or aggressively prosecuted. This variability results in some people paying a heavy debt to society and others who pay no consequence.

*John, who has an intellectual disability, was 21 years old when he hung around a couple of adolescents after school. One day, they talked him into 'playing doctor' with a child on the playground. When they got caught, the two adolescents each got probation for 2 years. John was sent to an institution and has been there for 13 years. No charges have ever been filed against him.*

Today we have a system in place, so it is likely that individuals who offend will have a justice plan to support them in a stable environment so opportunities to be accused again are limited.

**Question for Personal Reflection**

*Have you ever felt that the 'system' has been inconsistent or unfair?*

**Individualized Justice Plans**

Individual Justice Plans are developed for accused offenders or people who have a history of coming into contact with the law. These plans include alternatives to a trial or prison, and may be a condition for probation. These plans are developed by a team of professionals in the areas of disabilities, law, and law enforcement. The team may include therapists, lawyers, police, judges, and advocates. These plans are put



into place as an alternative to a person with developmental disabilities having to enter into the long, confusing and complex world of the criminal justice system. Appendix B contains a sample IJP.

As with any individualized plan, the outcome will be different for each person, but the purpose is to try to keep the individual from reoffending or being accused of offending, to protect the community and to avoid criminal proceedings or sentencing. The plan will outline the specifics of probation, and supports to avoid opportunities to offend, i.e. environmental limitations or rights restrictions.

Some people, due to their disability, will need support to fulfill any legal requirements. Staff are responsible to ensure the terms of the plan are not violated, i.e. arrange for transportation to probation meetings, identifying time one must leave to arrive on time, getting to & from labs for urine screens, attendance at Alcoholics Anonymous or Narcotics Anonymous meetings. Successful advocacy and building relationships with the criminal justice community is an expectation of all staff who work with people who have offended.

**Question for Personal Reflection**

**Have you seen or read an IJP?**

## Feedback Exercises

### Chapter 3

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1. What is considered best practice for individuals with cognitive disabilities who are convicted of crimes? Explain why.
  
2. List the three criterion which must be met to be determined competent to stand trial:  
-  
-  
-
  
3. Megan's Law is for offenders who have victimized \_\_\_\_\_.
  
4. What is the purpose of an IJP?

## Chapter 4: Treatment

North Dakota Developmental Center provides an in-patient, specialized program with qualified therapists. In this setting, various approaches or therapies are integrated for each individual based upon their own needs as identified through an assessment and outlined in an individualized plan, with specific goals and objectives. The strategies used are current best practice approaches used with sexual offenders who do not have cognitive disabilities. In some cases the therapies may be modified so that a person with intellectual disabilities is able to benefit from the intervention/teaching. While the person is in this program, he is in a therapeutic environment for 24 hours a day. The challenge of the direct support professional in the community is to continue to follow the individualized plan that addresses the sexual offending behavior as well as other personal outcomes identified in the individual's plan.

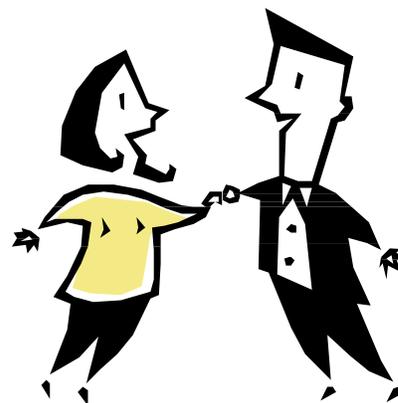
### Skill Development

Social and socio-sexual skill development is a priority for most individuals, because not having these skills often leads to stigmatization, depression, loneliness and isolation. The individualized plan will include areas that the team, including the person with a disability, has decided are most important. Some examples include:

- Greeting others
- Boundaries (proper touch) and social roles
- Assertiveness
- Conversational skills

These skills are best taught through practice in role-play and in actual social situations. They are complex behaviors and will require many repetitions, with a variety of different staff and in a variety of settings before the person learns. All staff need to be consistent in the way they teach the person. The words used and the feedback given must be the same in all situations.

Sometimes, writing scripts for staff and the offender helps the person learn the desired behavior. For example, "Stay this far away." "That's too close." "Back away."



Sex education and developing sexual relationships is included in this area, as there may be many myths and misinformation that must be shattered. Historically most training in this area has been insufficient and or non-specific enough to allow the person to learn appropriate behavior. It has been found that people who offend others often don't know the proper dating behaviors making them more likely to be perpetrators or victims.

Training in other areas also may be a part of the person's individualized plan. Some plans for offenders with intellectual disabilities may include skill building in the following areas (Mikkelsen & Stelk, 199; Haaven, Little, & Petree-Miller, 1990):

- Academics: Improvement in basic capabilities has shown a decrease in inappropriate behavior.
- Leisure skills: Pivotal in keeping the mind and the body busy with positive behaviors.
- Self management/Self control: Including coping skills, anger management, and stress management.

## Medical/Psychiatric Treatment-Focus Area

Mental illness combined with intellectual disability, or dual diagnosis, increases the complexity of treatment. The proper medications and proper administration of those medications is priority. Close medical oversight is necessary in some cases. Some programs include basic health education to increase overall health and to teach the person how to recognize the need to seek medical help.



## Alcohol/Drug Treatment

If not addressed, substance abuse can override any attempts to teach impulse control and behavior change. Alcohol and drug use must be part of the therapeutic treatment. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are accepted treatment approaches. Sobriety is reinforced as a key to non-offending.

People with cognitive disabilities will not learn the 12 step concepts by attending only one meeting per week. They need repetition and practice opportunities to learn the language and recovery behaviors. If all staff are familiar with the program language and use it in everyday activities, the individual is more likely to be successful.



The confidentiality restrictions for closed meetings for these groups will prevent staff who are not in recovery from attending the meetings. If the offender's plan requires 24-hour line of site supervision, he cannot attend community meetings without staff. Therefore the only staff who could attend are those in recovery themselves. However, it is not advised for staff to reveal information about themselves in front of an offender whom they

support. In other words, the staff would need to attend meetings at a separate time from the individuals they support.

## Personality Disorder Treatment

Deviant behavior is common in individuals with a distorted perception of the world and themselves in it. This distorted thinking is commonly seen in people who perform criminal behavior. A person with a personality disorder may swing between feelings of being super-powerful and powerlessness. So they act from a sense of being in control of the situation or as a victim of external events.



The back and forth flow of a pendulum might provide a picture of this imbalance. When the pendulum is at the highest point on the right side, Kenny feels super-powerful, elated, and superior. However, when he is low, he will desire to return to the high point. His thinking might follow this pattern, “I feel powerless to control things, but I know that I can take control of a situation by fondling little boys. This behavior will make me feel ‘high’ again, so I can feel good about myself.” Kenny tells himself that little boys like him accosting them, and that he’s really a good guy as he’s giving them what they want. He feels in control and he seeks that feeling when things aren’t going his way. For some offenders, this is so extreme they get an adrenaline rush, and excitement they find no other way.

When the pendulum is on the left side, Kenny feels worthless, hopeless, angry, dejected. He can blame others for his feeling this way. He may feel left out, like he can’t perform satisfactorily, or that he is a bad person. “Poor me, it’s someone else’s fault.” (i.e., the staff or the roommate.) He can quickly swing to this side when he is corrected, doesn’t get his way or something he wants, is criticized or afraid or makes an error. For some individuals, this is so extreme they feel powerless, less than zero, dumb and embarrassed. In their attempt to gain control, they may act out the behavior that gives them that high feeling again.

It is important to realize that the basis of offending behavior may not be about sex at all. For some, the behavior is about the power and control the person feels. The offender either feels too much power or not enough and he uses the offending behavior to compensate.

The therapeutic focus is on the individual finding a balance of choice-making and taking responsibility for those choices. Staff can assist the person by supporting him to find his own personal power. It will help to respond with, “We all make mistakes. It’s okay to make a mistake. We learn from our mistakes. Try that again, I’ll help you.” Recognition, compliments (when deserved) and gentle awareness of choices of behavior helps. Behavior contracting is a common form of treatment. The goal is to find a balance somewhere in the middle of the pendulum swing, where the person is in control, knows he is neither superhuman or zero-state, but an average guy making personal choices and being responsible for them.

## **Sexual Deviancy Treatment**

Some offenders need concerted efforts on changing their deviant sexual behaviors. There are various methods available, these are the most commonly used:

### **Arousal Control and Cognitive Restructuring**

The person is assisted to identify his specific thoughts, fantasies, literature or pictures that cause sexual arousal, and his inappropriate sexual behaviors. Then, he is assisted to find alternatives to his inappropriate sexual behavior.



## Appropriate Relationship Development

Social anxiety, in addition to lack of knowledge, is a common reason for a person's lack of developing appropriate relationships. Desensitizing the person to interact with peers and staff of the opposite sex can help overcome social anxiety. In addition, there are resources available to teach adults with developmental disabilities about "courtship behaviors", appropriate sexual relationships, and selecting appropriate partners.



## Maintenance

When a person's deviant arousal patterns have been reduced and has been able to maintain the reduction over time, he is prepared for transition into a community setting.

When a person has replaced the offending behavior with a more appropriate behavior, the treatment team may recommend a gradual reduction in supervision and controls. However, staff must stay vigilant and watch for signs of relapse. The transition team continues to implement the relapse prevention plan (i.e, stay busy, avoid triggers), remains supportive, and attends to (reinforces) appropriate behaviors.

### Question for Personal Reflection

*Do you think that sexual offenders can be rehabilitated?*

**Note:** Across the country, neighborhoods and communities are very sensitive to the label "sex offender." While this vigilance is understandable, it is important to remember that many people with DD and a "history of sexual offense" have never been charged or convicted. They may have been institutionalized at a time when there weren't more appropriate treatment options for individuals with cognitive disabilities. They may have entered the institution voluntarily and are only guilty of poor judgment or a lack of appropriate social skills. These are not the people that fit the classification of "Sexual Deviants". People with intellectual disabilities who have a history of inadvertent sexual offense (see Chapter 1) can learn appropriate social skills. Through discrimination training, individuals can learn when, where, and with whom different types of sexual expression are appropriate. Unless staff are able to get past personal biases (subconscious or conscious) toward people with this label, they will not be effective teachers for this population.

## Feedback Exercises

### Chapter 4

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1. The lack of socio-sexual skills can lead to:
  
2. List some types of behaviors that can be taught as socio-sexual skills:
  
3. What are some skills training areas that might benefit an individual with DD and history of sexual offense:
  
4. Written scripts would be used for
  
5. What concurrent situations make treatment more complex?
  
6. A person with a personality disorder may swing between feelings of being \_\_\_\_\_ and \_\_\_\_\_.
  
7. Staff can help a person with a personality disorder in these 3 ways:
  - 
  - 
  -
  
8. Social anxiety can cause:

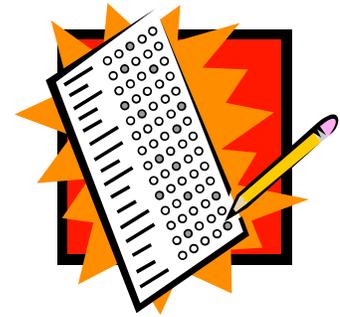
## Chapter 5: Relapse Prevention Planning

Each person who has offended and is going to live and continue treatment in the community is involved in planning for relapse prevention. The plan is a direct result of the personalized assessment of risk.

### Risk Assessment

Every offender needs a professional risk assessment performed as the primary tool in the development of his individualized plan. A qualified therapist uses scientifically based risk assessment tools, along with their own experience and knowledge. Based on the results of this assessment, they determine the likelihood of the person reoffending and/or the risk that the person is dangerous.

The results of the assessment will help the therapist recommend to the person's team how much and what type of support and supervision is needed in the future to avoid a relapse of the offending behavior.



Staff must always be vigilant, even when it appears that things are going well and progress has been made. Decisions to reduce the level of supervision or lifting other restrictions can only be made **by a team of professionals** after careful and deliberate evaluation of data that indicates a reduction in risk to the community and potential victims.

Read this example of two staff who failed to follow the plan:

*Two male staff were supposed to always be present in a home that housed three male sex offenders. One staff went grocery shopping alone. He did not take a resident, as the one scheduled to accompany him was ill that day. The other staff needed to give one resident a ride to work. Since it would only take about 10 minutes, he left the ill man and the other home alone for those few minutes. After all, they were really good guys, surely nothing would happen. Upon his return, he found that the more powerful man raped the ill man during the time he was gone.*

**The level of risk and resources needed to manage risk must be determined by a professional on the planning team.** The results of second guessing a therapist or court ordered supervision can be disastrous. What we think is easily identified may not be. And, as was illustrated in the previous example, a seemingly minor deviation from the plan can result in victimization (the man who was ill) and reinstitutionalization of the offender. Think of the ramifications to the whole program if the offender had raped an elderly neighbor or young child. **So whether staff agree or disagree, everyone is safest if the risk assessment and individualized plan are followed.**



When a person has replaced the offending behavior with a more appropriate behavior, the team may recommend reduction in supervision and controls. However, support workers must watch for signs of relapse. Staff must continue to implement the relapse prevention plan (i.e., stay busy, avoid triggers). Remain supportive and attend to the appropriate behavior.

## Offender Specific Training Plans

An individualized plan is developed, with information from the risk assessment, by the person's team. Not all offenders or offenses are treated the same way, so each plan is personalized. It is crucial to the person's success that these plans are followed across all environments and staffing. The plan will contain all the regular elements of any plan for those supported in community programs for people with DD as far as skill development, medical services, etc. But, it may contain additional elements that are not as familiar.

**Self-control programs are pivotal to relapse prevention.** The purpose is to learn, transfer and generalize ways to redirect negative behaviors. These include teaching the person to identify safe:

- people
- places
- activities

These plans also teach the offender about their own high risk factors, as identified through the risk assessment

- antecedent thoughts
- feelings
- environments that put him at risk of offending

After acknowledging the risk, the offender is taught to use his own, personalized coping strategies, such as:

- avoiding the situation
- escaping from the situation
- using stop thoughts
- contacting support

### Example:

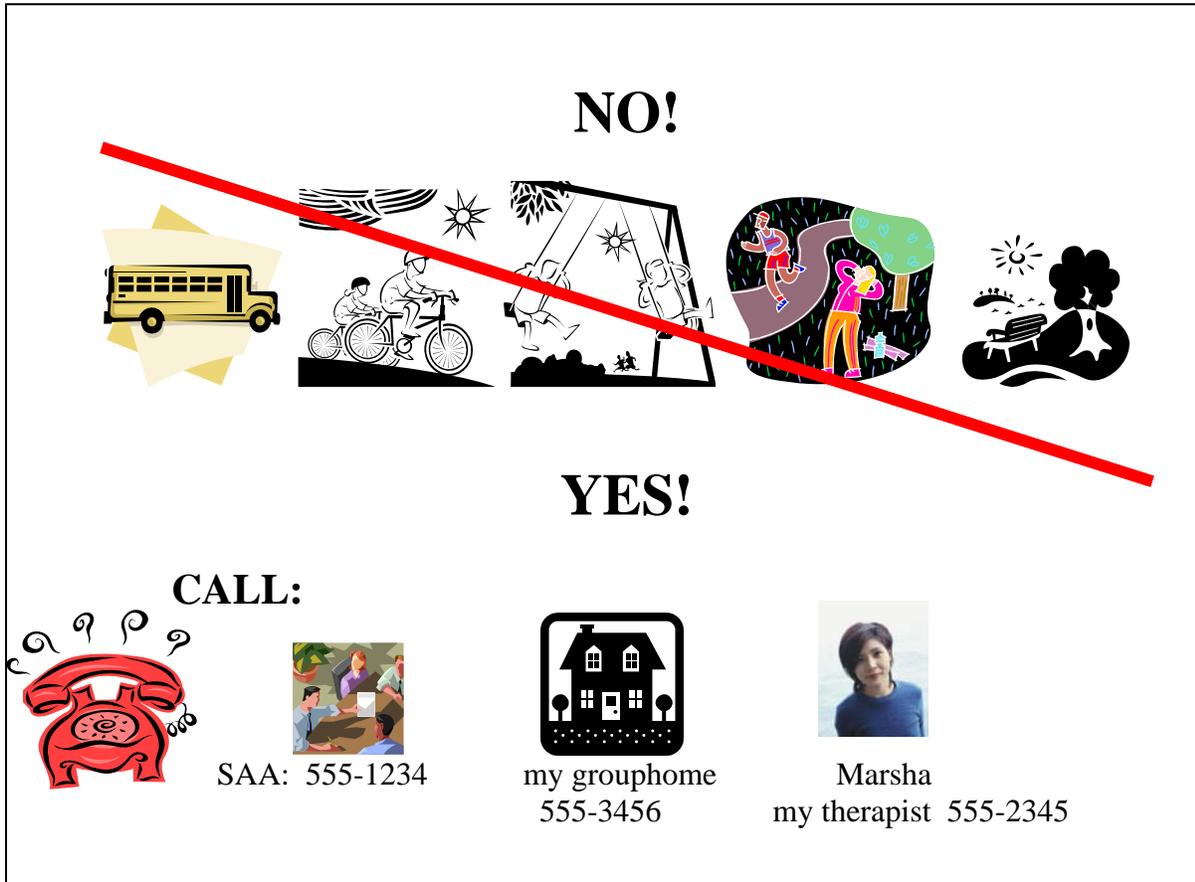
*Joseph is aware that his sexual preference for boys is not acceptable social behavior. He has identified that it is safe for him to hang around the YMCA adult basketball court, his UFO (Unidentified Flying Objects) club and the drop in center. He spends time with his fellow residents, with staff, those at the drop in center and friends who use the Internet at the library for UFO research.*

*He knows that he is at risk of offending when he gets lonely and he feels sorry for himself. His personal grooming deteriorates at that time and he begins to have strong sexual*



*feelings when thinking about boys. He considers going to schools, playgrounds or local parks, and tries to convince himself that the boys would like it, too.*

*Joseph knows that he must stay away from those dangerous places when he feels this way. He also needs to read the card (see below) he carries that instructs him to: “Go home or go to the drop in center”; repeat to himself, “STOP, I don’t need unacceptable sex.” The card also has the phone numbers of Sexual Addicts Anonymous, his therapist and his group home (from which staff will come and get him anytime he calls).*



The individualized plans may also include such items as restrictions, limitations, rules, consequences, probationary or medication requirements. Your role as support staff is to become familiar with each person’s relapse prevention plan and to help them live it every day.

While many of these skills may be taught in an individual or group therapy through role-playing situations, it is imperative that the teaching be transferred to practice in real settings. The person needs to be able to demonstrate the appropriate behaviors and demonstrate self-control in all settings and in the presence of many different people. What level of supervision is necessary for the person to use these coping strategies with 100% compliance? Most of the time it is not good enough.

## Question for Personal Reflection

*Can you follow the plan consistently and report any portions of it that don't appear to be working rather than change it yourself?*

## Antecedent Control

Anything could be an antecedent to anti-social sexual activity. Antecedents are precursors or things that occur before a behavior. Not allowing individuals to have opportunities to sexually offend is known as antecedent control.

By controlling the antecedents, victimization can often be avoided. When assisting offenders to find a place to live, it is essential to avoid areas near a school or on the school bus route and locations with views of back yards from the windows. Choose locations that do not allow pets and avoid areas where there are children or elders as neighbors. It is important to select the setting itself to control commonly known antecedents of sexual aggression.

Antecedents to anti-social sexual activity by offenders do not have to be things that we might consider erotic or sexual. Therefore, it is critical to watch each individual for signs and patterns of arousal at all times. Record comments the person makes about how these stimuli affect him and report them to others on the treatment team. Examples of antecedents include things like:

- Sounds: i.e., bus brakes, swing squeaking
- Smells: perfume, socks
- Touch: different for each person
- Animals: often the first victims of abuse by predatory offenders
- Pictures: can appear neutral to others
- Television shows and movies: can be kids shows or movies showing violence
- Advertisements in magazines for underwear, etc.
- Catalogues (i.e., lingerie, swim suits)

Become familiar with each person's antecedents to deviant sexual behavior so you can help to ensure he does not offend again.

Example: (This behavior took a long time to identify)

*William used to leave copies of small pictures of himself under chairs in staff offices or the agency meeting rooms. It seemed to be just strange or harmless until he finally disclosed his motivations. He liked to masturbate while fantasizing that he was looking at women staffers sitting in the chairs through the eyes in the pictures.*



## Random Stressors

Random stressors are those uncontrollable and unpredictable life events that can rock you to your core. The death of a parent, loss of a job, or being victimized are events that increase risk of re-offending. It is recommended to refer the individual to counselors and therapists immediately to help the person through such traumas without risk of re-offending.

## Destabilizing Factors

Destabilizing factors are those issues that may affect the person's successful rehabilitation. A history of alcohol or drug abuse, or a mental illness would be such factors. It's difficult to determine the level of risk with these two factors as there are other variables. If the person continues his medications and is committed to sobriety, he may be able to stabilize and not re-offend. On the other hand, if he, like many with mental illness, discontinues their medications for any reason, and/or he relapses into chemical dependency again, he can lose his own defenses against sexual offending. There also exists the possibility that he will reoffend and then lose control of alcohol and/or medications. It might help to think of treatment for each diagnosis as pillars supporting the person's recovery. If one pillar goes, the others become weaker.

### Example:

*David had successfully completed inpatient therapy and had lived free of offending in a specialized group home for over seven years. Then one day he bumped into some old friends who talked him into going into a bar. He relapsed and drank liquor for the first time in seven years. A week later, he sexually molested a young man.*



Staff can reinforce the involvement with a substance abuse recovery program like Alcohol Anonymous or Narcotics Anonymous and make sure the person can get to meetings. Being in a residence that reminds people of their medications can greatly aid in managing the mental illness and preventing relapse.

## Recognizing Cycles of Aggression/Offending Behavior Patterns

### Example:

*A young man was observed following teenage girls around the local mall. When the manager of the mall called and talked to the residence manager, together they decided upon the solution. The young man's access to the mall was restricted by the mall manager\*. Removing him from the trigger of his offending behavior was an effective solution.*

\* Note: This restriction is determined by the team and reviewed by the appropriate agency committees. This restriction is not an individual staff person decision to make.

When the offender behavior is truly impulsive, it is extremely difficult to treat. Treatment in these situations must involve limiting access and vigilant supervision. However, for many offenders there is a pattern or cycle of aggression. Support staff must know each person's cycle of offending behavior, watch for behavioral indicators, and intervene appropriately. Ultimately the goal is to teach the person to recognize their own cycle of aggression or offending and use the coping strategies in their relapse prevention plan, but that may take years of therapy and teaching. Until the person learns self-control to redirect their own thoughts and actions, support staff must implement the intervention plan.

The cycle of aggression may take days to unfold. In other situations, the person may escalate from an event to action in seconds. While each person's triggers and responses are truly individual, the cycle often looks like this:

**Event:** Something happens. Anything can trigger the cycle. It can be anything from having a bad morning to seeing someone the person likes or doesn't like.

**Negative anticipation:** The person obsesses on the event. "Now my whole day will be bad."

**Avoidance:** Doing things to avoid interaction with staff or others who could help.

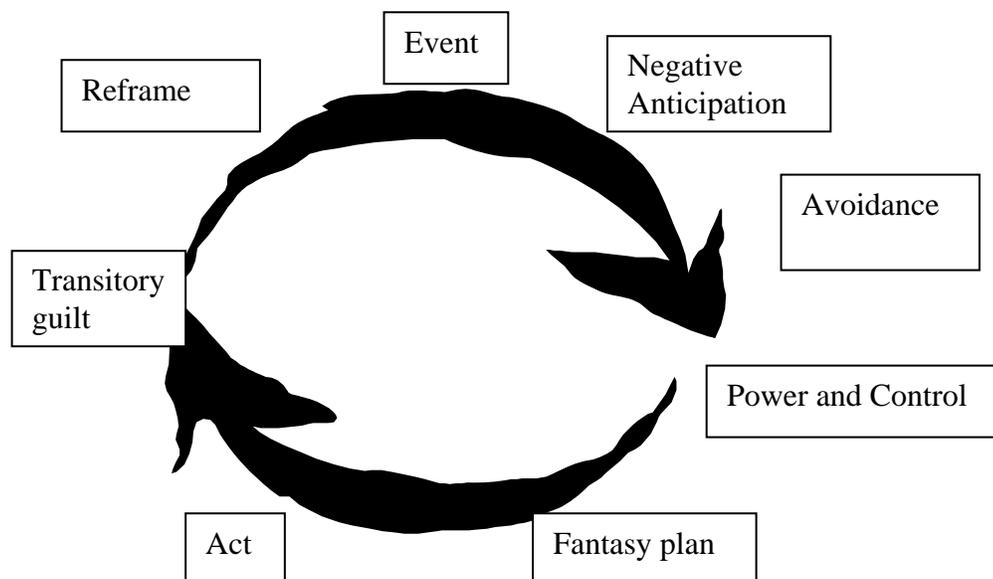
**Power and control:** The offender may try to set up others to get them into trouble. The person is trying to take control by activating emotional triggers in others, making others feel bad, or seeking revenge. For example if Joe knows that Harold has a favorite chair to sit in, he will sit in it when he knows that Harold will find him sitting in it.

**Fantasy plan:** Plan to act to get even- often no specific target.

**Act:** Act out the behavior or offense.

**Transitory Guilt-** The person feels sorry, mostly because they are caught.

**Reframe:** It really didn't bother the person. I won't ever do it again.



Staff need to know each person's cycle of abuse. Offending behavior often begins with more benign (harder to recognize) behaviors than the example above. Staff need to be able to recognize those precursors to abusive behavior. They also need to know when the person has lost those controls, and may start aggressing. These 'red flags' are different in each person. Here are a few examples of some signals that indicate when the offender is losing control: stops shaving, appearance deteriorates, sadness, boredom, anger, and withdrawal.

### **Fluctuating Supports – Crisis Intervention**

There may be times when the person temporarily needs increased supports. These can be identified in the plan to some extent, but these emergency needs can be a stumbling block to service providers. It's just another reason why teams must be very flexible and creative in providing necessary supports.

Additional staffing may be necessary. A local therapist, law enforcement officer, pastor, or AA sponsor may be able to help the team identify strategies or local resources. Sometimes the ND Developmental Center may serve the person for three to five days to help the person reestablish boundaries. For some, it "scares him straight."

#### **Question for Personal Reflection**

*Can you deal with this much unpredictability and unknown?*

## Feedback Exercises Chapter 5

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1. Relapse prevention planning includes self-\_\_\_\_\_ programs.

In these, people identify safe:

and personal high risk factors such as:

also, their personal coping strategies, such as:

2. Give at least five examples of antecedents to anti-social sexual activity:

- 
- 
- 
- 
- 

3. What types of things can staff do to control dangerous antecedents? Give four examples:

- 
- 
- 
- 

4. Unpredictable and uncontrollable events which are traumatic are called \_\_\_\_\_  
\_\_\_\_\_; three examples are:

- 
- 
- 

5. Decisions to reduce the level of supervision or lifting other restrictions can only be made by \_\_\_\_\_.

6. Each person's cycle of aggression is different and will produce "\_\_\_\_\_ \_\_\_\_\_", three examples are:

- 
- 
- 

7. The cycle of aggression may take how long?

## Chapter 6: Balancing Rights with Protection of Vulnerable People and the Community

“The best predictor of future behavior is past behavior.” Unknown

It is a simple deduction. One is free to exercise all their rights and liberties for as long as others’ liberties are not violated. When a person sexually offends, they have violated society’s rules. They are expected to be responsible for their actions through payment of a debt to society. Since research indicates that they are likely to violate the rules again, their future rights may be restricted.

Because someone has a developmental disability does not mean he should be free of responsibility. But his culpability, or fault, may be questionable. So, we try to mediate the possible aversive effects, which they may not comprehend.

### Question for Personal Reflection

*Do you acknowledge the difference between responsibility and culpability?*

### Value Base

Though it may seem unnecessary to put this in writing, all must be clear as to the intent of these approaches. The following philosophical statements are critical in community programs for individuals with a history of sexual offense:

- If a person has had any sexual behavior with a child, there must be intervention to ensure that it will never happen again.
- The community and society must be protected from sexual offenses by those who are known to offend as well as those who have been accused of such.
- Other consumers with DD must be protected.
- The agency serving offenders must be protected from community attack, lawsuits and closure as many consumers and their families, as well as employees and their families are reliant upon the agency for services or employment.
- The offender with DD must be ensured as much liberty as possible while being protected from re-offending and possible consequences of sexual offense including:
  - Further stigmatization
  - Accusations which could lead to institutionalization
  - Criminal proceedings or imprisonment

## Question for Personal Reflection

*Does this value structure match with yours?*

### Limiting access to Vulnerable Populations

Protection of others is a critical component of the program and staff's responsibilities.

#### Example:

*Manuel has been living in a supported living apartment with roommate Niles for about five years. Although both have a history of sexual offenses, neither of them has reoffended in that time. Manuel admits though, that he still desires and masturbates to fantasies of teenage girls. He claims that knowing that he is supervised at all times is the reason he hasn't molested. If given an opportunity he thinks that he would. Niles agrees that he feels safer in this structured environment; otherwise he'd "be in jail instead".*



If a person spends years in a highly supervised setting with no offenses, it does not mean that restrictions should be lessened. It may be impossible to know if internal controls or external controls are limiting the reoccurrence of sexual aggression. A controlled or supervised setting may need to continue permanently.

### Sufficient Supervision in all Environments

What is sufficient supervision for one may not be for another person. Staffing patterns are usually higher when serving this population; often one-to-one staffing is required. In addition to an increased number of staff on duty, the activities of staff are different when supporting individuals with a history of sexual offending. Staff are often not allowed to sit with other staff to visit or complete paperwork. They need to be close enough to the individual to intervene within seconds.

#### Example:

*Roger tries to cover up his anger at his lack of freedom with his charm. But about once a week he tries to go out for a walk by himself. So about once a week, during this event, staff must physically restrain him from going out of the home alone. After they stop him, he needs two staff to help him relax in his room to overcome his distress and relax back to a normal level of function.*



There must be enough staff to handle Roger's outbursts while protecting and calming all other residents and having life continue as normal as possible.

## **Rule Setting**

For many people, moral values are ingrained, often without having to be stated out loud. We learn them by watching others and the way we are treated. For people with DD, the rules must be clearly stated and repeated. Treatment for individuals with DD and a history of sexual offense boils down to: "Set the rules; teach the rules; and arrange the environment and supervision so the person follows the rules". (P. D. Kolstoe & L.L. Orvedal, personal communication, July, 2004) "Relationship Rules" are rehearsed with the offender. Rule following is monitored and taught for generalization in all environments. Rules are monitored the same by all staff and are non-negotiable. The following rules are taught to individuals with a DD and a history of sexual offense who are served at the ND Developmental Center.

Rule #1: It is never OK to have sex with minors. Minors are children (under the age of 21). ND Developmental Center uses the age of 21 because there are markers that a person with developmental disabilities can recognize, i.e., A person over age 21 isn't in school any more; someone under 21 can't go in bars, etc.

Rule #2: It is never OK to have sex with anyone in your family.

Rule #3: It is never OK to have sex with staff.

Rule #4. It is never OK to have sex that is nonconsensual (when the victim says no!). It's only OK to have sex when it is consensual (both people want to have sex). Who can give informed consent? People who can tell you yes or no. In some settings, it will be critical to also teach people with history of offending, how people who cannot speak give or refuse consent.

Individuals who cannot understand, explain, and follow these rules correctly are at risk of offending.

### **Question for Personal Reflection**

*Do you understand and accept the need for rules than cannot be bent?*

## Feedback Exercises

### Chapter 6

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1. T F A highly supervised and controlled setting may need to be permanent.
  
2. It is never OK to have sex with
  - 
  - 
  - 
  -
  
3. The offender with DD must be ensured as much liberty as possible while being protected from re-offending and possible consequences of sexual offense including
  - 
  - 
  -
  
4. T F The highest level of learning is when one can teach it to others.

## Chapter 7: Quality Community Supports and Supervision

### Matching Supports to Individualized Assessment

#### Accreditation Standards

Most staff training for staff working in community programs that serve individuals with developmental disabilities is based upon the concepts of:

- Normalization, regular rhythms of the day and life;
- Control, self-determination and being able to choose how and where one wants to live, work and play;
- Protection of one's basic rights to freedom of movement, including sexual and other relationships;
- Dignity of risk, or the right to make mistakes or make 'poor' decisions.

When working in community programs with people labeled as sexual offenders, the realization of the above concepts is modified. They will now be approached differently, with the focus on safeguarding the community and potential victims, the provider agency's reputation and good will, and the rights of all people with disabilities.

- Choice will now be within certain allowable parameters.
- Normalization and freedom of movement only when the safety of others can be assured.
- Individual rights of the person with a history of sexual offense are less important than protecting the safety of others. There are high expectations of responsibility for one's actions.

*Let's look at some of the examples used in this module.*

- *Joseph is aware of and has agreed to stay away from playgrounds, parks and schools.*
- *Manuel knows he must stay away from teenage girls at malls and middle and high schools.*
- *David is committed to sobriety and agrees to stay away from bars.*
- *Kenny is learning why and how he should avoid school bus stops and the boys club.*



For those who have been accused of offending against children, staff will not plan trips to Disneyland or the zoo, but might arrange to go to adult swim sessions at the local pool, men's basketball at the Y, or travel slide shows at the library. Freedom of movement, choice, and normalization are still possible, and much more than if the person was incarcerated. However, inclusive activities require thought and planning ahead.

Proper treatment means getting all environments across the board to be therapeutic – living the rules everyday and everyplace. Some therapeutic restrictions may be stated in the Individual Justice Plan. When necessary, the team's relapse prevention plan and

any restrictions are submitted to human rights committees. Whenever appropriate, the person's agreement will be elicited.

## Residential supports

Some individuals maybe able to successfully be served in group living situations. However, others living in the home must be protected and their safety must be ensured. There may be alarms installed on the windows and doors of the offender's room. Other offenders will be better served in an individualized apartment setting. Staffing levels are dependant on the person's plan and any recommendations in the IJP.

## Structured Activities and supervision

Dr. Tom Pomeranz uses the following phrase in his presentations: "Time is the enemy." Most often when human service staff hear him say this, their first thought is, yes, I never have enough time. But Dr. Pomeranz quickly points out, that for individuals with DD, the phrase refers to the abundance of time; time that isn't filled with interesting, engaging, and productive activities. It is imperative, and perhaps key in controlling offensive opportunities, that staff keep the person with a history of offending behavior very active and busy. Offenders need staff to help them find ways to fill up their time. This limits the time available for fantasy and engagement in inappropriate sexual behaviors.



Time could be spent teaching or doing activities of daily living. There are always household chores to do in any home. Involve the person in household activities. They can are more fun when done with others in a team atmosphere. Leisure pursuits, hobbies, collections, and games, can make life interesting. These activities are also confidence- and skill-building, as well as enjoyable alone or with others. Difficulties in maintaining this pace should be communicated to one's supervisor. Staff have to support each other and pick up the slack when necessary.

### Question for Personal Reflection

*How can you help people make their life's time productive, full and meaningful?*

## Using community resources

Controlling the environment does not mean the person is on "house arrest." Be sure to include community resources in life's daily schedules. The only warning is to plan these activities and opportunities in advance. Spontaneity may be dangerous. Use places and resources that you know well, and ensure enough staff for the protection of society. Give people lots of opportunities to use their best



social skills and set them up for success. Avoid settings where known triggers or opportunities for re-offending will be present.

## Employment

Work is the place that most of us get our self-esteem (Mercer, 1997). We all need something important to do. We all love to get that paycheck that says what we do is valued by society.

For offenders with developmental disabilities the place and type of employment needs to be carefully considered to ensure success. Placing Tom, who is a self-professed child sex offender, into a job bussing tables at a McDonald's with a playground would be irresponsible. Nor would the restaurant manager want Tom working there. Consider antecedents and risks. Consider confidentiality. Will the person be able to fade staff oversight to natural supports? Or will the person always work in staff supervised groups/clusters/enclaves.



### Question for Personal Reflection

*Do you know how to “set someone up for success”?*

## Feedback Exercises Chapter 7

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1. Time is the \_\_\_\_\_ because too much of it gives offenders time for \_\_\_\_\_ and \_\_\_\_\_.
  
2. List at least 3 things that you are skilled at that you could bring to share with others during leisure time:
  - 
  - 
  -
  
3. List at least 3 types of domestic skills that you are good at and enjoy doing that you could do with others:
  - 
  - 
  -
  
4. How might you set someone up for success?

## Chapter 8: General Guidelines for Staff

### Adopt the Proper Mind Set

Often the most difficult part of the job for staff who provide community-based supports to individuals with developmental disabilities and history of sexual offense may be the ability to adopt a successful mind-set and effective personal approach. This includes attitudes and behaviors that:

- Protect one's personal, physical, and emotional safety
- Are positive and effective interactions with consumers
- Provide a sense of positive contribution for society



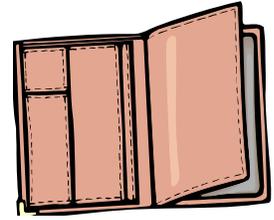
It means finding a balance between a “prison guard” mentality and a “laissez-faire” or indulgent attitude.

“Professional detachment” is a term often used for this mind-set. Staff are more effective when they can separate themselves from the outcome or result of your efforts on behalf of others. One way to explain “detachment” is to describe “attachment”. When one is attached, he/she hangs values or feelings on behaviors. Everything needs a weight or judgment: good or bad. So staff who adopt a prison guard mentality are “attached”; they believe that offenders are bad and need to fear authority (staff in this case) or they will do bad things. Staff who accept a lenient or permissive attitude toward individuals with DD and a history of sexual offense are also “attached” if they believe that people are good and will do good things at every opportunity.

Attachment is not good for those who work with individuals who have a history of sexual offense. It is not good for the staff, their employer, or for the person with a history of sexual offense. It makes their work too full of emotional ups and downs and can interfere with steadfast adherence to the treatment plan. After all, if you pat yourself on the back for another's successes, do you then chastise yourself for their failures? You can't have one without the other. So it's best to let go of personal responsibility for either. Attachment leaves oneself open to feelings of disappointment and betrayal. You are more vulnerable to employee burnout due to unnecessary stress on yourself.

Having “professional detachment” in human services means that the staff person isn't tied personally or emotionally to the behavior of the individuals he or she supports. The staff person doesn't take credit when a protégé succeeds and don't feel betrayed if the person reoffends. These staff can operate on a more even keel because they remove themselves from feeling responsible for the person and his or her behavior. They follow the plan at all times; they perform the processes and procedures as outlined. They care, but not so much to be on the roller coaster of being ecstatic or devastated at any turn. Therefore they can last longer and be more effective in this some times difficult human work. It is sometimes referred to as “detaching carefully”.

For example, you don't leave your purse, checkbook or wallet in full view in an unlocked car on a busy parking lot. You are vigilant but detached in your self-protection and check the car for anything out in the open, hide it or put it in the trunk as a matter of course. Not because you believe people to be "bad" or untrustworthy, but because you know that an easy opportunity like that is tempting for some people. You protect yourself and others from the negative side of human nature, even though you know most people usually operate on the positive side.



### Questions for Personal Reflection

*Can you accept clearly defined parameters of behavior, yours and others', as a 'matter of course'?*  
*Are you attached or detached care-fully?*

When working with those who have a history of offending behavior, as a matter of course, there are some actions you will need to take to ensure other's safety and reduce the person's opportunity to re-offend. The guidelines in the following sections pertain to individuals with deliberate, predatory behavior and will help you be successful in protecting yourself and others. These suggestions will also help the person with a history of sexual offense to avoid arousal, fantasy, and access, which may lead to an offense toward you or your family. Depending on the degree of risk, the plan may require guidelines similar to the following:

### Keep personal life private

- Do not discuss anything about your personal life, places you frequent, or your personal schedules. Do not discuss your social life and most especially avoid conversations about any personal sexual encounters.
- If you cannot avoid letting the person know what car you drive, be sure to keep it locked at all times.
- Do not share names of your spouse or your children. Do not disclose the schools your children attend or take any phone calls at work from your kids.
- Do not keep pictures of any of your family members at work. You would not want an offender masturbating to a picture of your child.



### No pet names

- Do not use any endearing nicknames for the individual such as "honey", "sweetie pie", or "sonny boy".

- Do not allow any nicknames for staff such as “Mom”, “gramps”, or “uncle”.

You never know what these nicknames mean to the person or others, or what may ultimately come from the allowance of such familiarity.

### **Appropriate Work Dress**

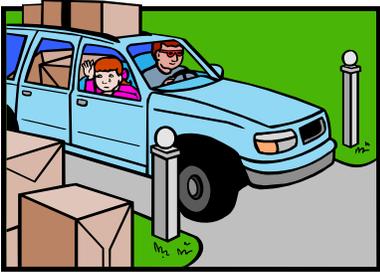
- A common rule of thumb to apply in the workplace is to make sure there is more skin covered than skin showing; no short shorts, tank tops, bare midriffs, or mini skirts.
- Wear little jewelry.
- Avoid clothing with print or advertisements especially those for musical groups, bars, and alcohol products.
- Wear shoes that cover your feet, no sandals.



### **Supervision in Public**

- Outings cannot be spontaneous. They must be planned and carefully staged. It’s best to go to places that are known to you so you will know how to manage within the environment.
- Think through how people will be transported to and from, the number of staff needed, gender of staff needed, how restroom use will be handled, etc.
- Keep the individual not only in line of site but in line of reach as well.
- Stay close to the person, always observing what they are paying attention to.
- When going to a restaurant think of the seating at the table, i.e., staff should be looking out, the consumer should be looking at the wall.
- What happens if it’s necessary to leave an event or return abruptly from an outing due to escalating behavior or a determination the people present, the setting, or anything in the environment are creating a situation that is in conflict with the person’ re-offending prevention plan? Does everyone who is participating need to leave? It is important to have a plan, just in case.
- Always let your supervisor and co-workers know where you are going when

## Transportation safety



Common-sense is crucial when transporting an offender.

- Never transport someone alone. Always have another staff person to accompany the driver. Have a second person who can observe everyone on the bus at all times.
  - Consider the persons' access to the driver, to the door, to the keys, and to the window.
- 
- If using a bus, consider where to sit, window/aisle, back/front.

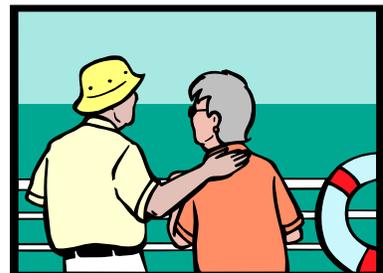
## Manage Environments

- Calming environments can be created through manipulation of lights, choice of colors, noise and textures.
- Keep private areas such as staff work rooms and file rooms locked at all times.
- If there is a threat of property damage, always protect the person(s) first, instead of 'things' like windows, doors, or walls.
- Know what TV programs and magazines are off-limits.
- Egress from windows, outside doors or bedroom doors may need to be alarmed.
- Always let other staff know where you are. Have other staff watch you when you walk to your car alone at night.
- It is also important to keep routines and supervision patterns flexible and varied. If staffing is always a little lax during shift changes or at mealtime, offenders, even those with limited cognition, can identify times where they are more likely to be successful in their attempts.



## Use appropriate touch

- Know how to touch each person appropriately. For some a 'hand on shoulder' or a grasp of the arm between the shoulder and the elbow may show support or approval. For others, even that may need to be avoided.
- Rules for activities may need to change as well based on the person's individualized plan. For example, at the ND



Boys and Girls ranch, recreation activities such as playing basketball may have strict restrictions on touching other players. Players wore hula hoops while playing to teach appropriate distancing. Some individuals may never be allowed to participate in co-ed activities.

- Careful attention must be paid to even the simplest activity, i.e., in some settings rules are in place that only allow one person on the stairs at a time.
- If there is a need for physical control over a person, make sure you get the help you need to ensure that everyone is safe and that only approved procedures are used.
- Staff also need to recognize and demonstrate appropriate social boundaries when working with this population. Horseplay and other antics are never appropriate for those in therapeutic roles. Never forget how your role as a professional in this setting must be different than the role you have with your family, your friends, or even your coworkers.

### **Avoid manipulation**

- Be aware of capable individuals who can be very manipulative.
- Some offenders “groom” staff much the same as sexual predators “groom” their victims. Be wary of
  - compliments
  - comments or behavior showing that you are their favorite
  - offers to protect you from “others”
  - a “heads up” about some activity being organized
  - leading questions to draw unnecessary information from you.



- Know yourself, know what frightens you, shocks you, and alarms you. Predatory offenders are systematic observers of people. They will be watching you for indications of fear, uncertainty, surprise, etc. They may try to tap into those vulnerabilities in the future.
- Define your personal, physical boundaries if a person becomes too familiar and crosses too close into your personal space, i.e., taking lint off your shoulder.



- Distinguish the inability of the offender to identify boundaries from boundary violations. An example of a boundary violation would be a man passing by a female staff while purposely making physical contact with her breast or foot.
- Do not accept any gifts or borrow any items, as you may be innocently obligating yourself. The person may later expect

something in return.

- Do not allow yourself to be sweet-talked into letting minor rule infractions go without proper reporting.

### **Know the Person**

- Know support plans for individuals served, their quirks, their antecedents, their triggers, and their preferences.
- Report anything that is strange or odd. Even if seemingly innocent, it could explain or point to something else.
- Follow the plan at all times. Do not be conned into bending the rules in order to be a 'friend'.

### **Question for Personal Reflection**

*Can you provide an environment of respect and dignity while holding people accountable for their behavior and responsible to change?*

## Feedback Exercises Chapter 8

---

1. Those who adopt \_\_\_\_\_ in human services have no values tied to the \_\_\_\_\_.
2. Identify 3 of the most important guidelines for *you*. The ones that may be the most difficult for you to follow. The ones you will need to remind yourself of on a daily basis.  
  
-  
-  
-
3. Calming environments can be \_\_\_\_\_.
4. Do not discuss anything \_\_\_\_\_.
5. Do not use endearing \_\_\_\_\_.
6. Have little \_\_\_\_\_ showing at work.
7. Never transport someone \_\_\_\_\_.
8. \_\_\_\_\_ can not be spontaneous.
9. If physical control is needed, follow \_\_\_\_\_ only.
10. Capable people can be very \_\_\_\_\_, so be wary.

## Chapter 9: Staff Support and Training

### Staff Self Care

Not everyone can do this work. It is different than working with non-offenders with DD. This work can affect your own sexual or dreaming behavior. Some staff experience increased fear for their own and their family's safety. If these feelings cannot be channeled or dealt with through successful coping mechanisms, the staff person may need to request to be reassigned.

The role of the direct service staff is key to protecting the community at large, other consumers, fellow staff, as well as the accused person himself. The goal is to keep the accused person from offending again, entering the very confusing and complex criminal court situation, or having to meet the competency requirement to stand trial or imprisonment.

Staff may have a difficult time accepting that the person they come to know and like is capable of doing the things for which they are accused. Remember that social workers report that there is a good side to everyone, even those imprisoned for murder. That does not mean that they let their guard down as they work with them. Professionals who work with criminal minds know that they are extremely difficult to rehabilitate and move them into the 'normal' levels of supervision and restriction.



When you watch TV news, pay attention to the interviews of neighbors and friends of those convicted of serial murder or rape. They usually say something like, "He was just the nicest guy;" "He seemed so normal;" "It's hard to believe that he could do those things." Your judgment must be clear instead of clouded by pre-conceived notions. You must be realistic in what you expect from others.

#### Question for Personal Reflection

*Can you live with realistic expectations for growth and reoffending?*

### Detach with Care

Do not allow yourself to be convinced of a person's innocence. At the same time, look beyond the past or current aberrant behaviors to the underlying causes. Staff must proceed with all the protections and safety procedures in place, while hoping for and working toward successful rehabilitation for the person.

## Set Boundaries

There are two boundaries you must be able to set and sustain.

- Program or plan boundaries and the rules exist to guide the person and help him to avoid re-offending or being accused of re-offending. Follow the rules yourself.
- Your personal boundaries must be firm. The offender's life, freedom and movement revolve around you, the staff. You hold the power and the authority. They may be constantly attempting to diminish your power. For many sexual offenders the issue is control; and they don't like to give theirs up to you. If your boundaries are not firm, you will flex, which is dangerous.

In order to retain both of these boundaries you must be clear in their delineations, be confident, and able to ask for help when needed.

## Separate the Behavior From the Person

Remember the old adage: Be tough on the behavior but gentle on the person. It is possible to be firm while being friendly and supportive. You can be firm without being threatening or intimidating. You can be friendly without being friends. You can simply be the one who is hired to enforce the rules. The enforcer of the rules is not aggressive or hostile, but matter of fact. "These are the rules, everyone knows the rules and everyone knows the consequences if the rules aren't followed."

For example, you probably don't speed on the road because you may get caught and have to pay the consequences (a costly ticket). You don't avoid speeding because the law enforcement officer is mean and you are afraid of him. He is simply the person responsible for reinforcing the law or the rule. The rule is more powerful than the officer. The rule is not the officer and the officer is not the rule.



Now, all of this does not mean that you can't laugh with and enjoy your time with the person. Just be firm with the behavior but gentle on the person. Look for the person's strengths and find ways for them to use and build on these abilities. Find ways for them to be successful and recognized for their appropriate behavior.

### Question for Personal Reflection

*How will you separate the behavior from the person?*

## **Additional Staff Training**

This work requires additional and specialized staff training. With more training the staff become stronger and more skilled. One therapist claims that those we serve cannot become any greater than the staff who provide support to them. Make yourself the best and most effective staff you can be through taking advantage of on-going training in topics such as:

- Avoiding manipulation
- The language of sexual offending and paraphilic behaviors
- Risk assessments
- Verbal control
- Safe physical control
- Personal proximity: proper touching
- Individualized Justice Plans
- Legal definitions and considerations
- Behavior analysis
- Behavioral limit-setting
- Mental illness
- Substance abuse
- Psychopathy

### **Question for Personal Reflection**

*Are you willing to get all the training you can?*

## **Confidentiality**

Community education and disclosure of private information will be decided upon on an individual basis by the person's team. When there are various community resources involved with a person, such as attorneys, advocates, probation officers, therapists, AA groups, the issues of confidentiality become more complex. It is critical that staff understand with whom specific kinds of information can be shared; or who has a "need to know" for each individual.

The rules of confidentiality applied by staff may be more important for these individuals than the norm, as they are already negatively labeled and at risk for a life of stigmatization and institutionalization. Refer any requests for the person to sign a release of information to the team or case manager.

### **Question for Personal Reflection**

*Can you work in such an anxiety producing environment without breaching confidentiality?*

## Communication

Excellent communication among staff is essential. Passing data and information to every person who is currently on duty, the people on the next shift, as well as the rest of the treatment team is essential. Good shift logs are mandated reading and should be signed off by all staff.



All successful programs have constant and ongoing inter and intra agency collaboration and communication. Understand the role of each person on the team so that there is clear differentiation as to responsibilities and boundaries. Although different, each team member's role is just as important and valuable as any others'. When more than one organization is involved with a person, as in the case with an offender, the relationship between them is crucial to the success of the individual. Information sharing must be constant and ongoing. When a new staff joins the team or a new

consumer is introduced into the program, the staff should learn the person's history prior to working with him.

Some agencies structure group opportunities to de-brief the events of the week, or employee assistance programs so that staff can get the emotional support necessary to continue this work and stay healthy and effective. If those are available to you, be sure to take advantage of them.

It is imperative that staff provide their observations of the individuals whom they support. In addition information they learn through informal conversations and self report by the person with a history of offending behavior should be shared. Remarks that the individual makes about situations, people, and/or events where he becomes aroused are critical to development of the relapse prevention planning.

### Communications with People with Developmental Disabilities

Staff must be sensitive and responsive to the communication abilities of people they support. In general, people with intellectual disabilities do not understand non-verbal communications or body language, such as a shrug, expressions, or a raised eyebrow. This can be difficult with any consumer, but it can be dangerous to overlook for a person who has a history of sexual offending and is in treatment. It is imperative that they clearly understand your messages. Use specific cues to guide proper and acceptable behaviors.

In order to ensure messages are clear and unambiguous, the team, along with the direct staff may need to deliberately develop these messages for the individual. These may be exact phrases to be repeated by any and all staff in specific circumstances. They should be defined and explained in the person's relapse prevention plan. Here are several different situations.

1. For example, if Sam has a habit of getting too close to female staff, all female staff will respond to him when he gets too close with: "Back off."

2. Another example is Jose, who gets irritable and looks for comfort (which will become unhealthy for him and others) when he stays up late at night. Staff will suggest he take a nap and remind him of the HALT message used in recovery programs: “Don’t get too hungry, too angry, too lonely or too tired.” The HALT message can be used for the other three scenarios also.
3. For those who need AA or NA messages, keep them simple and specific. Even if they are not trained as drug and alcohol counselors, all staff should be familiar with the basic principals of recovery from substances or behaviors. They will also know phrases to use. An example might be Lars, who begins to complain about his fellow roommates when he starts to backslide. Staff will remind him of the “courage to change” from the serenity prayer. This may infer that Lars must be the one to change, like a real hero would, and not expect others to change.

Dr. Lou Brown, a long time staff teacher and expert in DD, warns staff of a parent who told him, “If my son will only learn so many things, make sure they are the important things.” Some people with intellectual disabilities will only learn and transfer their learning to life, with a few, carefully chosen, individualized and repetitive messages. Make sure they are the important ones. Teach them messages that will keep them from entering the criminal justice system, until and if they are able to provide themselves with successful messages.

## Feedback Exercises

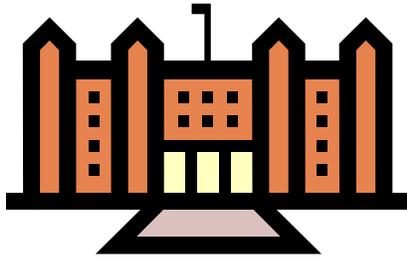
### Chapter 9

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1. The two boundaries you must maintain at all times.
  - 
  -
2. Separate the \_\_\_\_\_ from the \_\_\_\_\_ means:
3. Identify the 3 priority areas of training that you think you need to get:
  - 
  - 
  -
4. People with cognitive disabilities cannot understand \_\_\_\_\_, so you must find \_\_\_\_\_ to communicate with them.

## Chapter 10: Dangerous Charlie

Charlie had been living in an “individualized supported living arrangement” (ISLA) situation for many years when I came to know him. Prior to those types of community programs he had lived at the state asylum since childhood. When he was a young adult, he was accused of smashing in a staff’s head when she refused him sex. She died 2 weeks later. She could only report that he was responsible. No one will ever really know what happened as it was just the two of them in the room at the time. But his fate was sealed for the duration of his short life.



Charlie was never charged or convicted for her death, but his access to grounds was restricted and he lived an isolated life. After 6 years he could hardly carry on a conversation any longer as he had lost his ability due to lack of opportunity. He was kept locked in a private room on the third floor of the massive dormitory and was brought all his meals. He was showered separately from other residents and was not allowed to attend classes or off-campus outings.

When they deinstitutionalized the asylum, Charlie, now 26, was one of the last to move out. He was discharged with staff bitterly disagreeing with the placement. For the protection of the community, staff were told of the woman’s death and of Charlie’s guilt. He moved into a group home of men, but he couldn’t get along with them very well, although he never assaulted any of them. Again, he was ‘protected’ in a corner room by 2 male staff at all times. An average of 3.5 times a week Charlie needed to be ‘taken down’. He attended a day program, but had his own work area and was followed around by a male staff, one to one. Charlie liked to gently touch women’s hair. Some women in the administration and day program building would occasionally let him touch their hair. When they did, he got a soft smile and a dreamy look in his eyes.

When funding was made available, Charlie moved into a house, alone. The idea was that he had more room, freedom and privacy, as the other setting was too restrictive. The same 2 male staff were assigned to him on the afternoon shift and 2 new staff were hired for the evening shift. A psychologist specializing in dangerous people with developmental disabilities was hired to observe him for a week. The doctor developed and trained the staff in special programs just for Charlie. He was not taken down all that week.

Charlie was taken to lots of places, i.e., video stores, video game arcades, the YMCA, the neighborhood swimming pool, the mall, the bank, fishing at the lake. An average of 2.3 times a week Charlie needed to be ‘taken down’. By this time Charlie was 32 years old.

After living in his own home for only 16 months, Charlie died. The staff on duty that evening reported that he acted out at the time of shift change and that it took all four male staffers to take him down and keep him down. Charlie suffocated and died.

This happens more often we would like it to (Mercer, 2003). Staff were placed in a situation where they were scared of a person they believed to be dangerous. Their adrenaline started pumping because they wanted to remain in control; that is how they saw their role. The more

Charlie struggled against the restraint, the more staff fought back. They forgot the approved procedures.

Anyone who has worked with people labeled “dangerous” will acknowledge; those who are viewed as the most dangerous, are the most endangered.

### **Questions for Personal Reflection**

*Do we know how dangerous Charlie really was? Explain.*

*Do you think Charlie ultimately had more freedom or less? ...more opportunities or less? . . . more privacy or less?*

*Was Charlie living in the least intrusive or the least restrictive environment? Explain.*

*Do you think Charlie asked to go to those places in the community? Why?*

*Do you think that the staff followed the plan developed for Charlie? Why?*

*Do you think Charlie fought the men? Why?*

*What questions do you have about Charlie’s habilitation?*

*Why are those who are the most dangerous, the most endangered?*

*What can agencies do about this phenomenon?*

*What can you do about this phenomenon?*

### **Conclusion**

Offenders with developmental disabilities may not ever be “cured” but they can be successfully supported in the community with appropriate supports from staff and programs. Knowing the risks increases the chances that they can be managed well. In many situations, this approach is more appropriate than incarceration in a dangerous place, and loss of liberty for the offender with DD. This approach promotes habilitation and allows people with disabilities to take their rightful place in the community. This approach keeps vulnerable people safe from being victimized.

### **Question for Personal Reflection**

**Are you going to be able to successfully assist and support sexual offenders who are developmentally disabled?**

**Feedback Exercises**  
**Chapter 10**

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1. \_\_\_\_\_ people are the most \_\_\_\_\_.
  
2. Why?

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## GLOSSARY \*

Coprophilia: involves sexual arousal from involvement with feces. Some people consume, eliminate, masturbate with feces or give enemas to others. Poor hygiene skills or toiling skills are not necessarily indicative of this condition.

Exhibitionism: involves exposing one's genitals to unsuspecting persons, sometimes involving self-stimulation in front of the victim. This category may also include performing sexual acts in public regardless of the risk of observation by others. A common goal for exhibitionists is to shock or surprise their victim with the fantasy that the victim will become aroused and sexually interested. This sometimes occurs without the intention of the observation by others i.e. behind bushes or in vehicles.

Fetishism: involves using nonliving objects to become sexually aroused, i.e. shoes, lingerie, pictures, sex toys. In order for this behavior to be of great concern the object must become more important than having a human partner.

Frottage or frotteurism: involves gaining sexual pleasure or arousal from touching or rubbing against a non consenting person.

Hypoxiphilia or autoerotic asphyxia: involves erotic pleasure gained while reducing the oxygen supply to the brain. Sometimes referred to as " terminal sex " due to the lethal risks involved, such as temporary hang by the neck, chest compressions, plastic bags over the head, etc. during masturbation. Hypoxyphilia is a form of sexual masochism.

Masochism: involves erotic pleasure gained from receiving the infliction of physical pain or humiliation; could be self induced or inflicted by a partner.

Narratophilia: involves use of obscene words with a sexual partner.

Obsessive or compulsive masturbation: related to pictophilia, involves autoerotic behaviors that can develop into compulsive habits.

Pedophilia: Most often involves sexual arousal or fantasizing about or touching of a pre-pubescent child. Such deviant arousal is identifiably the strongest predictor of sexual re-offense against children. Not every person who molests a child is a pedophile.

Paraphilia: a disorder manifesting typically socially unacceptable or repugnant behaviors. Some experts argue that paraphilliac behaviors done in private are acceptable and need not be scrutinized.

Pictophilia: involves obsessive use of pornography, frequently related to compulsive masturbation. For some people with developmental disabilities their version of pornography may include pictures from catalogs, the daily newspaper, children's pictures, ads of children in swimsuits, children's TV programs.

Professional sexual misconduct: involves sexual involvement between a client and a care provider or other persons in authority over the client or supervisee. One study found that approximately 41% of perpetrators of sexual abuse among persons with DD living in placements were service providers and not family members, peers, or strangers.

Sadism: involves gaining sexual arousal or gratification from inflicting real physical pain or injury to another.

Sexual assault or battery: legal terms that may include uninvited or unwanted sexual touching. Includes illegal acts such as date rape, coerced sex, spousal rape. Some forms of frottage may fit into this legal category as well.

Telephone scatophilia: involves making unwanted verbal expressions of a sexual nature, often involving or insinuations of sexual aggression over the phone. This conduct is a form of sexual harassment therefore is illegal.

Transsexual ideation: involves believing they should have been born as the opposite sex. They desire sex change surgery to complete their transformation.

Transvestism or cross dressing: involves sexual arousal or gratification from wearing or fondling clothing of a person of the opposite gender.

Urophelia: involves erotic pleasure from the use of the urinary stream with or without a partner.

Voyeurism: viewing or peeping at unsuspecting persons who may be in the process of undressing or engaged in sexual activity. Many voyeurs attempt to look up skirts or down necklines in subtle and not so subtle ways.

Zoophilia or bestiality: involves sexual contact with an animal for the purpose of sexual arousal or activity.

\* The information in this glossary was amended from Blasingame's work.

## INDIVIDUAL JUSTICE PLAN WORKSHEET

### I. PROBLEM IDENTIFICATION

#### A. Presenting Problem(s)

1. Definition:

2. Social and Legal Implications

#### B. Past offenses (dates, descriptions, outcomes)

#### C. Present offenses (dates, description, status)

- II. ASSESSMENTS (current status and situations which may cause contribute to, or hinder treatment of problem; areas where changes may help eliminate the problem)
- A. Residential
  - B. Vocational
  - C. Educational
  - D. Social/Recreational
  - E. Family
  - F. Medical
  - G. Psychological/Psychiatric
  - H. Transportation
  - I. Advocacy
  - J. Money Management
  - K. Are further assessments needed? Yes\_\_\_ No\_\_\_
  - L. Other relevant information

III. TEAM RECOMMENDATIONS/SUGGESTED SENTENCING ALTERNATIVE (describe, reasons why)

A. SUGGESTED SENTENCING ALTERNATIVE

1. Behavior Modifications
2. Counseling
3. Supervision
4. Community Service
5. Hospitalization
6. Agency Transfer
7. Other treatment/training
8. Fine
9. Probation (supervised/unsupervised)
10. Jail Sentence
11. Prison

B. ADDITIONAL RECOMMENDATIONS

C. ANTICIPATED OUTCOME

IV. IJP THEMES ADDRESSED

A. Accountability

Is the client being held accountable for his/her behavior?

YES  NO

Comments if necessary.

B. Competency

Is the client presumed to be competent in the spirit of this IJP?

YES  NO

C. Control vs. Incarceration

C. Due Process

Does the IJP ensure due process is followed?  YES  NO

D. Least Restrictive Alternative

E. Normalization

Does the IJP constitute an effort towards a normalized lifestyle for this client?  YES  NO

V. INTEGRATION WITH IPP

A. Goal and target date

B. Objective(s) and target date(s)

C. Procedures and persons responsible

D. Proactive Measures

VI. METHOD OF REVIEW  
(Clearly identify lead person and how/when the IJP will be reviewed)

VII. RESPONSIBLE PARTIES (persons/agencies, areas of responsibility)

**STATEMENT OF AGREEMENT AND CONSENT TO IMPLEMENT THE IJP**

I have reviewed the attached Individual Justice Plan for \_\_\_\_\_  
\_\_\_\_\_. I hereby agree to this plan as written and agree to the  
implementation of such plan.

Planned Date of Next Review: \_\_\_\_\_

Comments:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian or Witness Signature

\_\_\_\_\_  
Date

## FEEDBACK ANSWERS

### Introduction

We serve:

- community taxpayer, who pay for services to those with developmental disabilities
- neighbors, who can become victims
- all people with disabilities, so they can retain their rightful place in society
- agency, as provider and employer
- person with disability who is an offender

### Chapter 1

1. Some impulsive and inadvertent behaviors which were not sexually motivated may be interpreted by observers as sexual.

2.

- differentiating relationships
- lack of courtship behaviors
- understanding of proper and improper touch
- lack of impulse control

3. Intent makes no difference to victim, as they are traumatized, regardless of the intention of the person.

4. Boundary differentiation is understanding the differences in how close you can get or how you can touch someone in different relationships, i.e. friends, teacher, mother, spouse, stranger, etc.

5. List may be personal and may include

dating, holding hands, arm around, head to head, different levels of kissing, touching private body parts, use of words such as endearments or nicknames

### Chapter 2

1. If accomplices are not retarded, they have more cognitive ability which enabled them to escape, lie, blame others or otherwise be free of consequences.

2. concrete, meaning they can only comprehend that which is tangible or real and can be seen or touched.

3.

- adjustment disorder
- bi-polar disease
- borderline personality disorder
- schizophrenia

- depression
- brain injury

4. predatory  
 opportunistic  
 impulsive  
 inadvertent or accidental

5. only able to relate to or understand one's own feelings, cannot empathize with others or 'put themselves in their shoes'

6. sexually abused

7. males boys

8. intellectual disability mental illness

9. criminal thinking thinking errors

10. predatory

11. nuisance

### **Chapter 3**

1. keeping the accused out of the courts and out of jail or prison, as many people with do not benefit from the traditional criminal justice system due to their cognitive disabilities

- 2.
- The ability to work with an attorney
  - Basic knowledge of the workings of the court
  - Understanding of the possible consequences if found guilty

3. children

4. to try to keep the individual from reoffending  
 or being accused of offending,  
 to protect the community  
 and to avoid criminal proceedings or sentencing (deflect from incarceration)

### **Chapter 4**

1. stigmatization, depression, loneliness and isolation
2.
  - Greeting others
  - Boundaries (proper touch) and social roles
  - Assertiveness
  - Conversational skills
3. sex ed, courtship beh, developing sexual relationships
4.
  - Academics: Improvement in basic capabilities has shown a decrease in behavioral acting out.
  - Leisure skills: Pivotal in keeping the mind and the body busy with positive behaviors.
  - Self management/Self control: Including coping skills, anger management and stress management
5. staff to be consistent in verbal responses or directives, so the person will come to know and respond in specific and desirable ways
6.
  - sexual deviancy
  - personality disorder
  - alcohol or drug abuse
  - medical or psychiatric conditions
7. super-powerful and powerlessness
8.
  - Supportive comments like, “We all make mistakes.”
  - Behavior contracting
  - Recognition
  - compliments when deserved
  - and gentle awareness of choices of behavior
9. a person’s lack of ability to develop appropriate relationships

## **Chapter 5**

1. control
2.
  - people
  - places

- activities
3.
    - antecedent thoughts
    - feelings
    - environments that put him at risk of offending
  4.
    - avoiding the situation
    - escaping from the situation
    - using stop thoughts
    - contacting support
  5.
    - bus brakes, swing squeaking, perfume, socks, Victoria's Secret TV commercials, underwear ads in newspapers or catalogs
  6.
    - know each person's antecedents
    - convey to others when you learn more about one's antecedents
    - control places they go
    - limit things they see like TV or catalogs or magazines
  7.
    - random stressors
    - death of a family member
    - becoming a victim of a crime
    - loss of a job
    - a move
    - change of staffer or case manager
  8. by a team of professionals
  9.
    - red flags
    - withdrawal,
    - sadness,
    - stops shaving,
    - boredom,
    - anger,
    - appearance deteriorates,
    - criticism of others,
  10. from seconds to days

## Chapter 6

1. permanent

2. minors, family, staff, those who do not consent
3. Offending  
Further stigmatization  
Accusations which could lead to institutionalization  
Criminal proceedings
4. one can teach it to others

## **Chapter 7**

1. enemy fantasy pursuit
2. of personal choice, such as scrabble, scrapbooking, gardening, playing piano
3. of personal choice, such as cooking, laundry, vacuuming, mowing lawn
4. Create a situation in which you know the person will succeed by giving choices in which any choice is acceptable;  
Asking them to do something independently that they know how to do;  
Work beside them so they will produce the desired result.

## **Chapter 8**

1. professional detachment results.
2. Personal answer
3. created
4. personal
5. nicknames
6. skin
7. alone
8. outings
9. approved procedures
10. manipulative

## **Chapter 9**

1. attachment
2. program/plan, personal
3. behavior person      Be tough on the behavior but gentle on the person.
4. personal choice from these, or others:
  - Avoiding manipulation
  - The language of sexual offending and paraphilic behaviors
  - Risk assessments
  - Verbal control
  - Safe physical control
  - Personal proximity: proper touching
  - Individualize Justice Plans
  - Legal definitions and considerations
  - Behavior analysis
  - Behavioral limit-setting
  - Mental illness
  - Substance abuse
  - Psychopathy
5. body language      words

## **Chapter 10**

1. Dangerous      endangered
2. Because staffers are afraid of them, adrenaline goes into action and the staff may over react, over control and do harm. When the person fights back they may not be able to breathe, not just being difficult.

## **APPENDIX RISK ASSESSMENT PROFILE**

### **Demographics**

Age/sex: 38 year-old male  
Level of intellectual disability: moderate  
Living environment: Group home  
Level of supervision: *use Table 1: continuum of services scale*  
awake overnight staff; option 5

### **Actual incidents** *use table 2: aggression rating scales*

physical:

- 1 attacked staff person with knife, severity level 7
- 2 set fire to residence, knew no one was in building , severity level 6

sexual:

- 1 exposed self to minor female 4 years ago, severity level 4
- 2 2 charges of molesting under age male 20 years ago, severity level 6
- 3 allegations of sexual involvement with adolescent male but no filed complaints. Activity occurring may be consensual. If allegations are true -severity level 7

### **Risk probability rank** *use Table 3: risk probability ranking scale*

Level 7: high severity, low frequency, recent past

### **Legal history**

- 1 police called after assaults, no charges filed.
- 2 arrested after fire but charges dismissed.

- 1 no charges filed
- 2 arrested and returned to group home with no criminal charges
- 3 police came but no charges filed

### **Destabilizing factors**

Borderline personality disorder with potential to develop psychotic symptoms under stress.  
Only partial response to current drug treatment.  
History of extreme early physical and sexual abuse followed by multiple foster home placements.  
History of alcohol abuse.

### **Stabilizing factors**

Compliant with treatment and supervision.  
Likes therapist.

### **Systems issues**

Treatment team is conflicted over how to respond to aggressive physical acts. Suspicion of ongoing involvement with adolescent males but no grounds for criminal complaint at this time.

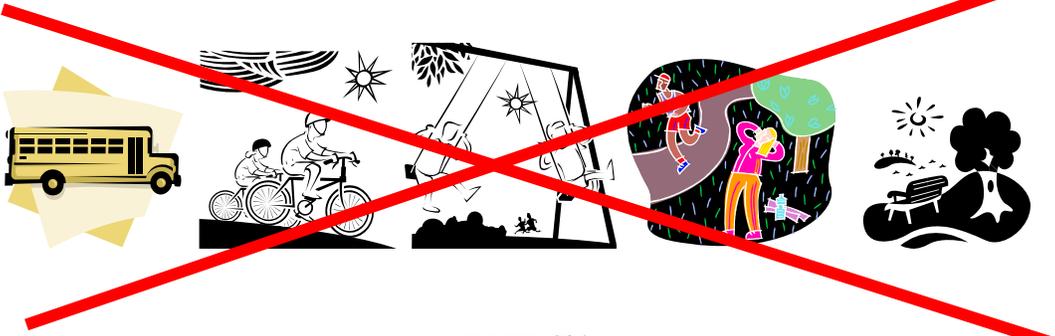
**Overall risk assessment**

Moderate risk with continued treatment and ongoing search for proper medication.

NOTE: Complete understanding of this risk assessment would only be possible with knowledge of rating skills referenced. Clinical application is deemed from a team of professionals who interpret these subjective and objective findings.

Compiled from examples in Mikkelsen and Stelk.

**NO!**



**YES!**

**CALL:**




SAA: 555-1234



my grouphome  
555-3456



Marsha  
my therapist 555-2345

Sample of pocket card for person to carry to remind him of correct behavior when tempted to offend.