



## ***Constructing Supports for Sexual Offenders with Developmental Disabilities Living in Community Settings***

By Mark W. Benner, MSW, RSW

### **Where Are We Now?**

We have seen the light! People with a developmental disability are sexual! With that comes the fact that not only can they be sexual, but they also can be rapists and child molesters. Community agencies that provide support are being increasingly challenged to support sexual offenders who present various levels of risk. We know that there is limited funding, especially new money, and few, if any, treatment programs specifically for people who have a developmental disability. With few exceptions, generic services are still unable or unwilling to support people with a developmental disability. There are few therapists willing and able to provide treatment to this population, let alone sex offenders who have a developmental disability.

Ontario's institutions have closed or are closing. This monumental task of closing institutions has dramatically affected how we support people with a developmental disability. This author is convinced that if society could, we would send these individuals to that magical institution so that society and professionals could forget about them and get them off our caseloads. Perhaps even if we should not do this, we would anyway because it is easy to justify that an offender should be sent away. We still live with the legacy of indiscriminately sending persons with a developmental disability somewhere else. We learned long ago that it is easier to lock up people who are different or deviant.

There is also the increasing discharge of formerly institutionalized persons who are sex offenders. This is placing more demands on communities and the few clinicians and agencies who support persons with a developmental disability. Community-based services are at times, unprepared and ill-equipped to effectively support people who are offenders. Some services

actively avoid serving these individuals and blatantly refuse to assist. Communities and agencies are seldom prepared for the sudden arrival of the person in their community. More than ever before, new offenders are being identified — probably because we are getting better at identification. Since there is limited resources including financial and person power, we often have to “make do” with what we have. Just “making do” creates concern, when dealing with the potential risk to victims. This challenge represents a demand for creativity and the reorganization of existing resources. This results in the demand for those of us



in the field to commit to further develop our skills in learning to support these people. We need to always remember to maintain that delicate balance between effective risk management and advocacy.

Continued on page 2

## Responses to the Offenses of Individuals with a Developmental Disability

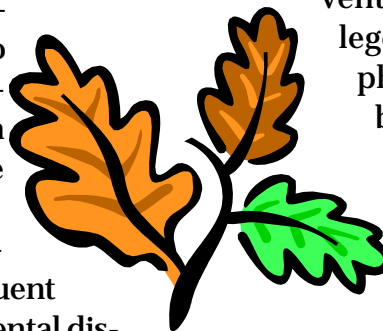
There are many individuals with developmental disabilities who have demonstrated a range of sexual offending behavior and who continue to present this risk on an ongoing basis. These individuals are identified by various service providers. A confirmed label of developmental disability or even a perceived developmental disability seems to dynamically influence prevalence rates, the responses to the offense, the assessment of risk, as well as whether treatment is available and how that treatment is provided. True prevalence rates of the numbers of offenders who are developmentally disabled as well as how many individuals with a developmental disability who offend are difficult to ascertain. There is controversy about the possible “differential arrest and convictions rates” for people with a developmental disability when compared to the non-labelled population (Day 1997). Confounding this issue is the concept of “Counterfeit Deviance” as suggested by Hingsburger *et al.* (1991). They identified “counterfeit deviance” as behavior which topographically is deviant, but which upon investigation is a result of some other unidentified factors. An individual’s public masturbation may not be an example of exhibitionism but truly due to a lack of social skills. Therefore, we often get stuck and not always certain what we are really dealing with. Is the person’s behavior really illegal or not?

Counterfeit deviance further complicates the identification and subsequent treatment of people with a developmental disability who actually do sexually offend. If we do not identify, we cannot treat. The individual’s developmental disability also may affect the manner in which risk is assessed. Assessment of risk by professionals who evaluate offenders may result in either underestimation or overestimation due to the evi-

dence of a developmental disability. The criminal justice system’s response is often a “bimodal” approach of either dismissal of the behavior or an overly punitive response (Mikkelsen & Stelk, 1997). The criminal justice system seems generally perplexed as to what to do with the offender with a developmental disability.

Treatment, and the necessary long-term support of people with developmental disabilities who sexually offend, is often difficult and at times seemingly impossible. Therapists specializing in offender assessment and treatment are often reluctant to support an offender with a developmental disability. Integrating developmentally disabled offenders into groups of non-developmentally disabled “...often creates frustration for the groups leaders, non-disabled participants, and most importantly fails to teach the disabled offender how to recognize and interrupt the cognitive chain of events which leads to relapse” (Demetral, 1994).

Many agencies who support individuals with developmental disabilities are finding that they are required to “learn as you go” concerning the offender aspects of support. Finding that you are suddenly needing to support a newly identified offender can test even the most seasoned frontline worker. There is no “Introduction to Relapse Prevention 101” offered at community colleges. Agencies may find their philosophies challenged to the core and their budgets strained. Agencies may struggle with how to philosophically apply the principles of empowerment, self-determination and person-centered planning to the support of an offender. The seemingly few existing specialized offender treatment programs are often unable to move graduates back into communities with adequate supports and resources, and supporting offenders in community settings can be costly. With limited financial resources to adequately meet offenders’ needs, community agencies are still being expected to de-



velop safe and effective support methods. What can develop, in spite of the limits, are creative and innovative methods of support using a coordinated team effort. There are many examples of agencies who support individuals with a developmental disability who have forged collaborative relationships in order to meet the needs of offenders, while maintaining community safety and client advocacy.

### **Essential Components of Community-Based Support**

Components of community-based support should include goals to minimize the risk to community, while facilitating the offender's control over his sexual impulses and reducing offending behaviors. Components should also address the facilitation of appropriate social skills, including sexual expression and reintegration into the community to enjoy a life-style that is as independent as is practical, given the limits of his developmental disability (Tudiver et al. 1997). Because the support is provided within the community, ethical considerations require that community safety supersedes individual choice and client wishes may have to be subordinate to the needs of the system and the demands of the community (Hingsburger et al.).

#### ◆ *Ongoing Assessment*

Initial and ongoing assessment of risk is essential. Assessments completed on-site, provide more of a systems perspective, allowing the clinician to evaluate not only the individual, but the strengths of the system to help prevent future offenses. Interviews with parents and other family members, teachers, support workers and other key persons provides the foundation of team building which will maintain a strong network of support. A major task of the assessor is to sort fact from fiction, to determine over-reaction from under-reaction and to determine true deviance from counterfeit deviance.

Risk assessments must be creatively adapted to the abilities of each individual offender. Standard assessments used with the non-labelled

population can be used, but always need to be revised, adapted, reformulated and individualized. As with all offenders, it needs to be stressed that any level of risk may increase or decrease dependent on both internal psychological and external social circumstances. Risk needs to be evaluated on an ongoing basis.

#### ◆ *Treatment That Works!*

It may seem superfluous to suggest that we should use "treatment that works", but it is worth highlighting that the specific treatment methods for individuals with developmental disabilities needs to be even more practical, efficient, flexible and individualized. Ideal treatment programs should provide sufficient structure and supervision to protect, with as little restriction of liberty as necessary. (Mikkelsen & Stelk, 1997). Cognitive-behavioral approaches involving reduction of deviant arousal while increasing appropriate arousal, social skill training, victim empathy and relapse prevention training are recognized forms of treatment for sex offenders (Grossman, Marits & Fichtner, 1999). Similar to the assessment of risk of offenders with a developmental disability, treatment strategy adaptation is necessary and requires creativity and perseverance.

A range of treatment should be available including strategies ranging from intensive weekly sessions, to the more long-term "booster" follow up sessions. Agencies supporting offenders with developmental disabilities may find the use of treatment contracts or service agreements helpful in clarifying roles, responsibilities and treatment approaches (Hingsburger & et al.). By using contracts, both parties become more aware of treatment goals with regular review and re-negotiation.

Professionals cannot wait until the individual with a developmental disability is in the criminal justice system. Often they do not get to that point. Most present no history of charges or convictions, but often they are clearly perpetrators. Some individuals living in the community have partici-

---

Continued on page 4

pated in years of offender treatment, often living under some form of graduated level of supervision, while others come to our attention presenting high risk, but with no history of assessment or treatment. The support team needs to be in agreement about what problems are being treated and the treatment approaches. If the support team members disagree that the behavior is really sexually offensive (“they don’t know any better”), treatment will be severely compromised and the support will fail. Follow-up must be long term, and treatment must be revised according to the risk presented at that time. Unfortunately, treatment is never really completely over.

◆ *Responsive Supervision*

Grossman et al. (1999) report the need for a comprehensive program for individuals at high risk of reoffending, but make no mention of supervision other than detention and confinement. Supervision seems to be a concept reserved specifically for those with a developmental disability. Often individuals with a developmental disability require some level of adaptive skill support and it is this support system that is often called upon to appropriately supervise the offender’s actual or perceived risk.

The “rose and thorn” concept of being labelled not only developmentally disabled but also an offender, represents both an asset and a liability. Being labelled developmentally disabled can provide an individual with the support and services required, including risk management and supervision. One needs to remember that despite risk, there are offenders who do not want the support and determined supervision. A non-labelled offender would likely walk away from the support and supervision, but an offender with a developmental disability is less likely to decline or refuse the support and supervision. This may be due to dependence on the system, lack of assertiveness and not always being aware of rights and choices;



or support providers assuming they have the prerogative to enforce mandatory supervision. One needs to remember our long history of overcontrolling individuals with a developmental disability. We need to ask the question, how many non-labelled offenders have access to, or the will to accept the degree of support and supervision afforded to the disabled population? Informed consent, from assessment through treatment and supervision, is therefore required.

The need for advocacy for an offender with a developmental disability is highly stressed. Ensuring neither an over- nor an under-reaction to an individual’s behavior, becomes a right in itself. For the individual displaying offensive and unacceptable behavior, their right to treatment needs to be advocated for, just as much as to fight the overcontrol and loss of freedom for someone who has shown motivation and proved a degree of change. Supervision in reality becomes a type of confinement. As Grossman (1999) warns, “precautions must be taken to ensure that treatment environments are appropriate for the risk level presented”.

Supervision should only respond to the particular risk that an individual represents at a particular place and a particular time. Thus, community supervision might range from minimal weekly/monthly “booster” sessions, one to one shadowing at school to 24 hour intensive supervision. The Harvey Approach or “invisible supervision” is an example of a creative and responsive method of providing the middle ground supervision to offenders with a developmental disability (Hingsburger et al). Here, community outings are scheduled with unseen supervision. Similar to the treatment contract, supervision levels need to be evaluated and adjusted according to the risk presented, trust gained, and responsibility assumed.

◆ *Teams of Support*

Teams made up of key participants in a person’s life, as well as paid professional supports, can be an effective method of supporting an offender with a developmental disability. Working in collaboration, parents and other family mem-

bers, friends, church members, probation officers, frontline support workers, police officers and therapists can all assist in the day-to-day support of an offender with a developmental disability. Training should be available to those providing direct support and information needs to be shared amongst all team members. Examples of this may entail the sharing of an offence cycle plan with a probation officer so that s/he is aware of specific high risk behaviors if they are reported, or teaching a foster parent the basics of relapse prevention strategies and concepts such as the role of SUD (or Seemingly Unimportant Decisions) or high risk situations.

Goals around non-offending as well as life goals need to be established and known to all the team members. Taking time out to celebrate another month, another 6 months or another year without another victim often becomes a team activity. Expecting consistency amongst team members about what defines risk behavior, and the sharing of decisions around changes in supervision, help the team members share the load of decision making and ultimate responsibility. If relapse occurs, and there is finger pointing and blame, then the team is not working together. This signifies a lack of coordination, communication and shared decision-making.

The availability of therapists willing to support offenders with a developmental disability is slowly evolving. Access to knowledgeable professional consultation, and ideally on-site consultation can be an effective support for communities with limited resources. Supporting offenders is hard work and expectations must be guarded. But the work is surprisingly rewarding at times. It is promising that professional associations and conferences are paying more attention to issues facing offenders with a developmental disability. The growing formal and informal networks of clinicians willing to share their successes and failures is helping to develop our ability to support this challenging group of people.



## References

- Day, K. (1997). Clinical features and offense behavior of mentally retarded sex offenders: A review of research. *The NADD Newsletter*, 16, 86-90.
- Demetral, G.D. (1994). A training methodology for establishing reliable self-monitoring with the sex offender who is developmentally disabled. *The Habilitative Mental Healthcare Newsletter*, 13, 57-60
- Grossman, L.S., Martis, B., & Fichtner, C.G. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services*, 50, 349-361 .
- Hingsburger, D, Griffiths, D. & Quinsey, V. (1991). Detecting counterfeit deviance. *The Habilitative. Mental Healthcare Newsletter*, 10, 51-54.
- Hingsburger, D., Hillis Ormiston, T., Naylor, D., Nethercott, A., & Tough, S. Community access for sex offenders with developmental disabilities: A process for dealing with trust, risk and responsibility. *The Habilitative Mental Healthcare Newsletter*. 13, 98-100
- Mikkelsen, E.J.& Stelk, W.J. (1997). Assessment of risk in criminal offenders with mental retardation. *The NADD Newsletter*, 14, 91-95
- Tudiver, J., Broekstra, S., Josselyn, S., & Barbaree, H. (1997). *Addressing the needs of developmentally delayed sex offenders*. Health Canada (Family Violence Prevention Division)

This paper was presented at the NADD 16th Annual Conference, Niagara Falls, Ontario, Canada, 1999 and was published in the *NADD Bulletin*, Vol. 4, No. 4, July/August 2001.

NADD is an association for persons with developmental disabilities and mental health needs and can be contacted at NADD, 132 Fair Street, Kingston, New York, 12401-4802 (845) 331-4336, E-mail [thenadd@aol.com](mailto:thenadd@aol.com).

## About the Author

Mark W. Benner, MSW, RSW  
Regional Support Associates  
Woodstock General Hospital  
293 Wellington Street North  
Woodstock, Ontario Canada N4S 6E1  
519-421-4248 519-421-4249 (fax)  
[mbenner@wgh.on.ca](mailto:mbenner@wgh.on.ca)



## QUALITY CORNER

### 'Tis the Season...

**By Lori Wertz and Novelene Martin**

'Tis the season of "Peace on Earth," "Good-will toward Men" —a time when just about everyone seems to dig just a little deeper and try just a little harder. All around us is the clanging of pocket change being dropped into red kettles, the ringing bells, the calling for an extra toy for the local church drive, the appealing for warm clothes, blankets, hats and scarves for the homeless or for the receiving homes.

Just about every street corner and television show seems to be intended to invoke memories of our own childhood while enticing us to make this special time of year a little more magical, or at least a little less difficult for folks who seem less fortunate. The transformation of Ebenezer Scrooge from a mean and petty soul to one who realizes the great happiness born of generosity and genuine caring has romanticized the Holiday and provided a certain amount of redemption for even the most cynical among us.

Let's face it, folks. The reality of the season is in long lines at the checkout, getting elbow to elbow with some of the fastest, pushiest, rudest, Pokemon grabbing, credit card slingin', check writin' grinchers this side of Whoville.

How many times this year did you feel offended, insulted or otherwise treated like an inconvenience by the clerk at your local retailer? When you asked for assistance, did you get a direct and helpful response? How many people did you have to talk to in order to get that help? How many

laps did you make around your locally owned, supersized SmartMart only to throw your hands up in frustration, vowing never to return again?

Shall we talk about those Christmas parties? Did you attend because you genuinely liked your coworkers and knew you would have a really great time? Did you feel obligated to show up? Did you feel like your absence would somehow reflect poorly on you or that you wouldn't be considered a "team player?" Did you spend the time at the party counting the number of things you could have been doing instead?

Money is short, time is still shorter, and whatever shall we get Aunt Ruth (who never even says "thank-you")? There are Jimmy's friends from school, and the neighbors (except for that one whose dog barks incessantly—and the one whose cat constantly digs up my crocuses) and then *his* family and my sister, and, and, and, and....

People seem to be cranky this year. Last week at lunch, one lady complained bitterly: "If my house was just bigger, I could stuff the whole tree into a closet and just pull it out once a year. That would save me the hassle!"

We also heard from a staff person, utterly bewildered, who was asked to donate cash so the "agency" could put together food baskets for "less fortunate people." This staff member commented on the number of car washes, group home house painting exercises, yard sales and sundry other events he had "volunteered" to cover already this year. He went on to mention the number of overtime hours and various extra duty assignments he had worked, all of which he felt were necessary given that his wages barely covered his rent and day care expenses. Now the agency also was asking for part of his "pittance" — money that would directly impact what he was able to do for his family. He added that he hoped someone was paying attention enough to know that he could easily qualify for one of those food baskets!



Charity that becomes obligation is no longer compassionate. Without compassion, we lose the contentment and satisfaction that come of giving. It becomes rote, mechanical and void of feeling.

Maybe that is what is wrong with our Holiday Season, and maybe that is what is wrong with our abuse prevention efforts too. When we lose our compassion due to, perhaps, burnout, long hours, constant crises, too many needs, not enough hours or people, or little pay. We stop *feeling* and get mechanical and custodial.

Do you suppose any of our consumers or staff ever feel like they are treated like an inconvenience, or have to talk to ten different people in order to get that direct and helpful response? Have our consumers become simply an obligation through the course of the day? Has our staff become a means to satisfy contract and minimal health and safety obligations? Do we stop to really consider the impact we have on the people around us every single day?

Like Scrooge, we need a change of heart and spirit. Charity begins at home, and so must our abuse prevention efforts. Genuine caring is not a seasonal event; it happens all year. We need the spirit of compassion and giving every day, no matter what we face. We need to slow down and remember that we are dealing with human beings at every turn: consumers, administrators, staff, and even state agency employees — each with his or her own personality, strengths and issues. Abuse prevention, like charity, must come from our hearts.

When the bills start rolling in January, and we collectively wince at the amount of money we spent, remember this: the holiday spirit should not be about spending *on* people. It should be about spending *with* people. Generosity is what we give of ourselves, not what we buy. This Holiday Season, please take a minute to consider the caregiving professionals and dedicated families who are working and making it possible for us to be at home with our loved ones. Maybe, just maybe, that counts more than a cash donation for a food basket.



New at the Library, from page 8

### *SPICE (Speech Perception Instructional Curriculum and Evaluation)*

A teacher auditory training curriculum designed for use with hearing-impaired children ages 3 years and up with cochlear implants and/or hearing aids. Accompanying video explains the curriculum and includes 18 teaching segments.

### *I Belong Out There*

A humorous, award winning video with many ideas for staff to use to encourage their clients to find fun and friendship in the community for integrated recreation, education and leisure. Includes packet of reproducible resources.

### *Part of the Community: Strategies for Including Everyone*

Discusses natural community supports rather than separate inclusion programs and gives examples of inclusion in the community from entering preschool to buying a home with models and strategies that worked and some that didn't.

### *Job Search: Handbook for People with Disabilities*

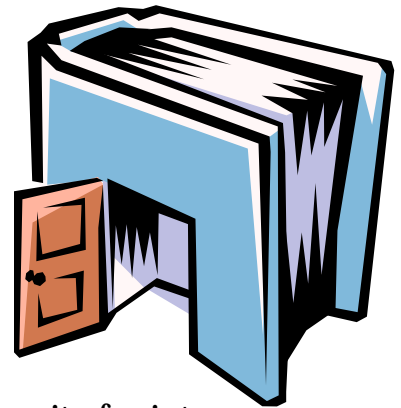
Step-by-step instructions to help people with disabilities find the right career field, learn successful job search techniques, tips for education, networking, mentors, negotiating and self-promotion.

### *Goodness of Fit: A Guide to Conducting and Using Functional Vocational Assessments*

Gives step-by-step instructions for conducting a functional vocational assessment in order to help ensure a "goodness of fit" between a person with a disability and the community businesses that employ them.

### *Where Is The Mango Princess*

The author writes a wrenching and often hilarious account about her families' experience after her husband suffered a traumatic brain injury.





**TRIC/ PLUK Library**  
**516 North 32nd Street**  
**Billings, MT 59101**



## New at the Library

The TRIC/PLUK Library keeps adding new materials. Contact the librarian at [jsand@pluk.org](mailto:jsand@pluk.org), or call (800) 222-7585 or (406) 255-0540 for more information or to check out these items. Materials will be mailed out to anywhere in Montana at no charge.

### *Shaking Off Stereotypes*

This curriculum uses video skits to recognize and challenge the misperceptions that others have of people with disabilities. Useful for staff, caseworkers, and self-advocacy groups.

### *It's Working: Learn Why Supported Employment Works*

This video shows people with significant disabilities working as valuable employees. Would be ap-

propriate for job coaches, transition coordinators, etc. to show potential employers.

### *Person to Person*

A video program about the sexuality education of persons with developmental disabilities that sensitively tackles a variety of issues in an open and honest manner. Both parents and their adult children express themselves on sexuality subjects.

Continued on page 7

## QUALITY MATTERS

Autumn 2001

**Editor** Janice Sand • **Circulation** 600  
**Layout:** Rosanna Buehl, *QBM Publishing*,  
 Billings, MT 59101-9121, [rosanna@mac.com](mailto:rosanna@mac.com)

This is a publication of *Parents, Let's Unite for Kids*, a private nonprofit organization founded in 1984 by a group of parents of children with disabilities and chronic health problems. This project is funded (in part) by the Developmental Disabilities Program of Montana DPHHS. Any statements contained herein do not necessarily reflect the opinion of the Department.

TRIC/PLUK Library • 516 N 32nd Street • Billings, MT 59101

Toll free: (800) 222-7585 (in MT)  
 Voice/TT: (406) 255-0540  
 FAX: (406) 255-0523

E-mail: [jsand@pluk.org](mailto:jsand@pluk.org)  
 URL: <http://www.pluk.org>