Intellectual Disability and Problems in Sexual Behaviour

A Quick Reference Resource Guide

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PEEL BEHAVIOURAL SERVICES
TRILLIUM HEALTH CENTRE

This resource is in dedication to the individuals we serve. Thank you for all you have taught us.

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A Quick Reference Resource Guide**

by Michele Burns, B.Sc. and Robin J. Wilson, Ph.D., ABPP

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Foreword

Every year, we receive calls to help an agency support an individual with an intellectual disability who is engaging in sexually inappropriate and/or offending behaviour. A thorough risk assessment may need to be conducted, or possibly a risk assessment may have been completed but treatment is not available. This quick reference resource guide was developed in an effort to help agencies support such individuals in their homes and communities while they wait to access either a formal risk assessment and/or treatment.

What you can do in the interim is described in detail in this guide, and includes such things as collecting data, enhancing supervision, educating both the individual and service providers, and supporting each other in the best possible manner to reduce the likelihood of victimization. Tools of the trade are shared here in the hopes of creating a community safety net, enhancing community capacity, and enabling individuals and front-line service providers to make evidenced-based decisions.

This reference resource guide represents a collaborative effort by Central West Network of Specialized Care and Peel Behavioural Services, Trillium Health Centre. The comprehensive capacity-building initiative was initially launched by a Central West Region community training event conducted by Dr. Robin J. Wilson and Michele Burns. Following the training event, broad community consultation across Central West Region was conducted to ensure the resulting outcome would meet your needs.

This Quick Reference Resource Guide is a much shorter version of a larger guidebook, entitled Intellectual Disability and Problems in Sexual Behaviour: Assessment, Treatment, and Promotion of Healthy Sexuality, and was written by the same authors.

A big thank you is owed to all of the staff at Peel Behavioural Services, in particular the Sexuality Team, and manager, Leanne Baldwin, for their contributions in making this reference resource guide possible. Last, we owe a great debt of gratitude to Trevor Lumb, Regional Coordinator of the Central West Network of Specialized Care.

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Service Flow Chart

This resource guide follows the outline of a flow chart designed to detail specific actions you can take when a client you are supporting exhibits sexually inappropriate behaviour. The flow chart that follows provides an overview of the process that workers should follow when they suspect that someone is engaging, or could potentially be engaging, in sexually inappropriate behaviour.

The chart shows potential stakeholders involved with the individual, as well as some red flags that may indicate someone may be engaging in inappropriate sexual behaviour. Should some of these red flags be observed we need to look for possible explanations. Collecting data, keeping notes of one's observations, and speaking with others is important in determining if a referral to a trained professional for a risk assessment should be made. It is the expertise of a trained professional that will determine whether the behaviour is sexually inappropriate and what the risks may be to others. The assessor will determine if the individual requires treatment and if the individual requires specific education. The assessor will also make recommendations that will assist in providing clinical and risk-management supports for the individual.

In the interim, there are a number of things that support workers can do to ensure that the individual and the community remain safe until either an assessment is completed or the nature and origins of the behaviour are clarified.

Finally, the flow chart outlines the responsibilities of staff to ensure that all involved parties communicate and work as a team. Suggestions are provided to help prevent burnout when working in this field. This is difficult work that is not for everyone. It is extremely important that those supporting the individual know their limitations.
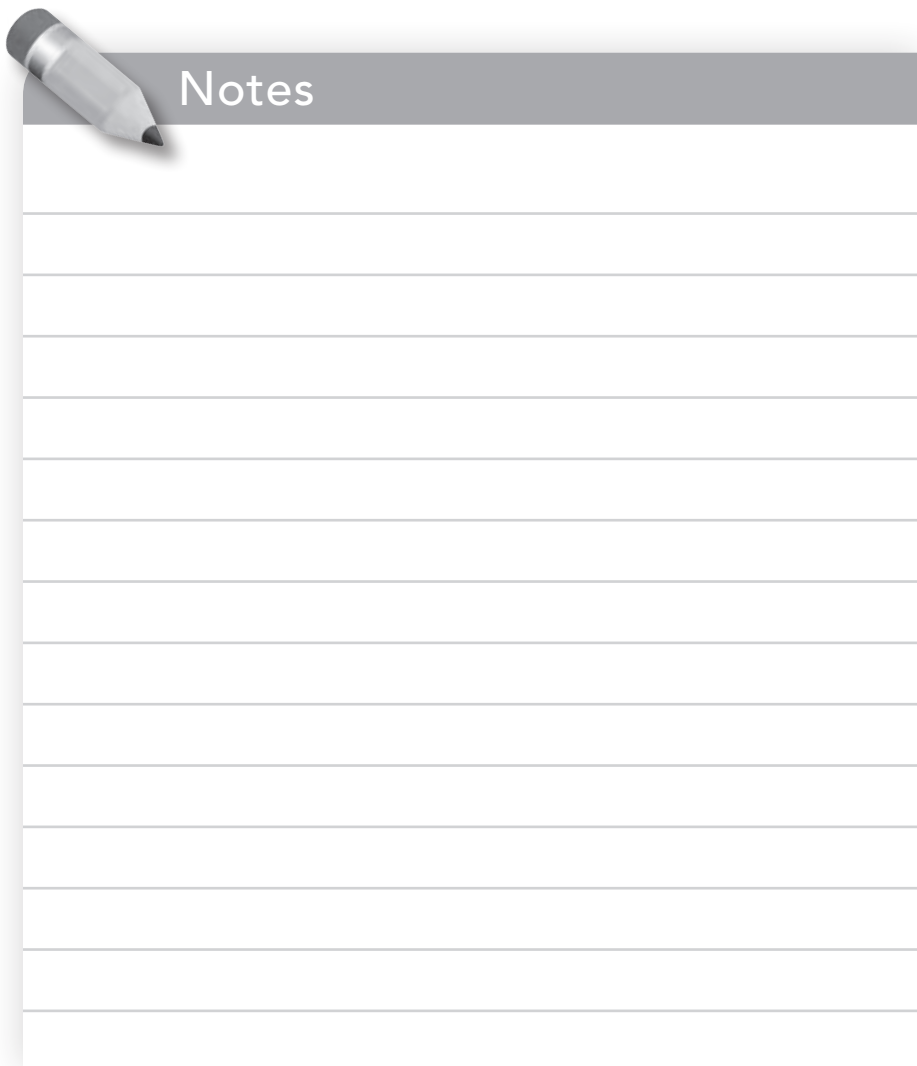
Service Flow Chart

The following is a service flow chart for persons supporting an individual with an intellectual disability who presents issues of concern regarding sexually inappropriate behaviour.

Individual with an Intellectual Disability

Stakeholders
- Care providers
- Citizens
- Mental health professionals
- Law enforcement
- Legal or correctional personnel
- Victims
- Media

Possible Red Flags
- Preoccupation with children
- Fetishes (e.g., diapers, urine, shoes, feet, etc.)
- Frequent touching of others'/their own genitals
- Inappropriate masturbation/exposure
- Increased preoccupation with sex and sexuality
- Increased stress
- Excessive pornography
- Grooming behaviour
- Alcohol and drug abuse
- Inappropriate perceptions of attitudes towards sexual relationships
- Secrecy

Look for Indicators

Functional Behavioural Assessment
- Bio-psycho-social (biological, psychological, social)
- Functional, direct, and indirect assessment tools
- Reinforcement

Collection of Data
- Frequency
- Duration
- Documentation of unusual incidents

Some Interim Measures
- Supervision
- Safety plans
- Outing journals
- Media
- Room checks
- Boundaries/Relationship education
- Age discrimination
- Social skills
- Communication
- Hygiene
- Self-esteem
- Healthy sexuality education
- Consent
- Healthy masturbation education
- Emotions management
- Abuse prevention

Staff Strategies
- Staff support
- Communication
- Documentation
- Staff meetings
- Team building
- External support
- Training
- Clinical and professional boundaries
- Disclosure documentation
- Vicarious trauma and stress management

Referral for Sexuality Risk Assessment

Non-Deviance

Education Skill-Building

Deviance

Treatment
To be done by a qualified therapist

Notes

Individuals with an Intellectual Disability

Working with individuals with an intellectual or developmental disability can be a really rewarding job. We can learn so much from each other, and as a result all of our lives are enriched.

For the purpose of this resource guide the terms developmental disability and intellectual disability are used interchangeably. We will be using Bill 77's definition of developmental disability, as follows.

PROVINCE OF ONTARIO, BILL 77
Services for Persons with Developmental Disabilities Act 2008

A person has a Developmental Disability for the purposes of this Act if the person has the prescribed significant limitations in cognitive functioning and adaptive functioning and those limitations,

a) originated before the person reached 18 years of age

b) are likely to be life-long in nature; and

c) affect areas of major life actively, such as personal care, language skills, learning abilities, the capacity to live independently as an adult, or any other prescribed activity.

Adaptive functioning means a person's capacity to gain personal independence, based on the person's ability to learn and apply conceptual, social and practical skills in his or her everyday life. Cognitive functioning means a person's intellectual capacity, including the capacity to reason, organize, plan, make judgements and identify consequences.

This definition includes a variety of disabilities such as intellectual, visual, hearing, and mobility. Various diagnoses may also be included, such as Down's Syndrome, Autism, Global Developmental Disability, and Asperger's Syndrome, to name a few. Within the scope of this resource guide, it would be impossible to address the various needs of every diagnosis. Each individual is unique and those supporting persons with disabilities will need to adapt the strategies provided in this resource guide to suit specific individual needs.

When working with persons who have an intellectual disability and who may also engage in sexually inappropriate behaviour, the work becomes more challenging. A heightened level of supervision is then required to ensure both the safety of the community and the individual in question.

Definition of Sexual Deviance

When defining sexual deviance, many factors must be taken into account such as age, diagnosis of the individual, etc. Obviously, sexual behaviour that is against the law constitutes illegal sexual behaviour. However, when considering individuals with intellectual disabilities it becomes more confusing. For example, an individual with an intellectual disability who seeks out diapers for the purpose of cleanliness when masturbating is not deviant. But when this individual seeks out diapers, thinks about a child wearing diapers, is aroused by the image of the child when masturbating, and subsequently seeks out opportunities to be with children, this individual may possibly sexually offend against children in the future. It is now of concern that the individual may engage in sexually deviant behaviour.

Sexually deviant behaviour is when the individual is not only aroused by, but is likely to act on the arousal, with an inappropriate aged person or thing—e.g., pedophilia or bestiality.

It is normal for people to be sexually interested or aroused by items that are deemed by some to have a sexual component. It becomes a problem when that person fixates on an object or behaviour that

is markedly different from what the "norm" would be interested in. "Fetishes" around such things as women's boots, stockings, and/or collecting urine to evoke sexual arousal are considered to be examples of sexual deviance, but they may not be of clinical concern. We consider these behaviours to be a problem and sexually deviant when they cause disturbances in personal or social functioning. For example if an individual seeks out these items in an inappropriate manner such as by touching a woman's boots when the woman is wearing them, without her consent, or asking someone to urinate on them.

So, there is sexual deviance and then there is sexually deviant behaviour that causes clinical concern. There may be many reasons why an individual engages in inappropriate behaviour. To confirm that the individual's behaviour is sexually deviant, an assessment needs to be conducted by a trained professional with expertise in the area of sexual deviance, under the supervision of a psychologist.

It is not uncommon to have negative and visceral responses when we hear these stories of individuals who experience inappropriate sexual arousal. However, it is important for staff to determine whether they can be objective and work effectively with such individuals in spite of their behaviour. It is important for those supporting the individual to know their limitations. It is better to acknowledge that this type of work is not appropriate for you than to continue to work with the individual. All involved will be negatively affected if one continues to work in this field when she or he cannot separate the person from the behaviour.

It has been said that each person actively engaging in sexually abusive behaviour has an average of five victims per year. For many persons working in this field, there is great satisfaction in knowing that when their job is done well, the number of potential victims can be reduced. If this is the case, those of us working effectively with persons at risk to offend are both ensuring that the individual is staying safe and reducing the number of potential victims who may suffer from sexual abuse.

Who Are the Stakeholders?

Individuals with intellectual disabilities typically have more stakeholders in their lives, due to the nature of their disability. When clients are young, they may have a variety of therapists working with them, such as speech and language pathologists, physiotherapists, occupational therapists, behaviour therapists, educational assistants when in school, and staff from community agencies. As can be seen from the flow chart, when an individual has offended or has engaged in behaviours that could potentially lead to offending, that number of stakeholders increases significantly—police, probation officers, court staff, Children's Aid Society (CAS) and other protection agencies, and the community at large all become involved. In order to ensure the safety of the individual and of the community, it is critical that all persons involved work as a seamless team to support the individual.

What Should We Look For?
Possible Red Flags

Persons directly supporting an individual with an intellectual disability may observe traits that cause some concern regarding the possible presence of inappropriate sexual interests. However, it is important to note that anyone may experience some of the things in the following list. It is not our suggestion that all persons with these interests are "sexually deviant," per se. Rather, it is the combination of factors and/or the intensity with which the individual pursues them that may cause concern.

Some things to look for:

- **Increased interest or focus on specific age groups (e.g., children):** The individual is overly interested in persons (or things) deemed inappropriate because of their age. This would include children's books, movies, television shows, activities, toys, outings, wanting to be with children, clipping pictures of children out of magazines, wanting to work in a daycare and downloading

pictures of children from the Internet. Some clients who present with these issues become agitated when they are unable to view specific media or to have access to certain things related to their inappropriate interests.

- **Increased interest or focus on a specific type of item (e.g., boots, lingerie):** Sometimes, clients will seek out individuals wearing specific types of clothing or they will try to gain access to a particular item. This may indicate that the individual has a sexual fetish involving a particular item. Many individuals use such items solely to increase their sexual arousal, without targeting other persons, which is not necessarily behaviour indicative of a problem. However, when the individual actively seeks out others to satisfy fetishistic interests, this may lead to inappropriate sexual behaviour. For example, if a person aroused by diapers actively seeks out a child wearing a diaper, there should be heightened concern that the individual may pose a risk to the child regarding how they intends to satisfy his or her sexual urges.

- **Secrecy:** When supporting persons with intellectual disabilities, caregivers may find items in the individuals' possession that they were not aware that they had. A caregiver may find children's underwear in their room, pictures of children on their computer or under their mattress, or pornographic videos in their room. When going out in the community, persons with inappropriate sexual interests may secretly deviate from their normal routines so that they can purposely walk by schools or daycare settings. They may also become verbally aggressive when discussing or being questioned about things.

- **Frequent attempts to touch their genitals or those of others, regardless of the setting:** Some individuals with sexual behaviour problems make attempts—successfully or not, and regardless of the setting—to touch the genitals, breasts, or other erogenous zones of others. They may also try to manipulate others to touch
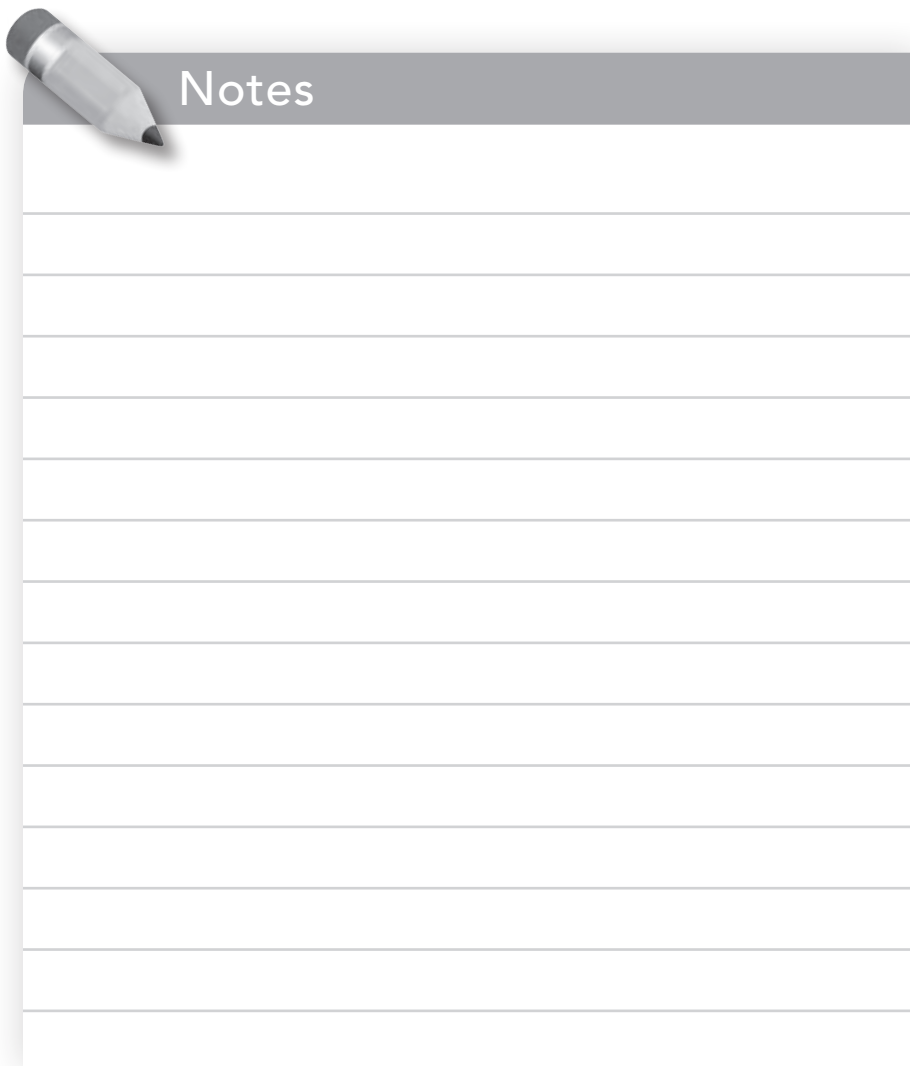
their genitals. This may occur at home, work, or in the community. They may also frequently touch their own genitals in public. This behaviour may be impulsive or intentional.

- **Inappropriate masturbation or exposure:** Some persons with sexual behaviour problems expose themselves in public and may attempt to masturbate in a public place. This may also include repeated urination outside of washroom facilities or the smearing of feces. Others may attempt to "hump" people without their consent. Sometimes, the practice of these behaviours is supported by engagement in inappropriate fantasies when masturbating.

- **Grooming:** Grooming is what we call behaviour in which individuals show an unusual interest in a certain type of person (e.g., age, gender, etc.) for whom they have sexual interest. They may use coercion, bribes, or threats to spend time with those desired individuals, or attempt to get them alone in secret. This often involves quite a bit of planning as to how, when, and where they will get access to the individual.

- **Pornography:** Some persons with sexual behaviour problems have inappropriate or illegal pornographic material in their possession, or they may possess an extraordinary amount of pornography. Such individuals may also spend an unusually large amount of time looking at or looking for certain types of pornography, often on the Internet. Depending on the individual's sexual target, pornography may be idiosyncratically defined.

- **Alcohol/drug abuse:** Alcohol/drug abuse can hinder one's self-control and, under certain circumstances, may increase the possibility of engaging in sexually offensive behaviour. People are often much more impulsive while under the influence of drugs/alcohol, and this type of chronic abuse can exacerbate the lack of control an individual feels in her/his own life.

- **Stress:** Stress can affect how a person deals with issues in his/her life. If you are working with persons experiencing stress, you

may want to assess whether they are experiencing chronic or acute stress, as well as the degree to which they are able to employ coping skills for dealing with their stress. In some cases, they may lack the skills altogether or use "skills" that are ineffective or maladaptive. Some persons engage in explosive behaviour as the result of stress, while others isolate themselves. You may need to assess whether your clients' behaviour is the result of generalized impulsivity or is the result of stress.

- **Inappropriate perceptions/attitudes towards sexual relationships:** Some persons with sexual problems may appear to have unusual or skewed attitudes towards sexual relationships, intimacy, and/or sexual behaviours. These factors may be the result of a lack of education or a misunderstanding about issues of consent, private versus public behaviour, and what constitutes an appropriate sexual relationship; however, they may also indicate serious offense-related cognitions and behaviour patterns. Such perceptions and attitudes may be evident in an individuals' verbal communication, the drawings they make, their physical reactions to others, fear of intimacy, overly familiar behaviour, a tendency to romanticize all relationships, a sense of sexual entitlement, or the blaming of others for breakdowns in relationships, to name a few.

- **Increased preoccupation with sex:** Some individuals have a preoccupation with asking about or discussing sexual issues. This may be evident in their wanting to view sexual content on television, on the Internet, or in other media. They may also repeatedly seek out individuals/things to have sex with. Such persons may also construct things to have sex with (e.g., making holes in furniture or stuffed toys), they may force others to play sexual games with them, constantly tell dirty jokes, or frequently display sexual frustration.

Notes

Looking for Indicators

In assessing the potential risk that a particular person with an intellectual disability may pose for themselves or others, we need to consider what the function of the behaviour is and look for possible appropriate replacement behaviours.

Behavioural Considerations

When seeking to change any behaviour, we need to understand behavioural principles. Knowing what behaviour you want to change, what functions that behaviour serves for the individual, and how to identify an appropriate replacement behaviour is fundamental to any behavioural program, for individuals who engage in sexually inappropriate or offending behaviour as with any other individuals. For example, when an individual has a difficulty with "fetish" behaviour, we need to attempt to determine what function this behaviour serves for the individual. Why the individual grabs at himself/herself while in public, and why the individual targets young children to touch in an inappropriate manner are other examples where we need to determine the function of this behaviour.

Functional Behavioural Analysis

Not all sexual behaviours are driven by an inappropriate sexual arousal. Some behaviours are a result of circumstances. There are a number of factors that may hypothetically account for an individual engaging in inappropriate sexual behaviour, including:

- Lack of sexual/social education

- Modelling or re-enactments of behaviour they have witnessed or been a part of, either positively or negatively
- Behaviours that are the result of a medical condition (for example, an infection in the genital area that results in excessive scratching, regardless of the setting).

To implement behavioural techniques to determine if one of these hypothetical scenarios applies to the individual you support, you must do a Functional Behavioural Assessment (Cipiani & Schock, 2007). These assessments focus on three main areas:

- Bio-psycho-social
- Functional
- Reinforcement

The Bio-psycho-social assessment

First, let's look at the Bio-psycho-social assessment. This assessment consists of three components—Biological, Psychological, and Social.

In the *Biological* component, it is important to summarize known medical conditions. Include all possible medical concerns that may influence the target behaviour, and the impacts of any medications that the individual may be taking. Behaviours such as inappropriate touching or exposure may be the result of side-effects from medication, or possibly of a sexually transmitted or other genital infection. It is always important to first rule out any underlying medical conditions.

The *Psychological* aspect considers conditions and associated cognitive or behavioural characteristics and/or deficits that may influence the behaviour. For example, a known diagnosis of Autism may account for a lack of understanding regarding social-personal boundaries.

The *Social* component summarizes details of the person's social environment (e.g., opportunities to engage in age-appropriate social activities, family life, and integration). For example, in cases where

an individual may be targeting younger individuals, but has not had an opportunity to socialize with age-appropriate peers, the behaviour may not be deviant. Rather, the behaviour may indicate a lack of opportunity to access age-appropriate peers.

The Functional assessment

The Functional aspect consists of two components: indirect and direct assessment methods. In the indirect assessment, we conduct behavioural interviews with all pertinent parties. Standardized assessment tools, such as the Question About Behavioural Functioning (QABF), Motivational Analysis Rating Scale (MARS), or the Functional Analysis Screening Tool (FAST) may be useful in structuring this assessment.

Direct assessment methods include such components as determining a baseline, creating scatter plots and conducting functional analysis/analogue assessment and observations, and assessing ABC data (antecedents-behaviour-consequences).

A baseline is a measure of the target behaviour before intervention, which usually includes either frequency or duration data. Scatter plots are charts used to plot occurrences of behaviour in relation to time. These plots help to gain an understanding of when the behaviour occurs at its highest or lowest frequency. This can assist in generating hypotheses related to the function of the behaviour (e.g., high rates of behaviours may be found to be associated with certain environments or activities).

Functional Analysis/Analogue Assessment is an experimental analysis of behaviour functions under contrived test conditions that typically include attention, demand, and being alone. These contrived conditions are used to mimic contingencies occurring in the natural environment that are hypothesized to be controlling the behaviour.

ABC data provides a descriptive analysis (e.g., antecedents, behaviour, consequences). When looking at a number of descriptive examples, patterns often become clear and show us which

antecedent conditions precede the target behaviour as well as which consequences serve to reinforce the behaviour.

The ABC Model

All behaviours have a purpose and a function. That is, the behaviour happens for a reason. The reason could be to gain access to something or someone needed or wanted (e.g., attention, control, activities, items), or to avoid or escape something (e.g., a task or a demand). Identifying the ABCs—Antecedents, Behaviours, and Consequences—can assist in determining appropriate replacement behaviour.

- An antecedent or trigger is what happens immediately before the behaviour occurs. This may include instructions, boredom, being told "no," loud noises, being "touched" in uncomfortable ways, or physical conditions (being tired/hungry), to name a few.
- A behaviour is what we can see or hear a person do. A behaviour is measurable.
- A consequence is what happens immediately after the behaviour occurs. The consequence can be positive, negative, or neutral. Consequences are important, because they strengthen or weaken the behaviour. Also, consequences often become the next antecedent in a cycle of behaviour.

Determining the antecedents to a behaviour can be difficult. There are times, such as when an individual sexually targets a young child, that the only acceptable immediate replacement behaviour is to keep both the potential victim and the individual safe by severely limiting or precluding the client's access to children.

There are many ways to change an antecedent (using antecedent control strategies) that will assist in increasing the positive behaviour. Some of these include establishing a routine, changing how instructions are given, providing advanced warning, offering redirection, changing aspects of the environment, and providing

choices. It is important for staff to know how to provide instructions and education, particularly with an individual who has an intellectual disability. Facilitators will need to establish good rapport with the individuals they support and know how the individual learns best.

If the consequence of a behaviour is pleasant, the behaviour is likely to increase; if the consequence of a behaviour is unpleasant, the behaviour is likely to decrease. However, sometimes a consequence that we might think is negative, such as yelling or assigning a time out or a punishment, may in fact be reinforcing to the individual.

There are a variety of reinforcers that may assist in maintaining the appropriate replacement behaviour. Reinforcers include social reinforcers, such as praise, high-fives, or smiles; activity reinforcers, such as going to the movies, going for a walk, or playing a game; material reinforcers, such as a small tangible item (like a gift certificate); and food reinforcers, such as going out for ice cream (please note that these should be used sparingly and with awareness of health concerns such as diabetes).

The many ways to teach a new behaviour include shaping, task analysis, chaining, modelling, prompting, using visual strategies, engaging in role plays, employing a token system, and practising the new behaviour. To maintain a newly taught behaviour, the individual must continue to use the strategies that successfully helped the individual to change the behaviour in the first place. The goal, then, is to have the individual generalize the appropriate behaviour to other settings and use the appropriate behaviour with other mediators.

Should we find that the desired behaviour changes are not occurring, we want to troubleshoot with the team by asking some of the following questions:

- Are you hoping to decrease too many behaviours at once?
- Is the reinforcer really motivating for the individual?
- Are all staff being consistent?
- Is the expectation realistic?

ABC Data Chart

The following is a chart that may be used to map out ABC data when doing Functional Behavioural Analysis.

Date	Time	Those Involved	Antecedent/ Trigger	Behaviour	Consequence	Comments

ABC Data

Daily Mood Chart

The chart below gives examples of what to look for in the way of behavioural and affective cues.

Hrs./ Day of Sleep	Time	Anxiety Level	Irritability Level	Depressive Symptoms				Manic Symptoms			
				Severe	Moderate	Mild	None	Severe	Moderate	Mild	None
	Morning	Low	Low								
		Med.	Med.								
		High	High								
	Afternoon	Low	Low								
		Med.	Med.								
		High	High								
	Evening	Low	Low								
		Med.	Med.								
		High	High								

	Mild	Moderate	Severe
Depressive		▪ Displays flat affect ▪ Seems groggy ▪ Stays in room ▪ Does not greet people	▪ Does not come out of room ▪ Appears completely withdrawn
Manic	▪ Overly talkative ▪ Uses moderate volume ▪ Performs excessive mimicking ▪ Shows some impulsivity ▪ Performs rhythmic tapping ▪ Invades personal space ▪ Wanders	▪ Consistently antisocial ▪ Will not engage ▪ Keeps to self ▪ Seems quiet ▪ Cannot regulate emotions ▪ Excessive laughing, crying, etc. ▪ Disregards boundaries ▪ Uses high volume, sweats, wanders excessively, shows increased impulsivity	▪ Hits, kicks, bites, threatens ▪ Holds head, cannot self-regulate, talks about head hurting ▪ Uses extreme volume ▪ Threatens harm

Daily Mood Chart

Bear in mind that all individuals learn differently, and the type of disability that the individual has will determine how we provide education. The facilitator will obviously have to make modifications if the individual also has a hearing, visual, or mobility impairment.

When implementing a new behavioural strategy, it is important for those involved to keep data. When working to change a behaviour, such as hitting, all persons involved must clearly identify the behaviour that they want to decrease and define the appropriate replacement behaviour. Staff then set up a data sheet to accurately measure if the behaviour is decreasing (and the replacement is increasing). It is extremely important that all those working with the individual record data accurately and consistently (remember standardization, reliability, and validity—they're important here, too!). The data recorded will assist the team in making critical decisions, such as whether the client may go on future outings or is ready for a decrease in supervision.

Referral for a Sexuality/Risk Assessment

If you feel that the Functional Behaviour Assessment did not explain why the client is behaving inappropriately, or if you feel that you are not qualified to perform this assessment, you should refer the individual for a Sexuality/Risk Assessment. It is important that the assessment be completed by a trained therapist under the supervision of a psychologist, as their expertise in this area will determine whether the behaviour is of a sexually deviant nature or not, and permit them to make the recommendations they feel necessary to assist the individual with their behaviour.

Interim Measures

When working with an individual that you suspect may be engaging in inappropriate sexual behaviour and as a result may be a risk to themselves or to the community, you have access to a number of measures that can and should be put in place while an assessment is being conducted to determine whether or not the individual poses a true risk. Similarly these interim measures can be used if you have an assessment and you and the client are waiting for treatment. Some of these interim measures may be very new to the individual and we must not forget that at times it may be challenging for them as well as us. Therefore, it is essential that all working with the individual remember that reinforcement of appropriate behaviours and the development of new skills is very important to the individual both in acquiring the skills and in maintaining them. Remember that reinforcement, when used appropriately, is very powerful.

Supervision

Although we know that it is best to provide a level of supervision that corresponds to the level of risk, at this point, while we are waiting for an assessment or treatment, the best thing to do is increase the level of supervision of the client when in places with high levels of risk or with any potentially vulnerable persons. For example, if you suspected that the individual had an interest in or is sexually aroused by children, you would want to ensure that the individual is never in settings where there are large numbers of children. Therefore, if the individual worked in a setting where there are children, it would be of benefit to look for another place of employment. If the individual regularly passes schools or children's playgrounds on the way to and from work, you would want to find another route. Should there be times that the individual is around children, you would plan to always have someone

else present to support eyes-on and ears-on supervision. Written Safety Plans are helpful in assisting all involved in supporting the individual in a consistent manner.

Active supervision is a key strategy in supporting the individual. While we recommend giving the individual room to initiate certain tasks and work as independently as possible, diligent supervision remains necessary in order to make individual-centered support work as well as it can. Being eyes-on and ears-on at all times is one of the best ways you can support the individual. Below are some useful tips:

- Create and implement effective protocols and procedures for management and supervision of the individuals you support. Ensure that each protocol is specific to each individual's needs, behaviour, and overall status. For example, if you know the client calls on friends to bring diapers, you may need to screen that client's calls. You may need to go one step further by ensuring that when friends bring items into the home, bags, purses, or backpacks are not taken into private areas, such as the individual's bedroom or bathroom.

- Plan ahead. Pre-planning affords both the service provider and the individual an opportunity to anticipate problems and come up with solutions or a contingency plan. For example, if you are going to the movies consider that the best time to attend will be when fewer children are likely to be present.

- Review and update protocols and procedures on an ongoing basis, to ensure appropriate and effective supervision. The goal is to ensure that all who support the individual are consistent when supervising and implementing protocols that will in turn assist the individual by providing them with a clear, consistent, structured approach.

- Be vigilant and get to know the person you support, so that you can detect changes. Active supervision consists of being eyes-on and ears-on at all times. It is essential for those that support the

individual to be "present" while working with the individual. Support persons need to have keen observational skills to detect changes in the individual's mood or behaviour, which may indicate a possible issue.

- Foster both a positive and an interactive environment with the individual you support. Provide a structured daily routine that allows the individual to be involved and participate in daily activities.

- Keep good records. Effective supervision involves proper documentation of that supervision. Support persons need to ensure that appropriate documentation is completed each day, which assists in keeping everyone who is involved with the individual "in the loop" while ensuring the individual's and the community's safety.

- Pre-plan every event as a team and ensure that all parties involved are aware of the event and the details involved.

Safety Plans

When we work with clients with problems that potentially place themselves or others at risk for harm, we need to be sure that appropriate intervention strategies are put in place. In essence, we need to create a "safety plan" that will help ensure that risks to these persons will be addressed and that appropriate interventions will be effective.

What Is a Safety Plan?

A safety plan is a written description of what a supported individual needs to do to stay safe in designated areas (e.g., in the general community, on home visits, at the group home). It is an effective tool that can be used to keep the community safe, and it provides an opportunity for the supported individual to self-regulate using safety strategies while generalizing her/his skills.

Making a safety plan involves identifying the steps that the individual you support needs to take to increase his or her safety in various settings. A safety plan presents clear and direct guidelines as to what the supported individual would need to do to remain safe and appropriate in an environment that may become dangerous. Not only does it help the supported individual, it also prepares support staff in advance for any possibilities when encountering a potentially dangerous situation such as increased access to targeted individuals or engaging in paraphilic behaviour.

Who Should Receive a Safety Plan?

Persons with intellectual disabilities engaging in potentially inappropriate sexual behaviour should develop a safety plan in partnership with their service providers. Having a safety plan promotes a sense of responsibility by ensuring that the supported individual actively uses the strategies that he or she has learned, to keep everyone safe.

In order to make sure that the individual receiving support receives consistent support, all service providers who support the individual should have access to the safety plan. The safety plan should clearly state what steps need to be taken to keep the individual safe. In group homes and other communal environments, copies of all client safety plans should be kept in a common area for staff to have easy access at any given time. It is also advised that both staff and clients consistently review their individualized safety plans to keep the information fresh. In addition, persons outside the group home must have access to this information. For example, if the individual has a safety plan for when he/she goes home, the family should be provided a copy as well.

Individualized Safety Plans

Not all persons who sexually offend are alike. Other than the common denominator of committing sexually inappropriate acts, individuals experiencing such difficulties differ in personality,

triggers, and their overall behaviour patterns. Although some safety plans can be generalized, it is prudent to ensure that the safety plans are comprehensive, relevant, and individualized. In other words, each safety plan should be designed and tailored specifically for the particular individual being supported. There are several key issues that should be considered when developing a safety plan.

First, an individualized safety plan requires general assessment of the risk level and the needs of the supported individual. For some individuals, a safety plan may need to specify restrictions on specific activities, such as certain employment opportunities or extracurricular activities that may increase the risk for them. At the same time, the activities above may not be problematic or potentially dangerous for other supported individuals. Based on their different needs, some individuals may require different types of support strategies. Hence, it is important for staff to have a full understanding the needs of the individual with whom they work. To create a safety plan that is relevant to the client and to the client's prioritized needs, it is first necessary to review the available assessment reports, prior treatment records, behaviour patterns, and individual tendencies. Identifying the supported individual's strengths and assets is important in identifying the individual's capabilities to excel in a certain area and, furthermore, provide a clear indication of the type of safety plan that is best suited for each individual.

Next, it is important to take into account the needs and safety of potential victims. Remember that inappropriate behaviour can be triggered by potentially vulnerable persons as well as by objects, animals, and images that arouse individuals. In these circumstances, safety is a sensitive issue and can become particularly challenging in cases where the individual offends against a family member. In such cases, the safety plan must clearly state the specifics of what is restricted and what is allowed. For instance, if the individual you support has sexually offended against a family member who is a minor, the safety plan for that individual should clearly indicate the

restrictions involved in a home visit, if applicable. This may include adult supervision or no contact with minors (including the victim), among other areas of concern.

Safety Person

Safety persons are important in helping persons with intellectual disabilities to manage any risk they may experience. In typical daily living, most people have family and friends on whom they can rely to assist them in attending to personal goals and issues. Often, persons in care or under supervision do not have access to the same sort of family or friendly support, and they receive the bulk of their supervision from persons who are paid to do so. However, whenever possible, it is quite helpful to involve other persons important in the client's life. As such, other than staff, family members (both immediate and extended) or a friend can also be safety persons. It is important that safety persons go through a process of standardized training sessions before they are considered to be potential safety persons. It is highly recommended that all external contacts be identified as a "safety person" before independent supervision (i.e., without front-line staff accompanying them) is established.

Below are the necessary requirements for an external contact to become a safety person:

- The supported individual should establish rapport and feel a sense of comfort with the safety person.
- Safety persons must be committed to safety for both the community and the supported individual.
- The supported individual must agree that the proposed safety person will be added to their safety plan (a meeting/session is usually set up to go over the requirement and conditions of a support individual).
- A safety person must have solid background knowledge of the supported individual's issues and the strategies needed to best support them.

- The potential safety person must undergo training—this may be going out with front-line staff and the supported individual on numerous occasions to ensure consistent implementation of the safety plan.

- The safety person should be responsible and conscientious (i.e., they must be knowledgeable of the plan, believe in the plan, and do their best to further the intent of the plan).

- The potential safety person should be willing to undergo a police background check.

How to Create a Safety Plan

First, ensure that the text is clear and concise. Language should be written at a level that the supported person can understand. Avoid jargon and technical terms. Second, the supported person should be actively involved in creating the safety plan(s). This provides a sense of accountability in following through with the steps required to keep them safe. Be sure to consider time and place when creating a safety plan. For example, an individual who becomes hyper-aroused around children may want to consider the time of day and the places that he or she can go. It is also important to consider the relevance of the plan; that is, how significant the safety plan is to the individual's current status and situation. Consider the replacement behaviour, and identify the most appropriate response to a potentially dangerous situation.

There are several issues and conditions that need to be considered when creating a safety plan. Specifically, it is important to consider:

- **Time:** Curfew restrictions.
- **Time period:** Consider the time when the individual is going out, as this may be a key component in determining appropriate areas.
- **Place:** Restrictions on encountering potentially vulnerable persons and objects that may trigger inappropriate behaviour is necessary, but it is important to understand that safety plans are designed to provide a safer option for the supported individual.

The goal is to integrate the supported individual into society while providing safety strategies for them to regulate their behaviour. For example, an individual who is attracted to children can go to the mall (within reason); however, an amusement park should be prohibited because of the high volume of potentially vulnerable persons who might be present. Also, an individual who engages in inappropriate sexuality with pets or other animals should not go to a pet store or animal shelter; an outing to an arcade may be an acceptable alternative.

- **Safety person:** Other than staff, it is important for external support (e.g., family members) to have a clear understanding of the individual's issues and what is required to keep him or her safe—before considering support. Individuals who are not on the safety plan should not be allowed to take a supported individual into the community.

- **Media:** The supported individual's access to the Internet, television, and movies in the community should be consistent with the viewing allowed in a more supported environment.

- **Emotional readiness:** The individual and the support team should be aware of the individual's level of negativity and anger, as strong emotional reactions and states are suggested in the literature on risk management as strong dynamic predictors of potential reengagement in problematic behaviour. The individual should be calm and focused on the task at hand.

- **Triggers and antecedents:** What sets the individual off?

- **Troubleshooting strategies:** Safety plans should also incorporate strategies to use should the individual encounter difficulties while out in the community. Planning ahead for what to do should things go differently than expected is extremely important. For example, if you have planned to go to the adult swimming program at the recreation centre, what do you do if, upon your arrival, you learn that there is a children's birthday party on

the other side of the pool? Everyone involved in creating the safety plan and in planning outings must think ahead as to what strategies will be used when the situation changes.

Because not all persons who sexually offend are alike, not all safety plans should be alike. Conditions should be imposed and implemented selectively, based on the individual's circumstances and risk profile.

On the following page is an example of a safety plan for a client who may engage in potentially inappropriate behaviour with children. Please note the reference to Self-Regulation strategies: the individual receives training in how to use Self-Regulation strategies in the hope that he or she will use these strategies to notice and alter behaviour based on the circumstances.

Most persons with intellectual disabilities and sexual behaviour difficulties have individualized treatment and risk-management needs. A comprehensive assessment of the nature of the individual's issues allows us to create and implement a personalized risk-management plan. Clients with intellectual disabilities often need complex concepts to be simplified and put in easily understood terms. For example, risk factors may be called "danger zones" to assist clients in being better informed about the risks they may encounter and how to manage them when they do encounter them.

Generalized safety plans can be used in a group home for supported individuals who share similar issues. If the supported individuals vary in their backgrounds in terms of triggers, danger zones, and behavioural tendencies, an individualized community safety plan is the most effective option. We highly recommended that the supported individual read their safety plan each time he or she goes into the community. This serves as a prompt to remind the individual of his/her responsibility to utilize their safety strategies. The individual is also thereby held accountable for her/his actions. Prior to going into the community, the supervising adult should ensure these generalized safety plans are reviewed with the individual.

The introduction section of the Individualized Safety Plan can be deleted should it not be required.

Individualized Safety Plan

Introduction:

Individuals who engage in sexually deviant behaviours generally do not realize how much harm an offense causes. The victims often suffer extensive, long-lasting problems. They may have difficulty controlling their thinking and behaviour, lose their self-confidence, have problems with their sexuality, and experience sleep disturbances and actual physical illness. When the victim of abuse is a family member of the offender the problems are even worse.

For these reasons, all who support an individual at risk of offending must work together to be constantly vigilant. Although the individual is responsible for learning how to keep himself or herself safe, all must assist and support the individual so further offenses are not committed. This is the only way to keep both the individual and the community safe.

Plan and Agreement

A meeting was held with the individual and _____ (list parties) on _____ (date). The importance of ensuring that _____ (name of client) is provided with the appropriate levels of support and supervision when he or she is in the community, visits his or her family, etc. was discussed. It is recommended that _____ (name of client) be supervised by a responsible adult over the age of 18 [here one may adjust the age in keeping with the age of the client—an older client should have a

safe person whose age is closer to his or hers] who is aware of their Safety Plan, and the sorts of issues he/she might face in the community. This person is referred to as a *"safe person"* and can help to prompt _____ (name of client) to use safety strategies in the community. These strategies may include but are not limited to looking away, walking away, thought switching, and/or talking to a safe person.

The safe person agrees to abide by the agreement detailed below as indicated by signing the plan.

1. It is recommended that _____ (name of client) not be provided with the opportunity to exchange physical or close contact with any children under the age of 18, including family members. When appropriate, _____ (name of client) may give "props" or "knuckles" to teenage family members.

2. _____ (name of client) may not to be in the company of anyone under the age of 18 unless supervised by a safe person over the age of 18 who is aware of his or her issues.

3. _____ (name of client) is to be within eye- and earshot of a safe person at all times. This is not necessary when _____ (name of client) is in the washroom or in the privacy of his/her bedroom. _____ (name of client) should not have a television or computer in his/her room.

4. When _____ (name of client) is with family, he/she will not go into the community unless a accompanied by a safe person. _____ (name of client) is to review the plans prior to going out and determine if the outing is an appropriate one. Part 1 of the Outing Journal must be completed prior to the outing and Part 2 must be completed upon returning from the outing. The Outing Journal will be returned to those recording the data.

5. When _____ (name of client) is visiting people (i.e., family members), _____ (name of client) will never be left alone in the home.

Safety Plan 1

6. _____ (name of client) will never be left alone with children, or be requested to interact with children who may be visiting the home or in the community. _____ (name of client) is to be encouraged to use his or her Supported Self-Regulation Techniques when children may be in the area, and the safe person must respect _____ (name of client)'s decision to leave the environment should he or she report feeling uncomfortable. Should _____ (name of client) experience a Lapse and not leave the area, the safe person must prompt _____ (name of client) to either leave or move to a safer place.

7. Should _____ (name of client) need to use the washroom when in public, it would be preferable to find a single-stall washroom. If one is not available, the safe person must ask _____ (name of client) to make sure the washroom is safe prior to using the facilities. If _____ (name of client) is with a same-sex safe person, the safe person must go in the washroom with _____ (name of client).

8. When _____ (name of client) is at home, all media must be screened for appropriate content. Magazines, books, television programs, newspapers, catalogues, movies, DVDs , digital cameras, etc., should be monitored. Although all forms of media contain some level of child content, _____ (name of client) is to have limited exposure to children. Therefore, the types of television programs, movies, books, etc. that _____ (name of client) is exposed to when with the safe person should not be centered on children.

9. When _____ (name of client) is at home he or she is not to have access to the Internet. Should she or he be using the computer to play a game, he or she must be monitored so that she or he does not access inappropriate material on the computer.

10. (If applicable) Should the safe person feel that _____ (name of client)'s safety is an issue at home or something unexpected comes up, and the appropriate level of supervision cannot be provided, the safe person will immediately contact the agency that directly supports the individual and arrangements will be made to drop off or pick up _____ (name of client).

11. (If applicable) The safe person is responsible in ensuring that _____ (name of client) receives his or her medication at the appropriate times.

Please sign below to indicate that you have been fully informed of _____ (name of client)'s risk issues and that you intend to adhere to the Safety Plan in all aspects.

Signatures:

_____

Safe Person, (Name of safe person)

_____

(Name of individual)

Dated: _____

Danger Zone

My Danger Zone Feelings are:

- Angry
- Scared
- Sad
- Lonely
- Bored

My Danger Zone Thoughts/Fantasies are:

- Thinking about children
- Having sexual fantasies about children

My Danger Zone Behaviours are:

- Looking at pictures of children (in flyers or in magazines)
- Being around children
- Touching children
- Staring at children
- Talking to children

- Taking pictures of children
- Masturbating while looking at children or thinking about them
- Writing notes about children
- Taking brochures about children's programs or services
- Taking items that belong to children

My Danger Zone Places are:

- Schools
- Parks/playgrounds
- Malls
- Kids' stores
- My neighbourhood
- The Internet

My Danger Zone Times are:

- School Times
- 8:00 – 9:00
- 3:00 – 4:00
- School holidays

Safety Plan 2

Generalized Safety Plan

1. Before every outing in the community, I will read, understand, and accept the details of my Safety Plan. I will do this in front of the staff or other support person(s).

2. Before I go into the community, I will make sure that I am in a good/positive mood. If I am not in a good mood I will do something relaxing and calming before I go out.

   I MUST BE CALM AND POSITIVE BEFORE I GO OUT!

3. I have already completed the first part of my outing journal for this outing and have discussed my plans with staff. I will complete the rest when I get back.

4. An adult who is aware of my safety strategies will accompany me in the community to help me practice my SRT (Self-Regulation Therapy) and to help me stay safe.

5. When I go into the community, I will choose appropriate and safe places where there will be very few or no PVPs (Potentially Vulnerable Persons).

6. It is **my responsibility** to use as many of the following strategies as I can to stay safe in the community:

   • Stay focused on my task.
   • Choose places that are safe for me to attend.
   • Discuss my feelings or strategies with staff when it is safe to do so.
   • Keep a safe distance from PVPs.

- Make sure the environment is safe before entering.
- Walk away from any problem area(s).
- Look away from area(s) where there are PVPs.
- Leave the environment altogether if I am feeling uncomfortable or if there are too many PVPs to stay safe.

7. It is **my job** to remember to use my SRT (Self-Regulation Therapy) strategies in the community without being reminded.

8. Staff are there to help me stay safe, so it is best for me to follow their direction when on an outing.

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

_____   _____
Signature   Date

To provide an additional prompt for the individual when in the community, a wallet-sized safety plan can be developed that is void of any descriptors so that, if the wallet or card should be lost, the individual's confidentially will not be compromised. This wallet card serves as a critical reminder that can be used at any time, especially in emergency situations. It is also recommended that important contact numbers be kept on this type of safety card (e.g., police, group home safety person, and any additional number that may be necessary). An example wallet card is found below.

Individualized Safety Plan

Wallet-Sized Safety Card for the Community

I have a responsibility to:

a) Think safe and healthy thoughts

b) Stay focused, aware, and alert

c) Keep potentially vulnerable persons safe at all times

d) Respect everyone's personal boundaries

e) Speak appropriately

f) Plan only safe outings

g) Stay with safe person at all times

h) Stay with peer group my own age

i) Buy only items that are suitable

j) If I feel uncomfortable—leave

Emergency contact number: _____

The following Mental Health Safety Plan can be completed with the client when you suspect that he or she is considering hurting themselves or otherwise suffering emotionally. We suggest that you use caution when using this tool with a client, and be sure to continue to be vigilant in monitoring the client in all situations to observe any change in the behavioural/emotional pattern.

Mental Health Safety Plan

Am I experiencing the following?

Am I feeling:	Have I been thinking:	Have I been experiencing:
■ Desperate	■ "I won't be needing these things anymore."	■ Crying
■ Angry	■ "I can't do anything right."	■ Emotional outbursts
■ Guilty	■ "I just can't take it anymore."	■ Drug and/or alcohol use
■ Worthless	■ "I wish I were dead."	■ Recklessness
■ Lonely	■ "Everyone would be better off without me."	■ Fighting and/or law breaking
■ Sad	■ "All of my problems will end soon."	■ Withdrawal from family/friends
■ Hopeless	■ "No one can do anything to help me now."	■ Dropping out
■ Helpless		■ Putting affairs in order
		■ Prior suicidal behaviour
■ _____	■ _____	■ _____
■ _____	■ _____	■ _____
■ _____	■ _____	■ _____

What to do:

1) Contact a friend or family member who I trust:

If I am experiencing feelings, thoughts or behaviours as above, I can call:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

- I can talk about how I have been feeling.
- I can discuss the behaviours or thoughts that I have been experiencing.

2) Contact my formal resources:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Safety Plan 5

When individuals go home for family visits, it is important that they take with them all of the necessary tools to ensure a safe visit. If an individual is going into the community where staff will not be present, it is recommended that staff provide a package outlining all of the strategies/items that the individual will need to be safe. This includes relevant safety plans, outing journals, and daily journals, as necessary. Working as a team and having consistent contact can increase the potential for a safe and successful outing. Upon the individual's return, staff should ensure that inappropriate items have not been brought back.

Mental Health Safety Plans can be completed with a client when there are suspicions that the client is considering self-harming behaviour or is experiencing other emotional upset. We suggest that caution be exercised when using this tool with a client. In particular, it will be important to be vigilant in monitoring the client in all situations, to observe any behavioural/emotional pattern changes. Note that this is a good example of where we are providing you with information that will be helpful in understanding what assessment and treatment professionals might do, but that you may not want to do yourself if you are a front-line worker. When client safety is at risk, it is always best to consult management staff or trained professionals.

Outing Journals

Outing journals are designed to provide the necessary guidelines for remaining safe in the community and an overall structure for the supported individual to follow. Outing journals provide a sense of accountability for their actions, as clients are encouraged to take appropriate measures to remain safe and stick to their plans.

Important Items to Consider When Creating an Outing Journal

Safety plan review: The safety plan does not have to be in the outing journal; however, it is strongly advised that the supported individual review her/his safety plan before each outing.

Safety checklist: The outing journal should outline of all of the safety rules that the supported individual should follow while on an outing. The individual should review the checklist to ensure that he or she has followed it. The checklist should cover areas that the supported individual is required to work on in her or his daily routine. When creating a checklist, consider areas such as: behaviour in the community and social/physical boundaries.

Name/signature: Including names and signatures of both the client and the safety person is important for record keeping. It is also equally important for supported individuals to sign their outing journals, as doing so provides a sense of ownership.

Date and time: Day, month, and year is recommended; particularly, if you wish to pursue data tabulation.

Place: The journal should list where the outing will take place, and the type of outing it will be.

Pre-planning: In this section, the individual answers questions around pre-planning and premeditating safety strategies for the outing.

Post review: A post-review section is recommended, to reinforce what went with the individual on the outing and to problem-solve any situations that could be improved.

Potentially vulnerable person (PVP): In order to assess if the individual is able to independently utilize his or her strategies, the outing journal should include a section that covers possible strategies that a supported individual can use if she/he encounters one or more PVPs.

Prompt versus independent: The supported individual's ultimate goal is to self-regulate safety strategies by using them independently. In the post-review, it is best to note whether or not the individual utilized his/her skills independently, or if the support person needed to prompt the individual. This record-keeping will help both the safety person and the supported individual to get a sense of what area(s) require more work and support.

The following is an example of an outing journal that can be used with the individual you support. As stated previously, all documents should be modified to meet the individual needs of the person being supported.

Outing Journal

Part 1

To be completed before going on the outing:

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

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

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

Part 2

To be completed upon return from the outing:

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

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

Individual's signature: _____

Safe Person's signature: _____

Outing Journal

Outing checklists are valuable in debriefing after an outing; particularly, regarding pertinent issues and situations that may have come up, along with ratings as to how well those issues and situations were managed.

Outing Checklist

Safe person: _____   Outing: _____

Safe person signature: _____   Date & time: _____

SECTION A — To be completed by the mediator with the individual present

• REVIEWED SAFETY PLAN BEFORE OUTING (if no, no outing)		Yes	No
• Did the client behave appropriately with people he/she met?	N/A	Yes	No
• Did the client respect staff directions?		Yes	No
• Did client stay with staff?		Yes	No
• Did the client use appropriate touch & respect personal space?		Yes	No
• Did the client speak appropriately to staff?		Yes	No
• Was the client's hygiene acceptable? (if no, no outing)		Yes	No
• Potential victims present on outing? (Potential Victims = anyone under the age of 18)		Yes	No
• Was the client aware of potential victims?	N/A	Yes	No

If no potential victims present on outing — Proceed to Section B

Circle the SRT strategies used by the client (if potential victims present):

a) Self initiate safety strategies (without staff prompting)	Yes	No
b) Stay focused on task (avoidance)	Yes	No
c) Discuss safety strategies/feelings with staff	Yes	No
d) Keep safe distance from potential victims (avoidance)	Yes	No
e) Make sure environment is safe before entering (avoidance)	Yes	No
f) Walked away (escape)	Yes	No
g) Looked away (avoidance)	Yes	No
h) Left environment altogether (escape)	Yes	No

SECTION B — to be completed only by safe person

Age of potential victims: _____

Gender of potential victims   Male   Female

Did the client appear to be comfortable on outing?   Yes   No

Number of potential victims: _____

ADDITIONAL COMMENTS: _____

_____

_____

Media

Like persons who do not have intellectual disabilities, our clients are susceptible to influences in the media, such as TV, magazines, and the Internet. Many persons view "pornography" as being "all bad;" however, we believe that a distinction needs to be drawn between pornography and erotica. Like pornography, erotica consists of sexually explicit media. However, erotic materials are presented in a less obscene or overtly explicit manner. Materials labelled "pornography" may not necessarily be "bad" for our clients, if used appropriately and without potential harm to themselves or others. We need to make distinctions between "good" and "bad" pornography, accepting that what is good for one person might not be good for another.

Essentially, persons working with clients with intellectual disabilities need to assess how sexually explicit materials will affect those clients. We need to assess the distinction between appropriate versus inappropriate imagery. Our clients have a right to safe and healthy sexual expression. This may require that we provide them with masturbatory aids, such as pictures or videos, in addition to tools or "toys" that will facilitate masturbation.

Media Contracts

In order to ensure safety and consistency within a treatment protocol, all forms of media must be reviewed for appropriate content, depending on the needs of the client. This includes TV, Internet, video games and systems (e.g. PlayStation and Wii), books, magazines, newspapers, catalogues, iPods, MP3 players, and other means of storing and viewing sexually explicit media. All TV programs need to be monitored for the predominant presence of a type of individuals (e.g., children, women), amount of nudity, and amount of violence. Always remember that what is permissible for one person may not be for another—for example, diaper commercials are no big deal for most people, but clients with sexual interests in babies or with a diaper fetishes may be inappropriately stimulated.

Whenever a media protocol or contract has been established, all team members must act consistently. Team members must ensure that family members and other collateral supports are on board with the plan for when a client is at home for a visit. Gifts must also comply with the contract or protocol. Family members sometimes forget or lack full understanding of the contract and give clients materials that are ultimately detrimental to their treatment or behaviour management. For this reason, it is important to conduct a search of the client's bags when they return from visits in the community. This will help to ensure that any media content is appropriate on a variety of levels. It is also important to recognize that when clients are living together in group home environments, media rules must be in place that will ensure the safety of all.

Keeping the Environment Safe

Families, staff, and support persons need to work together to ensure that the environment in which the client lives is as safe as possible for everyone. Keeping the environment safe may require a number of different strategies, such as checking clients' rooms and screening or monitoring phone calls, Internet usage, and media.

Room Checks

It is important to ensure that clients do not have inappropriate material in their room, in their possession, or somewhere easily accessible to them. We often think that keeping people safe only applies when they are out in the community. We often forget that they must also be kept safe when at home. This means that their environment must be free of pornography or items that are potentially inappropriate. Inappropriate or "bad" pornography can be anything that potentially increases the client's sexual arousal towards a sexually inappropriate act. This could be media of any kind depicting children, animals, acts of violence, or inappropriate fetish material such as diapers, stockings, and so on.

Media Screening Protocols

One aspect of treatment is for the individuals to learn to control their inappropriate sexual urges and learn to engage in healthy sexual behaviours. During treatment, the behavioural team has determined that each of the persons supported, also have identifiable inappropriate anger/aggression challenges that must be addressed in treatment. Due to the above treatment concerns, it is necessary to screen all media content that enters your program for inappropriate viewing or listening content. The following content may trigger inappropriate urges or behaviours that counter treatment efforts being learned by the person supported.

For the purposes of the Media Screening Protocol, the term "media" is defined as "the means, or channels of general communication, information or entertainment in society." More specifically, these are the forms of media targeted by this policy:

- Television Programming
- Radio Programming
- Movies/Productions in Theatres, on Video, DVD and Blu-Ray
- Music/Audio Programming on CDs, Cassette Tapes, 8-Tracks, Records, MP3 files
- Computer Files – Games, Text Base Files, Video and Audio Files, All Other Programming
- Internet – Web Pages, Email, Messengers, Networking
- Video Games – PSP, Wii, Nintendo, and Other Video Gaming Systems
- Literature – Newspapers, Books, Magazines, Advertisements
- Live Entertainment – Sports, Concerts, Stage Productions, and Other Forms of Live Production
- Art, Photography, Audio and Video Recordings

Media content containing Potential Vulnerable Persons.

Potentially vulnerable persons/objects (PVP) is defined as individuals or objects that elicit inappropriate sexual arousal or deviant urges in the individual being supported. Please refer to each rindividual's safety plan to determine relevant PVPs for that person.

No content that contains any PVP is to be in the possession of the individuals.

No content that has themes or plotlines involving PVPs is to be viewed or read by the individuals. This includes animated cartoons or movies. (i.e., Disney films, The Simpsons)

No content that has primary and/or major secondary characters that represent characters who are PVPs is to be viewed or read by the individuals.

No content that has actors/actresses cast in primary or major secondary roles who are PVPs is to be viewed by the individuals.

Using proper filtering procedures, some media containing PVPs may be viewed or read by the individuals, but only under the careful supervision of staff. (Please view Screening Procedures for specific details on Media Filtering Strategies.)

Media 1

The following is an example of a Laptop/Computer Safety Agreement

Computer, Laptop, and Wireless Device Safety Agreement

The following is a contract, which outlines _____ (individual's name)'s obligation to use his/her computer (laptop) and all wireless-capable devices in a safe and responsible manner. This agreement also applies to the Wii wireless game system and any other wireless- or Internet-capable device in any location.

This includes all gaming devices, watches with memory storage, cell phones, MP3 players, cameras and digital picture frames.

1. Administrative changes to the computer are limited to _____ (designated safe persons) who have a special password, which is required to add, remove, or change programs. The administrator has disabled capacities to burn CDs and connect to the Internet.

2. Any removable data storage devices such as memory cards, memory-sticks, CDs, DVDs, CDRWs, including rewritable game cartridges, are not permitted.

3. _____ (the user) is expected to use the computer in a safe and responsible manner and must have all viewable (non-recordable) media i.e., VCDs, CDs, or DVDs screened by _____ (designated safe person) before purchasing and/or viewing. The user is also accountable for all content that they have written in word processing programs to be of an appropriate nature.

4. _____ has agreed that it is not safe to take her/his computer or any wireless-capable device on home visits or anywhere outside the home unless special permission is obtained from _____ (designated safe person).

5. _____ (designated safe person) reserves the opportunity to do a computer or wireless device spot check and view the device's contents to ensure that it contains appropriate content and that it has been used appropriately and safely.

6. (If applicable) All provisions set forth in the media agreement for the house also apply to computers and wireless devices. This means that the lending, borrowing, trading, giving, selling, or acquiring any data or data storage device from anyone is **not permitted**. This includes all data files such as pictures, video, music, etc. Purchasing music/data from online stores or approved sources will be supervised by a designated safe person.

7. The individual is aware that any violation of this contract will result in the suspension of computer/device privileges for an amount of time determined by the safe person/support team.

_____   _____
Individual   Safe Person

Dated: _____

Media 2

The following is an example of a camera contract.

Camera Contract

The following is a contract outlining _____'s duty to use her/his camera in a safe and responsible manner.

1. The camera is to be stored in the filing cabinet in the office.

2. A staff person or designated supervising individual must be with me while I am taking pictures.

3. I am not to take my camera with me while on home visits.

4. I will not bring my camera into work, the washroom, or my bedroom.

5. I will only take appropriate pictures such as scenery, wildlife, and nature.

6. I will only take pictures. I will not take any video footage.

7. I will not take pictures of strangers even if they are just in the background.

8. If I take a picture of a person they must be age appropriate (over 25 years old) and the person must give their consent.

9. I will return my camera (with media card) to the office immediately upon my return from my outing.

10. Staff will review all stored pictures before I can look at them, print them, copy them, or download them onto my computer.

11. I will not give copies of pictures to anyone unless approved by Staff.

12. I am aware that any violation of these guidelines will result in the loss of camera privileges for an amount of time determined by Staff.

Client: _____   _____
Signature   Date

Manager: _____   _____
Signature   Date

Support Staff: _____   _____
Signature   Date

Media 3

Personal Computer Protocol

This protocol will outline the use of personal computers by individuals within the group home.

- No Internet access will be allowed on laptops or computers. Wireless Internet devices will be disabled by staff through software or disconnecting the wireless components of the computer physically.

- Sharing files may spread viruses or allow for transfer of inappropriate materials. Sharing files is not permitted.

- The use of memory sticks / flash drives are for personal back-up use only. No one should share a flash/thumb drive with another person unless directed to do so by staff and under supervision. A flash drive should not leave an individual's personal room unless such is requested by staff.

- Laptop computers may be used outside an individual's personal bedroom only if a staff person is present and observing. A personal computer should be used where no other individual, except staff, may see the screen.

- All media to be used with or on a personal computer is subject to the *Media Protocol*.

- Staff may request to perform a search of files on any personal computer to identify, if any, inappropriate media.

- Files (i.e., .zip), thumb drives, or diskettes, that have been locked or password protected will be removed and/or deleted immediately.

- Printers with scanners are permitted if used appropriately.

- No one other than the owner of a personal computer is permitted to use it, unless they are staff.

Other Devices:

Nintendo Wii, Playstation 3, Xbox 360, Playstation Portable (PSP), Nintendo Gameboy, iPod Touch, and a large variety of devices are equipped with both Internet browsers and wireless Internet receivers. In light of this information, it is necessary to ensure that either:

• The device does not support internet capabilities; or

• The device's parental controls have been enabled and locked as per the user manual; or

• Wireless signals are not available (this must be checked on a weekly basis); or

• Use of the device is directly monitored during the period of use and the device is stored in a secure location not accessible to individuals other than staff.

Public Computers:

Public computers with Internet access are available in many locations within every community. Individuals shall not be permitted to use such computers unless directed to do so by staff. Individuals in educational settings are likely to be required to use a computer; these individuals should be monitored closely.

When looking for things that might present a problem, we really need to think outside the box. In our experience, items have been found stored on the Wii system, in laptops, and in video tape or disc cases; pictures have been stapled together to hide the inappropriate picture inside; and, items have been hidden in the vents of the room. In addition, we must take into consideration the artwork in the home as well as television program content. Even some music with sexual or violent lyrics may increase the individuals' sexual arousal. Items that are confiscated should be recorded, with either written or photographic documentation. The items should then be appropriately disposed of by the team.

Phone Calls

It may be necessary to screen phone calls, as some clients may use the phone to contact others and engage in inappropriate conversations. This is not about calling advertised sex phone lines; this is about calling others they know and asking them to tell inappropriate stories in order to satisfy their sexual needs. Where necessary, phone calls can be put on speakerphone or the support person can monitor the client's dialogue and reaction to it for clues as to whether the conversation is of an appropriate nature.

Boundaries/Relationship Education

Persons with intellectual disabilities often receive a skewed perspective of who they may appropriately talk to, touch, and trust. As mentioned previously, when a person is born with a disability there are often many more stakeholders involved in their lives. Depending on the disability, the individual will talk to, is touched by, and must trust many different people. The list varies considerably from client to client but may include caregivers, support workers, doctors, therapists, family members, and others. Often, this is done for all the right reasons, yet the message that the individual receives is that they can talk to, touch, and trust most people.

Developing relationships is a main part of reintegrating into society. Many of our clients demonstrate a desire for these relationships, but either do not have the necessary skill set or have learned inappropriate ways of developing relationships. There are a number of important concepts to address when educating individuals in this area.

The individual needs to:

- learn appropriate ways to develop relationships,
- learn where to appropriately meet others,
- learn to respect the opinions and wishes of others (accepting "No" and being able to say "No")
- learn how to make a good friend (who is trustworthy, who likes them for who they are, and who they have known for a long time),
- find common interests (understanding and accepting that everyone likes different things), and
- engage in appropriate conversation.

Once a relationship has been established, persons with intellectual disabilities often have difficulty maintaining the relationship. The individual needs support in learning the skills necessary to be a good friend (listening, empathizing, doing things both friends like to do), make plans, live/cohabitate with others, and to resolve conflicts.

When developing romantic relationships, our clients need further education and support. They need to learn how to develop a friendship, date eachother, and then, if both consent, move into a romantic relationship. It is important to stress that healthy relationships take time to develop.

Individuals need to:

- plan their dates,
- make appropriate partner choices (someone in the same age group, who likes the same things, and whom they have known for a long time),

- learn how to resolve conflicts they may encounter,
- learn healthy sexual behaviour,
- learn options in regards to avoiding sexually transmitted infections (STIs),
- learn how to use birth control, and
- learn what to do in the event of pregnancy.

The concepts of respecting each other, trusting each other, and engaging in activities that are based on mutual consent also need to be addressed with the individual.

It is important for persons with intellectual disabilities to be educated regarding the boundaries within each type of relationship. The Stanfield *Circles* Program was developed specifically for persons with intellectual disabilities to address the various types of relationships they may encounter in their lives and to teach them how to establish boundaries around the type of talk, touch, and trust that is appropriate within each relationship. The program is visual and, culminates in the individual's development of a unique "circles board." When the *Circles* Program is undertaken in conjunction with a support person or others our clients know, one of the natural outcomes is that they learn that each person is different and has a unique set of relationships.

Relationship and boundaries education can be accomplished in a variety of ways, using a variety of tools. Teachable moments provide real-life opportunities to put skills and ideas into practice. These can occur when the support person is out with the client, and the pair encounters opportunities to discuss boundaries within different relationships as they experience them. For example, when the individual is at work, the support person can discuss the appropriate boundaries at work. If the support person is a paid staff person, the support person and the client can discuss what type of relationship is or is not appropriate to have with a paid staff person. In this context, it is important to emphasize that paid support staff are not friends, since

friends do not get paid to be with their friends. Watching television provides further opportunity to discuss whether the relationships depicted in the program are appropriate or inappropriate. Staff members need to be well trained and be ready to take advantage of these windows of opportunity.

When seeking out and developing relationships, the individuals we support need to learn about the benefits and difficulties posed by Internet chat rooms, Internet dating, telephone dating services, and advertisements for "friendships" that they may find in newspapers and magazines. Persons with intellectual disabilities often seek out relationships in these sources and have fallen prey to the kind voice they find on the other end of the phone line. Tragically, some of our clients have received expensive phone bills as a consequence of talking to the person on the other end of the phone, whom they truly believed to be their friend.

It is wonderful when individuals have meaningful relationships with one another. However, some relationships are not always positive. For this reason, it is important to teach the individuals we support about some of the possible behaviours that may indicate that a relationship is turning negative. We need to discuss what should happen if the other person in their relationship becomes controlling or makes all the decisions as to what to do, where to go, and whom to see; becomes jealous of a client's possessions or of the other people with whom they have relationships; or, engages in put-downs, such as making negative comments about what a partner wears, about decisions a partner makes, or about a partner's achievements. We need to teach the individuals we support techniques for identifying warning signs of inappropriate behaviour, as well as strategies for self-assertion. Our clients require strategies on how to deal with these situations and ensure that they get the help they need.

Other useful ways of teaching socially appropriate boundaries are through the use of social stories, scripts for common interactions, and role plays.

Age Discrimination and Choosing Appropriate Partners

It is not uncommon for many persons who have developmental disabilities to be confused about who is of the appropriate age to have friendships or intimate relationships with. In society and through the media, it is increasingly common for young people to be portrayed as older than they are. In today's society, some girls wear makeup at a young age and may dress to appear older than they are. Sometimes, young girls' clothing appears provocative and "sex-oriented" (e.g., a pair of shorts or sweatpants featuring the word "juicy" on the backside). With all these factors blurring the distinctions between age groups, people without disabilities often confuse people's ages.

Simply put, we can assume that individuals with intellectual disabilities may have a difficult time knowing the right thing to do. Indeed, some individuals have such difficulty in distinguishing adults from non-adults that they develop an attraction to people who are of an inappropriate age. Sometimes, they truly believe that this person is older. In treatment, it is important to assist such clients in knowing how to accurately determine a person's age, rather than to simply assume that they have a sexually inappropriate preference.

In assisting individuals in determining someone's age, the support person can help a client identify characteristics of a specific age group (e.g., body types, hair growth, height, muscle changes, secondary sexual features). They can do this together with the client by reviewing pictures and identifying the appropriate age group. When out in the community or while watching TV, the support person can ask questions and have discussions as to what age a client thinks someone is and why. They can discuss how the media portrays people as older/younger, and the importance of knowing and asking someone's age. Other helpful strategies are to look through books that identify the changes in the body as people grow up.

Communication

Appropriate and effective communication skills are an important learning goal for our clients, as many clients lack these skills and may run into difficulties while attempting to converse and interact with others. When individuals are non-verbal we need to make every attempt to assist them in developing communication skills and in using tools to support this development, such as picture boards, sign language, gestures, or a combination of strategies.

The individual needs to learn whom to communicate with about what, as well as to be sensitive about appropriate social boundaries. Scripts can be used to assist them in starting a conversation.

The following is a possible card that someone can use to assist them to engage in conversation with others. Again it should be modified to meet the needs of the individual.

MY CONVERSATION STARTER WALLET CARD

Hi, how are you? My name is _____.
What is your name?

What are you doing today?

What do you like to do in your free time?

Where is your favourite place to eat?

What kind of music do you like to listen to?

What is you favourite television program?

I like the _____ you are wearing. Where did you get it?

Making Friends 1

Often a social story is helpful in teaching an individual how to make friends. The story can be very general, like the one below, or as detailed as necessary to suit the needs of the individual being supported.

1. I introduce myself to the person and ask them their name.
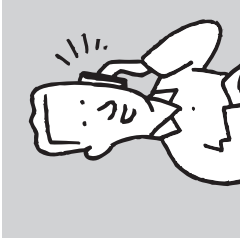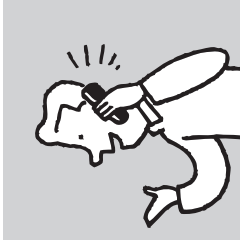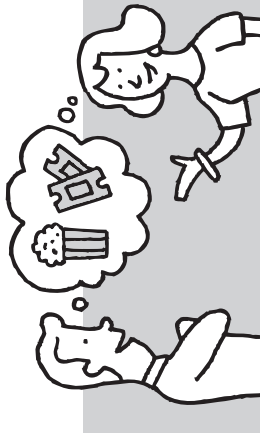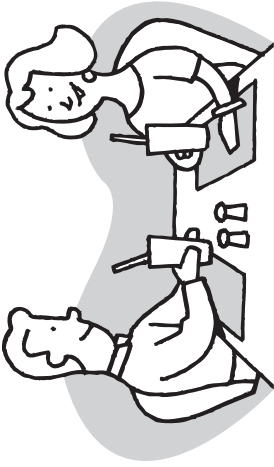
We are now acquaintances.

2. We talk about our interests and hobbies.

We are getting to know each other but are still acquaintances.

3. We continue to see each other in public and get to know each other better by talking more.

We are still acquaintances.

4. We exchange phone numbers and call each other sometimes.

We are becoming friends.

5. We make plans to go out together.

We are now friends.

Making Friends 1

Making Friends 2

Often a social story is helpful in teaching an individual how to make friends. The story can be very general, like the one below, or as detailed as necessary to suit the needs of the individual being supported.

1. I introduce myself to the person and ask them their name.

   We are now acquaintances.

2. We talk about our interests and hobbies.

   We are getting to know each other but are still acquaintances.

3. We continue to see each other in public and get to know each other better by talking more.

We are still acquaintances.

4. We exchange phone numbers and call each other sometimes.

We are becoming friends.

5. We make plans to go out together.

We are now friends.

Making Friends 2

The following social story is an example outlining the stages of how a romantic relationship starts and then builds. The story follows the colours and concepts addressed in the *Circles* Program, which teaches boundaries and relationships.

How a Romantic Relationship Starts and Builds: A Social Story

One day I will meet someone who may become my sweetheart.

Red One day I will see someone in the community that I am attracted to. This is okay if this person is of an age close to mine. This person is a stranger at this point and it is inappropriate for me to act on these feelings. I do not touch, talk to, or trust strangers.

Yellow Should I continue to see this person through a community activity such as work, church, the recreation centre, etc., I can be introduced or introduce myself to them. This person then becomes an acquaintance. I have casual conversation with them, but I do not touch, trust, or engage in personal talk with them.

Green If I continue to see this person through our mutual activity for a long time I may ask them to go out for a coffee. We may go out, enjoy each others' company, and feel comfortable enough to talk on the phone, email each other, and go to the movies. We may feel comfortable as friends and talk about general things in our lives. We may feel comfortable giving each other a hug when we greet each other. We do not have sexual/romantic touch, because we are only friends. I do not tell this person my private personal things. I have some trust, but not full trust, in this person.

Sometimes it is normal for me to have sexual and loving feelings for someone. If this happens, I will not act out in a sexual way with this person. I can talk to them about their feelings and about my feelings.

If they do not feel the same way, I will respect their feelings and respect their decision.

Blue If this person is feeling the same way, then the relationship can start to move towards a more romantic relationship.

If they do feel the same way, we may spend more time together, have closer hugs, hold hands, and kiss.

Touch happens only when both people in the relationship consent to the touching.

I must remember that consent is true and real when both people understand what is happening, are honest with each other, understand the consequences, have a choice to say "yes" or "no," and are not forced into giving consent.

Pink If we both agree and give consent then we might agree to become each other's boyfriend/girlfriend. We can be sweethearts.

As sweethearts we will have full trust with each other, talk with each other, and may have loving, gentle, consensual, romantic touch with each other in a private appropriate place.

Romantic Relationship

Hygiene

Some of individuals that we support require assistance with their hygiene. This could include anything from hands-on assistance to prompts to complete their hygiene routine. The best way to address this is to evaluate what the individual can do independently and what they need assistance with. The support person, in conjunction with the individual, can determine the best way to teach the skills that the individual may be lacking. There are a variety of ways to do this, including the use of a visual schedule, a reinforcement program, prompts, and hand-over-hand assistance. When using hand-over-hand assistance, as with any type of physical assistance, it is important to seek consent from the individual and to explain how and why you are touching the person.

Important parts to address are:

- cleanliness,
- personal care,
- hygiene routines,
- making good impressions,
- appropriate dress, and
- cleaning one's house/room.

Self-Esteem

Low self-esteem is often characteristic of both perpetrators and victims of abuse. Assisting individuals in increasing their self-esteem requires that you discuss with them things that they like about themselves, help them to accept the things they can and cannot change, help them to set realistic goals for the future, and help them to change negative thoughts they have about themselves into positive thoughts. Here are some other tips:

- Develop a list of positive self-statements. This may require additional support since many clients have difficulty seeing the things that they do well, often because they lack self-awareness.
- Look into a mirror and give themselves compliments.
- Learn how to truly accept compliments.
- Develop a "positive me" box into which they can put items that represent the things they like about themselves.

A scrapbook activity that we call "All About Me" is sometimes quite helpful in building and sustaining self-esteem. This is essentially a scrapbook depicting all the various things that are important in the person's life, such as where the person was born, the members of the person's family, the person's school, vacations, and living places, and things the person enjoys doing. It is a wonderful tool to reinforce all of the positive things in their life.

Group Sessions

Group sessions are another way of teaching the concepts above to individuals with intellectual disabilities. Social skills groups have been created to address clients' social skills and ongoing issues. The group typically meets for one hour per week and addresses a variety of topics identified by the participants.

Some examples are:

- communication, sharing, appropriate dress, individual's goals, understanding another's point of view, hygiene, sexuality, abuse prevention, money management, relaxation techniques, healthy living, boundaries, and etiquette, and
- playing board games, cards, and bingo, cooking, baking, and playing video games to increase the sense of community within the home and to increase the amount of positive interaction the individuals have with one another.
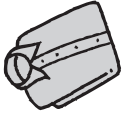
Morning Routine — Visual Schedule

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

Week Of : _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Wake Up (6:45 am)					
Take Meds					
Take Shower					

Morning Routine

Eat Breakfast	Use Washroom	Brush Teeth	Get Dressed for work	Go to Work

REWARD EARNED?

Healthy Sexuality Education

Over the years it has not been uncommon for persons with intellectual disabilities to be excluded from sex education classes or programs. This may occur for a variety of reasons, such as a belief that persons with disabilities are non-sexual or are incapable of learning, and that if they are excluded from education then they will not engage in inappropriate sexual behaviour. Nothing could be further from the truth. All people are sexual beings, regardless of disabilities. And, we know that knowledge is power. It is the lack of knowledge that often leads to behaviours that are inappropriate.

There are many aspects of sexuality that should be taught to the individual. Persons with intellectual disabilities often do not even know the appropriate words that identify the various body parts, particularly those areas that are associated with sex. Often, they only know a variety of slang terms.

Education regarding the various types of sexual activities must include discussion of the strategies that can be used to prevent sexually transmitted infections and unwanted pregnancies. The appropriate use of condoms and birth control options must be taught. It is also important to address sexual orientation and define lesbian, gay, bisexual, transgender, and questioning (LGBTQ). Specifically, it is important to debunk some of the sexual myths that the individual may have been subjected to so that they would not engage in certain behaviours, such as, "*When you masturbate you will go blind or grow hair on the palms of your hands.*" In his 2005 book, Blasingame provides suggested policies that agencies should develop to aid in the promotion of healthy sexuality.

Consent

Often there is an emphasis on teaching persons with intellectual disabilities about being able to consent to sexual activity; however, it is also necessary to teach the individual the need to be able to hear "No" to a request for or invitation to sexual activity. Both are equally

important. Persons receiving support need to learn the age of consent in their jurisdiction, what consent to sexual activity means, that consent is voluntary, that even if you have given consent you can still change your mind, and that a change of mind needs to be heard and respected. The individual also needs to understand what does not constitute consent, such as:

- when a person is threatened or bullied into sex,
- when a person has been drugged or has had too much to drink, or
- when someone who is in a position of power or control (e.g., a staff member, a family member, or a medical professional) touches the person in their control in a sexually inappropriate manner.

The individual must also realize that, in turn, all of these concepts apply to the individual with whom they want to engage in sexual behaviour. Consent must be mutual. This is sometimes a very difficult concept for our clients to grasp. Should our clients experience difficulties regarding issues of consent, it would be best for them to have strategies that they can use to help themselves, and they may rely on us to help them learn these strategies. These might include telling someone they trust, going to the hospital or a doctor, or calling the police.

Healthy Masturbation Education

Inappropriate sexual behaviour often results from the fact that the individual has limited or, at times, no access to personal private time. Or, the individual may lack education as to how to masturbate or experience personal sexual stimulation in an appropriate manner. Dave Hingsburger has developed DVDs for both men (*Hand Made Love*) and women (*Fingertips*) to educate them on how to masturbate in a safe and healthy way. These DVDs cover the aspects of privacy, cleanliness, the use of sexual aids (e.g., lubricant, appropriate visual aids or "sexy pictures"), and safety.

It is important that those who support the individual provide education on the subjects mentioned above. The issue of privacy needs to be addressed. If the individual shares a room and does not have a private place to masturbate, then modifications need to be made. For example, if the individual shares their room, a sign can be put up on the door that indicates their need for privacy. There may be cultural and religious issues that also need to be addressed with the individual and those who support him or her.

It is sometimes helpful to set up a healthy masturbation kit. The individuals we support have the right to safe and healthy sexual expression. Sometimes, this may require us to provide them with masturbatory aids, which may include appropriate pictures, DVDs, or stories, in addition to tools or "toys" that will facilitate the mechanical aspects of masturbation. A healthy masturbation kit may include one or all of the following items: lubricant, wet wipes or tissues for hygiene, appropriate "sexy" pictures/DVDs that aid in arousal, appropriate sexual toys, appropriate stories or fantasy starters, and a healthy masturbation protocol.

Emotions Management

Anger, frustration, depression, and even extreme happiness are all emotions that could potentially lead to offending behaviour. It is important to assist the individuals we support to be able to recognize and express these emotions in an appropriate manner. We often target only anger management; however, everyone experiences a full range of emotions, and it is necessary to understand all of them. Many of the individuals we support are typically black-and-white thinkers (they think things are either good or bad, nothing in between). They may have difficulty understanding how the reactions of others to events are different than their own. They may take a victim stance when dealing with their inappropriate behaviours. Often, they misinterpret others' reactions to their behaviour. For example, if someone shows kindness towards them, then they may believe that the person is interested in

them; whereas, if the person shows a lack of interest in them then they may feel that the other person is mad at them.

Thus, it is important to educate our clients on the variety of emotions that we experience and how these emotions affect us. People may feel emotions of all types as sensations in their bodies. For example, our hearts race, our palms get sweaty, our stomachs feel as though they were tied in knots, or we experience "butterflies" in our bellies. We need to discuss with our clients how they experience the many different types of emotions, as well as how to put in place appropriate strategies for dealing with these emotions. We must assist them in understanding that it is okay to feel the wide variety of emotions, including both the positive and negative ones; it is how we express these emotions that can sometimes get us into trouble. So, when we see something or someone that excites us sexually and we feel all tingly *inside*, this feeling is not an issue. But, if we run up to the individual and try to touch their breasts or penis, this behaviour then becomes an issue. It is understandable that our clients may get frustrated with a co-resident who will not change the television channel to allow them to watch a favourite television program; however, swearing and hitting that co-resident is unacceptable.

There are many ways to assist the individuals we support in learning to recognize their own emotions and those of others. Watching television programs with clients and discussing what they are viewing in terms of emotions is effective. Conducting role plays, developing individualized emotions booklets, and using a visual stress thermometer may also be helpful.

Relaxation training is an effective strategy to teach individuals to help them in controlling their emotions. This can be done in a variety of ways such as through the use of auditory relaxation tapes, positive visual imagery, and progressive muscle relaxation. Presenting the individual with a variety of options is the best way to determine what modality they enjoy best or is most effective for them.

The following healthy masturbation protocol can be shared with clients who are developing safer practices for expressing their sexuality.

Healthy Masturbation Protocol

1. All of my pictures must be legal. I cannot have pictures that are against the law.

2. My pictures are provided by (*Name of Agency or therapist*) and they meet the following rules. They do not contain any of the following:

   a. Objectifying the body (makes the person non-human)
   b. Violence of any kind
   c. Rape, sex with children, or any other illegal behaviour
   d. Anybody who looks like safe persons or others that I work with
   e. More than one person

3. All of my pictures will be of age-appropriate men or women.

4. I will not show my pictures to anyone. I will not show the pictures to anyone in my home, or to guests. If I have any questions about the pictures, I will only speak to (*name those who have provided the pictures*).

5. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private. They are to remain in my room and to never be taken out of the home.

6. I will keep my pictures in an envelope/folder. I will keep all my supplies (pictures, Healthy Masturbation Protocol, lubrication, Fantasy Starter [optional], data sheets, and wet wipes) in a safe place where no one else can find them. They will be put safely away after I use them, so that no one coming into my room can see them.

7. If I show my pictures to anyone I will lose them for a period of time, which will be determined by (*name of person setting up protocol*). If I share them a second time, then they may be removed altogether.
8. I will only fantasize to the individuals on the pictures (or to my Fantasy Starter) while I am masturbating.
9. Should I want different pictures in the future, I will speak to (*name of person setting up protocol*).
10. I will be very careful with my hygiene:
    - **a.** I will make sure that I wash my hands before I masturbate.
    - **b.** I will use wet wipes or tissues to clean my hands.
    - **c.** I will clean off the pictures with a fresh wet wipe.
    - **d.** I will use sanitizing wipes to clean any part of my room that I have touched.
    - **e.** I will use sanitizer for my hands before leaving my room, and then I will go and wash my hands thoroughly in the washroom.
    - **f.** Should I feel that a shower would be best to clean myself thoroughly, I will do so.
11. If I abuse my genital area in any way or violate any of the above agreements, my kit may be removed.
12. Self-reporting—it is a good idea to write about masturbation activity on a calendar. I will try to write about 1) Successful Ejaculation, and 2) Type of thoughts and fantasies involved. I will keep this data private in my kit. Being honest and open with those directly involved in my treatment about my fantasies and masturbation practices is an important part of my ongoing treatment.

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

Rules for Keeping My Pictures

1. All of my pictures must be legal. I cannot have pictures that are against the law.

2. I cannot have pictures that:

   a. objectify the body (make the person non-human),

   b. show pain or hurting,

   c. show rape, sex with children, or any other illegal behaviour,

   d. resemble staff or others that I work with, or

   e. have more than one person in them.

3. All of my pictures will be of age-appropriate men or women.

4. I will not show my pictures to anyone. I will not show my pictures to anyone in my home or to guests. I will not show my pictures to anyone at work. If I have questions about my pictures, I will speak only to _____.

   [support person]

5. _____ must approve my pictures.

   [support person]

6. My pictures are private. They are only for me. I will not talk about them to anyone. I must keep my pictures private.

7. I will keep my pictures in the following safe place: _____, where nobody else can find them. I will put my pictures back in the safe place after I finish using them, so that nobody coming into my room will see them.

8. If I show my pictures to anyone, I will lose them for a period of time to be determined by _____. If I show them a second time, they may be removed altogether.

    [support person]

9. If I am practising inappropriate masturbation in my bedroom with my pictures (for example, if I am urinating or harming myself), I will lose them for a period of time to be determined by _____. If I inappropriately masturbate a second time, I may lose

    [support person]

    my pictures altogether.

10. I will fantasize about the individuals in the pictures only while I am masturbating.

11. If I want different pictures in the future, I will speak to _____.

                              [support person]

_____
Client

_____
Support Person

_____
Date

_____
Support Person

Sometimes I Get Angry

The following example of a personal emotions book outline can be used to assist clients in better managing their anger. It is helpful to insert a picture of the client engaging in one of the suggested scenarios beside each of the statements below.
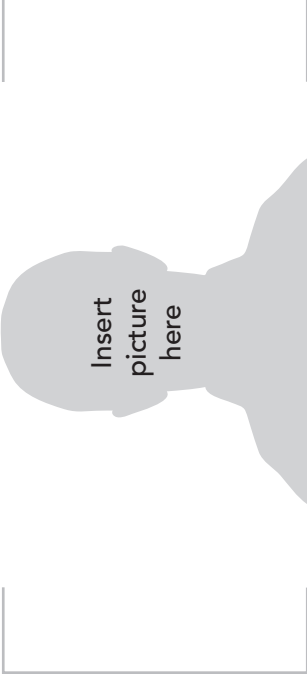
Insert picture here

Some things that make me angry are …

1. someone getting mad at me.

2. someone talking too much.
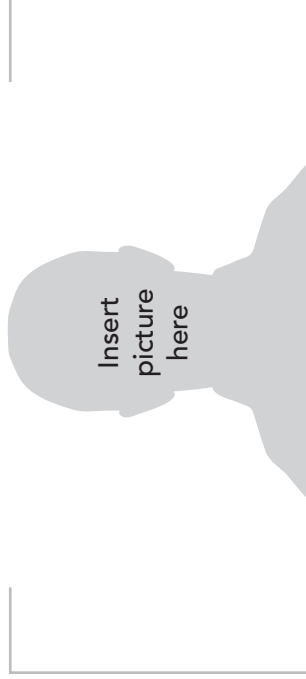
3. when I make a mistake.

4. when I don't win.

Insert
picture
here

Insert
picture
here
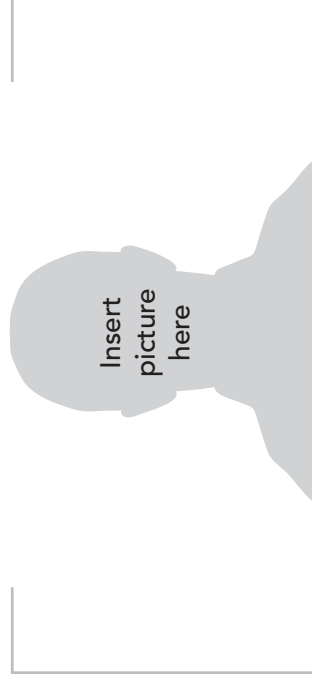
I know I am angry when …

1. my stomach gets tight.

2. my mind goes to another world.

3. my breathing gets stronger.

4. I make fists.

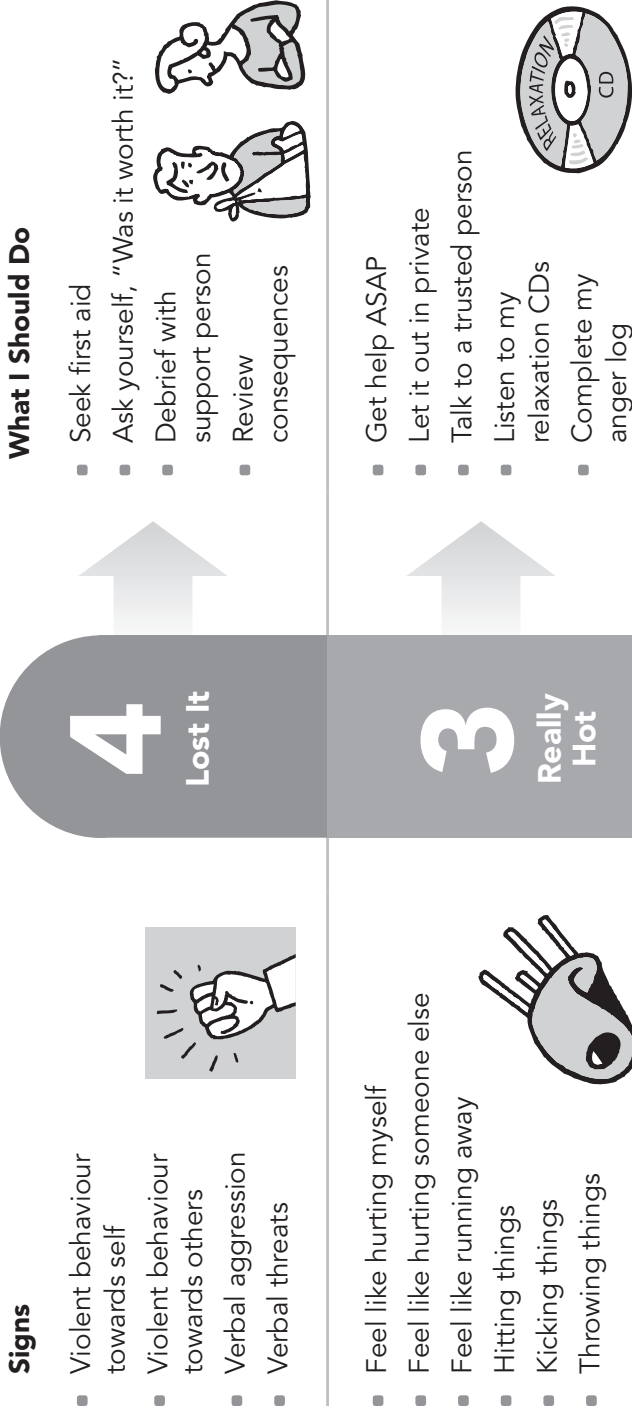Things I can do when I get angry are …

1. go for a walk.

2. rest in my room, thinking positive thoughts.

3. talk to staff when I am calm.

4. take deep breaths.

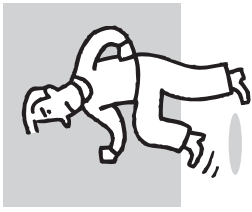I will reward myself for following my plan by getting a treat or an extra coffee.

Emotions Book

Stress Thermometer

The following example is a visual stress thermometer that those who support the individual can develop specific to the individual. This tool provides an engaging visual way to discuss emotions and triggers.

Signs

- Violent behaviour towards self
- Violent behaviour towards others
- Verbal aggression
- Verbal threats

4 Lost It

- Feel like hurting myself
- Feel like hurting someone else
- Feel like running away
- Hitting things
- Kicking things
- Throwing things

3 Really Hot

What I Should Do

- Seek first aid
- Ask yourself, "Was it worth it?"
- Debrief with support person
- Review consequences

- Get help ASAP
- Let it out in private
- Talk to a trusted person
- Listen to my relaxation CDs
- Complete my anger log

2 — Getting Hot

Signs:
- Yelling
- Hitting my head
- Rubbing or pulling my hair
- Stomping my feet
- Heart beating fast

Strategies:
- Call my family or a friend
- Talk to a support person
- Complete an anger log
- Review my anger plan
- Have a drink of water

1 — Getting Warm

Signs:
- Swearing
- Raising my voice
- Feeling funny in stomach
- Sighing
- Feeling overwhelmed

Strategies:
- Listen to music
- Watch a movie/television
- Read a book
- Count to 10
- Take a deep breath

0 — Cool and calm

Signs:
- Positive attitude
- Engaging in conversation

Strategies:
- Be with people
- Community outings

Escalation/De-escalation Patterns

It is important to have a good understanding of the escalation patterns of the individual you support. Once you know the patterns, you can problem solve in advance how to diffuse a situation before an outburst/action occurs. Below please find some headings you may want to follow in developing your plan.

Escalation Cycle
▪ Anger triggers
▪ Early warning signs
▪ Possible targets
▪ Patterns of outburst behaviour

De-escalation Cycle

- Ignore
- Talk-down procedures
- Removal
- Possible PRN (medication)

Debriefing Cycle

- With individual
- With service providers
- Documentation

Positive Guided Imagery

In this technique, the goal is for the individual to visualize himself or herself in a peaceful setting. What works will be unique to each individual, so before beginning, you will need to discuss some options with the individual that you support. The following resource lists some suggested images.

Some Peaceful Places

Lying on a quiet beach, listening to the waves, and feeling the soft breeze

Slowly swinging back and forth in a hammock

Lying on your bed listening to relaxing music

Floating on an air mattress in a pool

Rocking in a rocking chair

Steps in the Guided Relaxation Process

Ask the person to get comfortable and visualize herself or himself in this peaceful, safe environment.

Ask the person to slowly breathe in and out as he or she pictures himself or herself in the peaceful, safe place.

Ask the person to relax and enjoy the experience.

Encourage the person to use this type of positive guided imagery when she or he is feeling stressed.

Progressive Muscle Relaxation

Progressive Muscle Relaxation is a strategy that helps you to figure out where you hold the tension and stress in your body so that you can release the stress and feel calm and relaxed.

This is a strategy that helps to decrease anxiety and tension.

It helps you to be more focused and, as a result, to make better decisions.

It helps your mind to relax so you can think clearly and make good choices.

Progressive Muscle Relaxation (PMR) is a tension-reducing technique that involves the systematic tension and relaxing of specific muscle groups. Starting with the muscles in the face, the individual completely tenses all muscles and holds the tension for several seconds (usually to the count of ten), completely relaxes for the same period of time, then repeats the process with the next set of muscles (the neck, the shoulders, etc.) until every area of the body has been relaxed. With practice, the individual learns to completely relax the body within seconds and keep from storing up tension and stress in the body, a practice known as Deep Muscle Relaxation.

Try it—it is a lot of FUN!

Some helpful websites are:

1. http://www.umm.edu/sleep/relax_tech.htm

2. https://www.helpguide.org/mental/stress_relief_meditation_yoga_relaxation.htm

PMR

Abuse Prevention

Statistics show that sexual abuse occurs at an alarming rate. According to various studies of child sexual abuse, as many as one in four girls and one in seven boys will be sexually abused prior to the age of 18, although many consider these figures to be underestimates. Given these statistics, it is important that all of us play an active role in attempting to prevent abuse and to decrease these numbers.

There are several types of abuse other than sexual abuse. These include physical, emotional, financial, and spiritual abuse:

- Physical abuse may include pushing, kicking, and punching.
- Emotional abuse may include yelling, making inappropriate comments about a person, and not including the person.
- Financial abuse may include taking away money, and not allowing a person to choose how to spend money.
- Spiritual abuse may include not allowing an individual's spiritual practices, selectively using scriptures to justify abusive behaviour, and ridiculing another person's spiritual beliefs.

In Ontario, the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008 Ontario Regulation 299/10 defines abuse as follows:

> *Abuse* means action or behaviour that causes or is likely to cause physical injury or psychological harm or both to a person with a developmental disability, or results or is likely to result in significant loss or destruction of their property, and includes neglect.

Abuse includes any form of physical, sexual, emotional, verbal, and financial abuse. Neglect is the failure to provide a person with the support required for their health, safety, or well-being, including inaction that jeopardizes the health or safety of the person.

Those supporting individuals with intellectual disabilities must be educated and must follow the guidelines regarding abuse as

indicated in the provincial government's Quality Assurance Measures. Legislation requires that all agencies establish a clear protocol as to how staff are to deal with issues of alleged, suspected, or witnessed abuse, as well making sure they are in compliance with the Quality Assurance Measures set forth in the Ontario Regulation 299/10.

When we educate persons with intellectual disabilities about abuse, it is important to assist them to recognize, report, and avoid potentially abusive situations. Individuals need to know that abuse can take place in any type of situation or relationship—it can happen at home, at work, or at the mall, as well as among family or friends, with a sexual partner, or with staff. It is important to teach the individual to be assertive and to be able to say "No." It is also important for the individual to be able to hear and respect "No" from others.
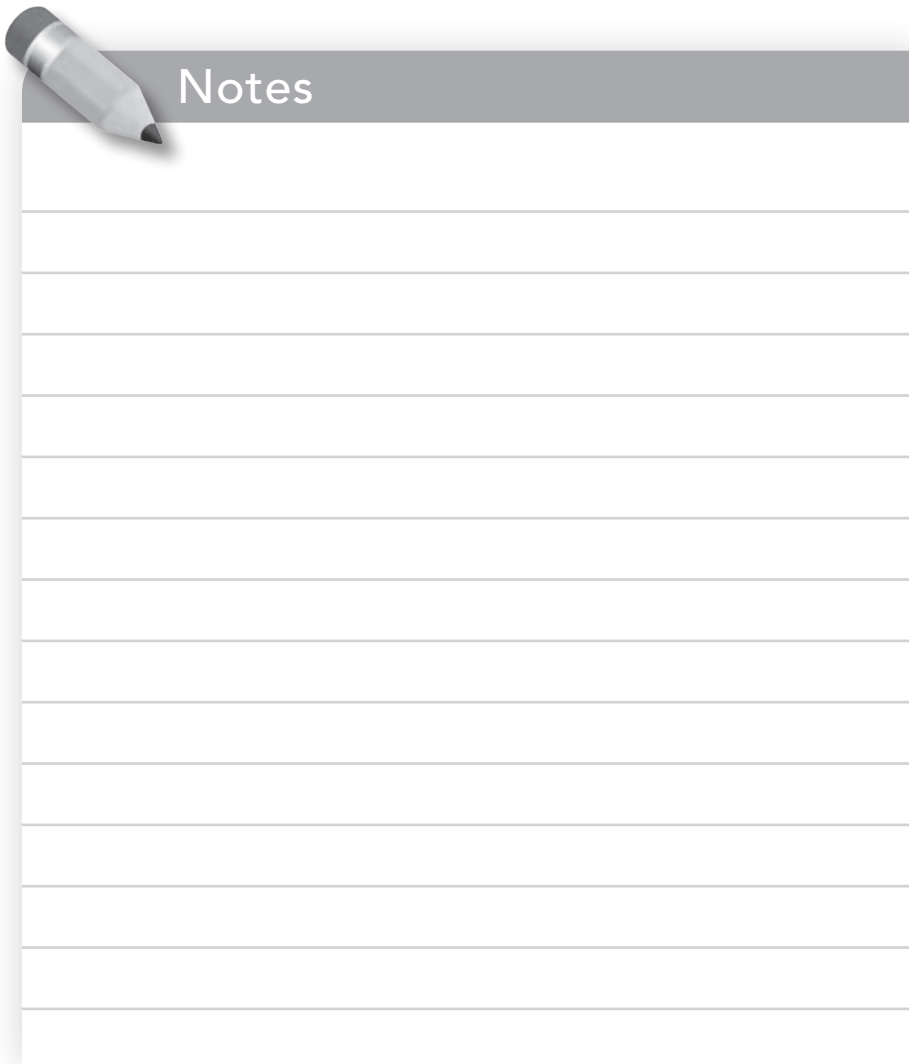
When addressing issues of abuse, many clients will have difficulty understanding boundaries regarding appropriate touch of others. Social rules can be confusing so setting concrete guidelines is important. Many strategies outlined in the sections on teaching boundaries can be utilized to address the importance of abuse prevention. Important concepts to address are where and when it is appropriate/inappropriate to touch other people (or have them touch you), protecting boundaries, and knowing your rights.

Those supporting clients with disabilities should be aware of some of the possible indicators of abuse. It is important to note that this list is not comprehensive. Furthermore, we should refrain from jumping to conclusions—when you see warning signs, be observant and investigate further. Warning signs can include a marked change in adaptive skills, withdrawal, fear of touch or intimacy, fear or avoidance of certain people or places, weight loss, sleep disturbance, and medical issues, to name a few.

When a staff member suspects that abuse has occurred, there are established ministry protocols that must be followed.

When teaching individuals about abuse prevention, personal rights, and privacy awareness, educators may be faced with a

disclosure of an act of abuse that has happened or is occurring. This may happen when the individual realizes that what has happened is actually abuse. Disclosures can occur at any time, and it is imperative that those working with individuals in such circumstances know how to handle the situation appropriately.

Notes

Staff Strategies

Staff Support

Clients with intellectual disabilities and sexual behaviour problems require many resources. Because of their unique clinical and interpersonal presentations, clients require assistance from trained professionals to ensure that their needs are met regarding housing, safety, treatment, and other clinical interventions, supervision, and community risk management. Staff who work with persons with intellectual disabilities often find this work very rewarding, but most will also tell you that it is quite challenging and emotionally exhausting. For this reason, it is important that staff who work with these clients receive sufficient training and support, while working as part of an organizational structure that is attentive to the needs of both its clients and its staff.

Skill Sets

Agencies seeking staff who will be effective in working with persons with intellectual disabilities and sexual behaviour problems need to be careful about whom they select. Preconceived ideas can signal that a candidate will have a hard time being open to new ideas, or will experience difficulty maintaining boundaries. The following are some issues to consider:

- What is the candidate's understanding of normative behaviours?
- What prior understanding does the candidate have regarding theoretical models of sexual deviance?
- Does the candidate have experience in the effective use of behavioural techniques, such as reinforcement, extinction, and modelling?

- Will the candidate be able to teach generalization of behaviours outside of the treatment environment?

- Does the candidate appear to be a team player?

- Does the candidate have good communication skills, both oral and written?

- Will the candidate be able to follow through with program goals?

- Does the candidate appear to have any negative feelings about working with persons who have engaged in behaviours that many find distasteful?

Staff Communication

Effective communication is a vital function in any organization. It is important to ensure that the process of transmitting information (e.g., ideas, thoughts, plans, etc.) is shared among the entire team so they can create a united front. Unity among staff members ensures that the vision of the organization is applied effectively. Furthermore, supported individuals are better able to adapt to a structured plan. A clear understanding of your agency's goals and objectives for clients must be built and fostered in order to encourage understanding and ensure commitment from all staff of the organization. Clear communication among all staff creates an environment with clear goals and direction and helps them identify how to work as a team that best supports the clients and themselves.

Importance of Written Communication

For situations in which more than one service provider is involved in assisting an individual, many agencies have established a communication book, support notes, diary, or similar record to ensure the continuous transfer of vital information between all pertinent staff.

Staff are accountable to each other in maintaining the programs, protocols, and policies that have been set in place. Constant

communication among staff is a must. Verbal communication is not good enough. Written communication must be detailed, clear, purposeful, and concise, using correct words, to avoid misinterpretation of any message. This is essential so that others can properly support the individual and foster a strong team unit.

Written communication provides a permanent record and may be critical in determining patterns of behaviour, for future reference. It is vital that staff document every significant piece of information that will assist other staff when working with the individual. When documenting information it is important to think of the five Ws: who, what, when, where, and why. Below are some examples of what should be included in the documentation:

- Date/Time
- Who is involved
- What happened
- Possible triggers (what triggered the behaviour of the client—antecedent)
- Consequence (Were there any consequences applied to the behaviour?)
- Person(s) involved in the issue
- The facts (avoid personal opinions)
- Future action

In the client profile, there is a section dealing with where an individual may possibly elope to. Anticipating this possibility and working with the local police department to develop an action plan for what to do if an individual leaves the supervision of a support person and is at large either in the home or in the community can be useful. The following is an example of the protocol that was developed with the police should an elopement occur.

Liaison and consultation with local law enforcement can often prove invaluable for clients in community settings (e.g., group homes). In order to ensure the safety of both clients and the community, it is helpful to draft a "police protocol" to ensure proper handling of elopements and other unapproved absences. This can only be done with the individual's consent.

Police Protocol with _____ and _____
(individual's name)   (organization's name)

At a meeting on _____, a response protocol was established with
(date)

_____. The following outlines the procedures to
(insert name of individual and name of regional police department)

be followed in the event of requested police intervention by _____'s 24 hours
(your organization)

a day, 7 days a week residential treatment home.

- In the event that a resident of this group home leaves the premises against staff advice, a search will be conducted internally and externally of the property and the surrounding area. This search will take a maximum of 30 minutes and if the resident is not found within that time staff will contact

the _____ at the appropriate _____ Regional
(insert job title)   (insert region)

Police department _____ and advise them of the situation.
(phone number)

Staff will re-inform the _____ , regarding the nature of the individual
(insert job title)

supported, and that all pertinent information is located in the folder at their office. Staff will provide any relevant information requested regarding the particulars of the current situation.

- In the event that the _____ is unavailable, staff will request to be
(insert job title)

  connected with the Communications Department where a folder of the resident's profile is also maintained. Staff will re-inform the contact, regarding the nature of the person supported, and that all pertinent information is located in the folder at their office. Staff will provide any relevant information requested regarding the particulars of the current situation.

- When this type of non-emergency call is made an officer will be dispatched at the first available opportunity to specific _____ residence. Upon arrival, the office will be
(your organization)

  updated with the most recent available information on the occurrence.

- In the event of an elopement, from staff, while in the community (e.g., mall, park, etc.), a maximum 5-minute search of the area will be conducted. If the resident cannot be located within the 5 minutes, an immediate 911 call will be made.

- In the event of an occurrence of a more serious nature, either on or off the premises, (e.g., the physical safety of staff, residents, or members of the community has been compromised) staff will make a 911 call. Staff will then follow all emergency procedures as directed by the responding authority.

Please attach any necessary contact information.

Client Profile

A Client Profile chart, for the individual being supported, is a useful tool that houses all of the pertinant information that the team would require, at a glance. It can be as in-depth as the team feels necessary. Below is a sample template.

PEEL BEHAVIOURAL SERVICES

CLIENT PROFILE

PERSONAL INFORMATION	Photo to be Inserted
Name:	
Birthday:	
Address:	
Phone No.:	
Diagnosis:	
Medical:	
Medications:	

Client Profile

CLIENT DESCRIPTION

Status:		Personality:
Ethnicity:		Education:
Eye Colour:		Employment:
Height:		Income:
Weight:		Transportation:
Hair Colour:		Has Children:
Style of Dress:		Religion:
Smoking Habits:		Diet Habits:
Drinking Habits:		

MEDICAL INFORMATION

Family Doctor:		Health Card #:
Optometrist:		Social Insurance #:
Dentist:		ODSP Member ID:
Psychiatrist:		ODSP Case File #:

FAMILY INFORMATION

Mother:	Father:
Sister:	Brother:
Address/Phone No.:	Address/Phone No.:

SPECIAL INSTRUCTIONS

FAVOURITES

Favourite Colour:	Favourite Outdoor Activity:
Favourite Indoor Activity:	Favourite Type of Movie:
Favourite Reading:	Video Games:
Favourite Music:	Concerts:

SPECIAL NOTES

SPECIAL INSTRUCTIONS

CAUTIONS

Client Profile

Staff Meetings

Regular feedback on the progress of the individual supported by the team is recommended for creating team cohesion. Meetings are necessary because they allow all persons involved with the individual to provide a picture of how well the programs are working, and whether they are in fact effective. Such meetings also allow for problem solving and finding alternative programs or tools that may be more effective. Some meetings may require the entire team, while others may only require those directly involved in a particular situation. Communication on significant issues that occur throughout the week should not be delayed, so that problem solving to find a resolution can occur in a timely fashion.

Meetings should also provide a safe environment in which staff can debrief. This creates an outlet for staff to talk about a stressful event and receive support. Addressing a pressing or stressful issue is an effective way to problem solve and come up with alternative programs or tools. In an ideal world, debriefing would happen immediately after the situation has occurred, as this is most effective. However, given the multiple tasks/roles that each staff member performs, immediate debriefing is not always possible. We recommend that time be set aside for team debriefing as soon as possible following an incident.

The frequency of meetings between all staff must be determined by those involved. Short, regular meetings, once per week, have typically proven to be most effective. All staff must be present, whenever possible, so that the entire team is aware of the issues and the action plans involved to bring about a positive change in the client(s). When everyone is informed of situations and has input into determining the "go forward" plans, staff are better able to operate as a unified body. There should be written documentation (minutes) of what took place in meetings so that all staff can reference it in the future. Assignments should be made as to who will be responsible for tasks in need of completion. If no one is assigned to the task or if no deadline is given for its completion, a task will not get done.

For those caregivers who are working with the individual in the community, the supporting agency must recognize that isolation can readily lead to burnout. The care provider must be able to connect with a supervisor/manager on a regular basis to ensure an avenue for debriefing. Staff need to be able to discuss issues in a timely and efficient manner, as well as receive support as needed.

Several care providers may be working with an individual in the community at different times. Here again, the use of a communication book (typically housed at the home of the individual being supported) has been effective. Maintaining a binder with anecdotal notes, data sheets, mood charts, and whatever other pertinent documentation is required to effectively meet the individual's needs, and will assist in ensuring all involved are consistent.

Supporting Staff

Team Building

Periodic team-building activities, when implemented effectively, can increase team spirit as well as reinforce commitment and foster awareness of the team's shared goals and overall objectives. These activities can develop strong interpersonal relationships, which help to bond the team, bringing them closer together as a unit. For example, there are professional workshops on how to give feedback to one another.

External Support

It is equally important to maintain strong lines of communication with any external support that is associated with the individual. Teamwork is not exclusive to those that are directly involved with the agency the service provider works for, but includes everyone involved in supporting the individual. Keeping the lines of communication open is a good way to provide or receive useful information to help the person you support. Some examples of external support persons are family, friends, probation officers, and other social service agents.

In keeping with a client-centered focus, it is important to pull in or provide any additional support as needed. Sharing information with the "whole support team," with the client's consent, is helpful in ensuring consistency as well as maintaining client and community safety. Here are some examples of information that should be shared among the entire team, including ancillary contacts:

- Significant incidents (e.g., incidents of aggression, physical outburst),
- Incidental (non-behavioural occurrences that may be significant),
- Medication changes,
- Program/protocol changes,
- Safety plan,
- Consequences for behaviours,
- Client progress,
- Success stories.

Training

Ongoing education not only gives treatment and supervision providers a refresher of what may already be established, but also keeps everyone abreast of new ideas and tools that can be utilized to enhance the support that you provide. Annual in-service training and specialized workshops can increase skill levels as well as understanding of the "bigger picture." Training opportunities also help convey a sense of being valued by the organization. Well trained staff do better work and are generally happier doing it.

Challenges

Clinical/Professional Boundaries

When working with individuals in clinical, mental health, or social service settings, professional boundaries must be maintained at all times. Those who are paid to support/teach another person,

for whatever reason, are not that individual's friend but a paid professional. This does not mean that the paid professional does not care about the individual. Rather, it means they must adhere to a defined boundary. This is particularly important when it comes to working with or supporting individuals with intellectual disabilities.

The boundaries between an individual with an intellectual disability and their staff must be respected, but it is often apparent that the boundaries have become blurred for the supported individual. This may have happened for a myriad of reasons and with no ill intentions. For example, the concepts of Private and Public may have become confusing for the individual. The individual may have lived in an institution where bathing or dressing was done naturally in front of others. The individual may have required hands-on assistance to complete hygiene routines and therefore may think that having someone touch them in their private areas is acceptable. Families and staff may have been extremely physical when providing gestures of affection or discipline; here the individual may have developed a belief that it is acceptable to hug, touch, kiss, pull on another's arm, grab, or slap others without consent.

Often the individual's most private issues have been discussed in a group with the client present and without the client's consent or awareness as to why the discussion is happening. In such a case, we have not modelled the appropriate type of communication skills required when out in public. Therefore, when an individual discusses private matters with a near stranger we, as service providers, should not be surprised.

As concerned professionals who support the individual, we need to teach the concepts of Private, Public, and "Be Careful" boundaries to the individual. Privacy is something that is learned by the individual and we have a responsibility to teach them the appropriate concepts regarding privacy. For example we may invade the individual's privacy in very subtle ways, such as walking into their bedroom without knocking first and getting their consent to do so.

We need to respect the individual's need for private time. All of us need some personal time to detach, decompress, and regroup when things are overwhelming or stressful. We often forget that an individual with an intellectual disability may not be as able to communicate this need or desire. We need to respect that "checking out" for a period of time is okay.

Traditionally, individuals with an intellectual disability have been omitted from sex education classes for a variety of reasons. Although the education is getting better, often the education an individual receives regarding "private body parts" is that breasts, genitals, and the buttock are private, when in fact most areas of the body are private. We need to teach that touch is contextual and that there must be a reason provided for the touch. As professionals who support the individual, we need to get consent to touch the individual. We should be requesting permission to assist them with their hygiene, dressing, lifting, and so on. Minimally, we need to tell the individual what we are doing and why we are touching them. We need to be aware that these acts should be done in private, providing as little assistance as possible for the individual to complete the task. We need to be aware that acts of personal care must be completed with discretion and respect for the privacy of the individual.

It is essential to establish professional boundaries (physical, verbal, and emotional) with the individual. The teaching of the *Circles* Program is a useful tool in this area. Establishing boundaries is often seen as a one-way street in which the individual discusses personal needs with the staff, but staff do not discuss their personal situations with the individual. The individual should be made aware that staff are there to assist them in their lives, not to be their friends. It is recommended that staff be located in the "yellow handshake circle" and never move any closer as long as they are a paid professional. Staff contact should be limited to handshakes, high fives, and the like. When actual physical contact is required, whenever possible, staff need to obtain consent from the individual to touch them.

Staff are often recommended to not discuss their personal lives with clients. Individuals are often very skilled at getting staff to discuss things with them that may seem benign; however, any given topic may be fulfilling a sexually inappropriate fantasy. For example, discussions regarding a staff member's family could be extremely arousing for an individual who experiences inappropriate sexual arousal to young children. It is deemed best that staff discuss only general situations with an individual versus any of the specifics of their lives. This includes discussions the staff have with one another or when they are having a personal conversation on the phone. Whenever discussing personal issues, the service provider should be aware of what content the individual is made privy to. Staff need to maintain awareness of the family photos that they have posted in their office or in their wallet, and of information that the individual may be able to access regarding where the staff person lives. Staff phone numbers and addresses should be secured in places that the individual does not have access to.

Staff need to adhere to appropriate dress codes. The wearing of low cut tops or pants, tight pants or see-through clothing is not appropriate.

Disclosure of Abuse

When a support person is working closely with an individual, it is not uncommon for that individual to disclose some type of abuse. Disclosure occurs when an individual tells you, or lets you know in some other way, that she or he has been or is being abused. Disclosure can be direct or indirect, or a third-party disclosure. It is important that all disclosures of abuse be reported, no matter where or when they happened.

Upping the Anti and *Black Ink* (Hingsburger, 2009) are two helpful booklets dealing with situations of abuse with respect to clients with developmental disabilities. These publications provide advice as to what one should do when faced with a disclosure of abuse.

Dealing with Disclosures

The following are strategies that staff should use when faced with a client who discloses current or historical abuse.

Stay calm

A person who is reporting abuse or neglect needs to know that you are available and there to help. Reactions of shock, outrage, or fear may make them feel anxious or ashamed. A calm response reassures them that what has happened can be worked through.

Go slowly and be reassuring

It is normal to feel inadequate or unsure about what to do or say when an individual tells you about their abuse. It is important to:

- Proceed slowly.
- Reassure the individual that they have not done anything wrong.
- Use gentle and open-ended questions, such as, "Tell me more about what happened."
- Avoid questions that begin with "*why*?"

Be supportive

Be sure to let the individual know:

- They are not in trouble.
- They are safe with you.
- You are glad that they have chosen to tell you about this.
- They have done the right thing by telling you about this.
- You are sorry that they have been hurt or that this has happened to them.
- You will do everything you can to make sure they are not hurt again.
- You know others who can be trusted to help solve this problem.

Get only the essential facts

Be brief and limit your discussion to finding out what took place. When you have sufficient information and reason to believe that

abuse and/or neglect has occurred, gently stop gathering facts and provide support.

At this point the authorities (e.g., the police) must be called. It is important that you not jeopardize the investigation by asking too many questions. While it is necessary to provide support to the individual, do not ask further questions. Unskilled investigators often ask leading questions that may unduly influence the abused person's reports to police or later testimony in court (if it gets to that level). Once the authorities have been called, you must complete written documentation. Do not make promises to the individual about what may or may not happen next. Provide only reassurance that is realistic and achievable.

Make notes

Make notes of all comments. Use the individual's exact words if possible. You will need to share these notes with the police and other legal professionals, if appropriate. Documentation must consist of only the facts and must avoid any emotional aspects on the part of the staff reporting the incident.

Supervisors receiving the report need to be careful not to interview staff or discuss the report, beyond the documentation. The witnesses (the victim and the staff who received and wrote the report) need to be kept uncontaminated by conversations with others or questions from supervisors. Debriefing can occur after the authorities (most often the police) have taken the witness's statements.

When it comes to issues regarding abuse, most people see successful prosecution leading to a conviction as the only acceptable success. Hingsburger suggests that we need to see success much differently:

> *Really, success is anything that reduces the likelihood of future abuse; it is anything that makes the world safer for those in care. Prevention of abuse is a much more worthy goal than mere successful prosecution after someone has already been abused.*

Indeed, even if there was no successful prosecution after an abuse event, this should not be seen as failure. The openness of the organization to making the report, giving the person in care the opportunity to tell their story to the authorities, and the fact that a police report was made are all part of a successful agency approach. Fear is created in perpetrators when they recognize that there is a real possibility of being caught. Making it difficult for abusers to hurt others is the ultimate success!

In compliance with the Quality Assurance Measures as outlined by the Ministry of Community and Social Services, when a service agency suspects any alleged, suspected, or witnessed incidents of abuse of a person with a developmental disability that may constitute a criminal offence, the service agency shall immediately report to the police the alleged, suspected, or witnessed incident of abuse and shall not initiate an internal investigation before the police have completed their investigation.

Vicarious Trauma and Stress Management

Given the challenges that caregivers experience when working in this field, it is understandable that workers commonly suffer from compassion fatigue or vicarious trauma. Staff are often privy to stories of offending behaviour that may evoke a visceral response. If is difficult to listen to the stories of arousal to children or interest in diapers, urine, feces, and so on. It is challenging to always have to be one step ahead of the individual, supervising them in the community, and enforcing safety plans. Staff are also not immune to being sworn at, having threats made against their physical well-being, or having threats made against their property or the people they care about (e.g., family).

Therefore, it is important for front-line care providers and managers to determine which support services and mechanisms are necessary for all involved to remain healthy. Researchers have identified circumstances associated with increased work-related distress. Some of these factors include being less than 25 years of age,

living alone, having experienced a traumatic event in the last 6 months, and having experienced sexual abuse. Personal characteristics of staff associated with increased distress include the following:

- Use of emotional or avoidance coping
- A tendency to ruminate on events
- High emotional inhibition
- High empathic concern for others
- An inability to detach from situations or persons
- Poor coping skills

When developing staff training curricula, we must consider including sessions that deal with coping strategies and emotional expression. Staff must feel that they can express their concerns, struggles, and emotions in a safe, supportive, and non-judgemental environment. The agency is responsible for ensuring that this is provided for all staff.

Why Do We Keep Doing This Work?

For most of us, we work with these individuals because we recognize that, in doing so, we can have a dramatic effect on reducing the number of potential victims. Research suggests that an individual who is actively offending in the community can have five or more victims per year. Therefore, if we are able to successfully manage the risk of even a small handful of potential offenders, we are contributing significantly to public safety.

We also do this work because we have a fundamental belief that these individuals have the right to receive appropriate treatment and care. They have the right to engage in the community safely, and that requires our assistance. Essentially, we want those we support to have the sort of "good life" that our treatment models tell us is possible, given appropriate treatment and ongoing risk management.

This work can also be extremely rewarding. Making a difference in someone's life, even in a small way, can be very gratifying.

However . . .

No matter how socially benevolent our reasons for doing this work may be, some key self-care elements are very important:

- We need to take care of ourselves and each other.
- We need to be able to leave our issues at the door as we enter into work and pick them up when we go out.
- We need to celebrate the small victories.
- We need to be able to take the time to debrief with our team.
- We need to attempt to have balance in our life.
- We need to be able to laugh.

We leave you with the following thoughts:

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

Teamwork is the key!!

Notes

About the Authors

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Michele Burns has been working for Peel Behavioural Services for the past 25 years. During this time, she has worked with a variety of individuals along with their mediators in addressing the behavioural challenges that they face. For the past 18 years, she has focused on working with individuals with intellectual disabilities who engage in sexually offending behaviour. Twelve years ago she assisted in developing a partnership with a residential provider to support individuals moving from an institution to a community setting. With the success of the first home, two additional houses have been opened which provide 24/7 residential treatment-specific programs. Michele has developed and presented materials at The Association for Treatment of Sexual Abusers (ATSA) conferences. Michele presently works as a therapist as well as supervises the three treatment homes and a community-based treatment program.

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Dr. Robin J. Wilson, ABPP, is a researcher, educator, and board certified clinical psychologist with more than 25 years' experience working with sexual and other offenders in hospital, correctional, and private practice settings. He has worked as a consultant with Peel Behavioural Services and similar organizations for more than 10 years, in addition to maintaining an international practice in consulting and clinical psychology. Wilson's current focus is on developing collaborative models of risk management and restoration as persons of risk are transitioned from institutional to community settings. He has published over 75 scientific articles, book chapters, and monographs and has presented internationally on the diagnosis and treatment of social and sexual psychopathology. Wilson is the elected Southern Regional Representative on the Board of the Association for the Treatment of Sexual Abusers (ATSA) and is President of Florida's ATSA Chapter. He is presently Editor of the *ATSA Forum* and *sajrt.blogspot.com*, in addition to being a member of the editorial boards of *Sexual Abuse: A Journal of Research & Treatment*, the *Journal of Sexual Aggression*, and the *Howard Journal of Criminal Justice*.

Useful Resources

The following is a list of resources that you may find helpful when working with the individuals that you support. Remember that no resource is perfect, and that we need to screen resources to make sure that the content is appropriate for the individual who is receiving support. Some resources depict children or other potentially vunerable persons/things. As with any teaching tool, we must bring a certain amount of discretion to our choices.

Life Skills

Title	Description	Contact
JobSmart-1 (Video and Reading Material)	Teaches students the bottom-line behaviors and basics of getting a job, getting along with co-workers, and satisfying the boss.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
JobSmart-2 (Video and Reading Material)	Focuses on job safety and productive attitudes that lead to advancement.	
First Impressions: Attitude (Video and Reading Material)	Body language, tone of voice, mannerisms, conduct, and demeanor: those hard-to-pin-down personal strategies that make the crucial difference between a successful social contact or job interview and a failure.	
SafetySmart-1 (Video and Reading Material)	Teaches students NotSmart and SafetySmart ways to avoid life's daily hazards and pitfalls—at home, on the job, and on the streets.	
SafetySmart-2 (Video and Reading Material)	Teaches students to recognize what to do if an accident does occur; when it's an emergency; what community agency to contact; and how to explain their immediate situation to authorities.	

	Life Skills	
Title	Description	Contact
In Search Of Character *Trustworthy* *Responsibility* *Fairness* *Caring* *Citizenship* *Honesty* *Courage* *Diligence* *Integrity* (Video and Reading Material)	*In Search of Character*™ spotlights 10 core virtues that help teens develop into caring, respectful, responsible people who make choices based on what's right, rather than what's easy. In this series, viewers take a fun, behind-the-scenes peek at the Dr. Mike Radio Show, where callers explore different aspects of character with "Dr. Mike" (Michael Thomson, Ph.D.).	Live Wire Media Phone: (800) 359- 5437 Fax: (415) 552–4087 Mail: Live Wire Media 273 Ninth Street San Francisco, CA 94103 Hours of Operation: Monday–Friday, 8: 30 am–5: 30 pm PST
Home of Your Own: *Cooperative Living* (Video and Reading Material)	*Home of Your Own* is part of the three-part Living With Others library. After meeting "The Housemates from Hell," your students will learn the cooperative living skills needed to successfully live with others.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail:
LifeFacts: Managing *Illness & Injury* *Basic Wellness Education* (Video and Reading Material)	This program teaches students 22 important lessons about health so they can live self-sufficiently and safely. Designed especially for people with learning difficulties who need preparation against the dangers of illnesses and injury so they may have a successful independent lifestyle.	James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com

Title	Description	Contact
ASSET *A Social Skills Program for Adolescents* 2nd Edition (Video and Reading Material)	A social skills program for adolescents that focuses on 8 areas. Tape 1: Giving Positive Feedback Tape 2: Giving Negative Feedback Tape 3: Accepting Negative Feedback Tape 4: Resisting Peer Pressure Tape 5: Problem Solving Tape 6: Negotiation Tape 7: Following Instructions Tape 8: Conversations	Research Press Phone: (217) 352-3273 (800) 519-2707 Fax: (217) 352-1221 Email: orders@researchpress.com Mail: Dept. 10W P.O. Box 9177 Champaign, IL 61826 www.researchpress.com

Relaxation		
Title	Description	Contact
Autogenic Relaxation—Audio (Eli Bay, 21 minutes).	Imagery-based	Eli Bay—The Relaxation Response Institute Tel: (416) 932-2784 Toll-Free: (877) 435-4229 Fax: (416) 932-2971 Mail: 1352 Bathurst St. Suite 201 Toronto, Ontario, Canada M5R 3H7
The Healing Light Audio (26 minutes)	Imagery-based	

	Social Skills: Hygiene	
Title	Description	Contact
First Impressions: Hygiene (Video and Reading Material)	Detailed demonstrations of showering, bathing, shampooing, bathroom clean-up, hand washing, and good hygiene associated with elimination.	James Stanfield Contact Information Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
First Impressions: Grooming (Video and Reading Material)	Hair and nail care, skin protection, shaving, and dental care basics are covered in the two Grooming modules, both tailored specifically for males and females.	
First Impressions: Dress (Video and Reading Material)	The basic pieces of "mistake-proof" wardrobes are illustrated, as well as fit, coordination, condition, appropriateness, and accessories.	

Social Skills: Money Management		
Title	Description	Contact
MoneySmart-1 (Video and Reading Material)	Focuses on careful budgeting, smart shopping, and wise spending.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
MoneySmart-2 (Video and Reading Material)	Teaches students how to keep their hard-earned dollars by avoiding the most common budget busters.	

Social Skills: Manners		
Title	Description	Contact
Manners for the Real World by Dan Coulter (DVD and Reading Material)	The DVD covers how people should act during their most common interactions with one another. There is a helpful section on how to use this DVD with persons who have Asperger's Syndrome or High-functioning Autism. This DVD also comes with subtitles for viewers who are deaf or hearing impaired.	Coulter Videos Phone: (336) 608-4224 Fax: (336) 608-4224 E-mail: info@coultervideo.com Mail: 1428 Pinecroft Drive, Winston Salem, NC 27104 www.coultervideo.com
Mind Your Manners (Video and Reading Material)	Encourage social success and acceptance through proper social behavior with the everyday situations portrayed in the *Mind Your Manners* program. *Mind Your Manners* is part of the three-part Living With Others library.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com

Coping With Conflict/Problem Solving		
Title	Description	Contact
Be Cool series (Video and Reading Material)	The *Be Cool* series is composed of several modules. The modules show various situations where conflict may arise. It provides three general ways in which people commonly respond to conflict: hot (angry), cold (withdrawn) or cool (calm and collected). There are a variety of programs offered for different grade levels and for those with intellectual disabilities. The curriculum is further broken down into concepts such as dealing with anger, teasing, criticism; give and take verses threats, demands, and intimidation.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
Imagery Procedures for People with Special Needs: Breaking the Barriers II by Dr. June Groden and Dr. Joseph R. Cautela (Video)	This video features training sessions in which clinicians use and demonstrate imagery-based procedures to help individuals with intellectual disabilities learn to cope with stress and develop self-control.	Research Press Publishers Phone: (800) 519-2707 Fax: (217) 352-1221 Email: orders@researchpress.com Mail: Research Press Dept. 11W P.O. Box 9177 Champaign, IL 61826 www.researchpress.com

Workbooks (Emotion Focused)		
Title	Description	Contact
Strategies for Anger Management: Reproducible Worksheets for Teens and Adults by Kerry Mole	This workbook is a good tool for professionals to help teens and adults learn how to cope with anger in healthier ways. This workbook is divided into three sections: Understanding Anger, Interventions for Anger Management and Conflict Resolution, and The Differences between Anger & Abuse. Each of the 34 topics covered has one or more reproducible worksheets and a facilitator's information sheet outlining the purpose, background information, and guidelines for leading an individual/group activity. This package includes a CD with reproducible activities.	Currently, there are no sellers for this item, but it can still be purchased on amazon.com.
The Self-Esteem Workbook by Glenn R. Schiraldi	Provides effective and practical strategies for raising ones self-esteem: liking oneself, conquering self doubt, rational thinking, affirming thoughts, body appreciation, etc.	Currently, there are no sellers for this item, but it can still be purchased on amazon.com.
Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety and Worry by Lisa M. Schab	Provides a collection of tools to help control anxiety and face day-to-day challenges. This workbook both gives anxious teens insight into their problems and offers practical guidance for overcoming them.	Currently, there are no sellers for this item, but it can still be purchased on amazon.com.

Resource	Description	Contact
Breaking Down the Wall of Anger: Interactive Games and Activities by Esther Williams	This book consists of seven units. Each unit contains activities that provide for group bonding, self analysis, personal goal setting, and practice. Each unit can be taught independently or the seven units can be used as a complete anger management program.	YouthLight, Inc. Phone: (800) 209-9774 Fax: (803) 345-0888 Email: YL@youthlightbooks.com www.youthlightbooks.com Mail: P.O. Box 115 Chapin, South Carolina 29036
141 Creative Strategies for Reaching Adolescents with Anger Problems by Tom Carr	This book provides the reader with some of the common causes of anger in our young people, but the bulk of the book is filled with 141 strategies that are divided in to five categories (levels of anger). Included are over 25 reproducible skill sheets to assist staff when working with the individual they support.	YouthLight, Inc. Phone: (800) 209-9774 Fax: (803) 345-0888 Email: YL@youthlightbooks.com www.youthlightbooks.com Mail: P.O. Box 115 Chapin, South Carolina 29036
Stress Management for Adolescents: A Cognitive-Behavioral Program by Diane de Anda	The aim of this book is to affect both cognitive and behavioural changes. It offers both knowledge and specific coping techniques to expand the individual's behavioural repertoires. The program includes information and activities to help the individual achieve a variety of goals.	Research Press Phone: (800) 519-2707 www.researchpress.com Mail: 2612 North Mattis Avenue Champaign, Illinois 61822

Title	Relationships: Communication and Boundaries	
	Description	Contact
Circles Curriculum	The *Circles* Curriculum teaches relationship boundaries and relationship-specific behaviors, using a simple multi-layer circle diagram to demonstrate the different relationship levels students will encounter in daily life. This will help your supported individuals generalize the skills they learn in their home and community.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
Intimacy & Relationships, Level 1 (Video and Reading Material)	Teaches relationship boundaries and relationship-specific behaviors. For example, it's okay to hug your mother, but it's not okay to hug the mail carrier.	
Intimacy & Relationships, Level 2 (Video and Reading Material)	Shows how to apply the rules of social intimacy in more complex settings.	
DateSmart-1 (Video and Reading Material)	Teaches students how to control their emotions and avoid impulsive reactions to intimate situations.	
DateSmart-2 (Video and Reading Material)	Teaches students how to control their emotions and avoid impulsive reactions to intimate situations.	
Safer Ways (Video and Reading Material)	Provides current information on avoiding and treating communicable diseases and ways to protect against sexually transmitted diseases.	

Resource	Description	Contact
PeopleSmart-1 (Video and Reading Material)	Teaches basic friendship skills and is the first video program to focus on the specific skills needed to make a "real" friend.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
PeopleSmart-2 (Video and Reading Material)	Helps students learn the difference between trust and gullibility and that "niceness" does not always mean "goodness."	
Relationship Series by the Young Adult Institute (YAI). (Video)	A comprehensive three-part video series for (young) adults with intellectual disabilities. It includes the following: 1) Friendship Series: focuses on the differences between strangers, acquaintances, and friends, becoming acquaintances and friends, and being a friend. 2) Boyfriend/Girlfriend Series: Focuses on starting a special relationship, building a relationship, and having a good relationship. 3) Sexual Relationship Series: Focuses on enjoying your sexual life, working out problems, and sexual acts that are against the law.	YAI Phone: (212) 263-7474 Mail: Central Office YAI Network 460 West 34th St. NY, NY 10001-2382 www.yai.org

	Healthy Sexuality	
Title	Description	Contact
Life Horizons 1 (Video and Reading Material)	Physiological and emotional aspects of being male and female. (I.e., Parts of the Body, Sexual Life Cycle, Human reproduction, Sexually Transmitted Diseases, and AIDS)	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
Life Horizons 2 (Video and Reading Material)	The moral, social, and legal aspects of sexuality. (i.e., Moral, Legal & Social Aspects of Sexual Behaviour [both male and female], Dating Skills, and Learning to Love). This module covers additional areas that may or may not be helpful for the supported individual (i.e., parenting), however, it is suggested to consider the areas that may be effective in attributing to generalizing their skills.	
LifeFacts: Sexuality (Video and Reading Material)	Basic sex education in a teacher-friendly format This program is designed to provide the essential materials and information necessary to teach human sexuality to adolescents and adults with intellectual and learning disabilities. With the help of two sets of explicit and non-explicit teaching illustrations and 35-mm slides, you determine the appropriate level of presentation suitable for student needs and community attitudes. Includes pre-test and post-tests.	

Resource	Description	Contact
LifeFacts: The Teacher-Friendly Life Skills Series (Video and Reading Material)	This series teaches sexuality, abuse prevention, AIDS avoidance, managing emotions, trust issues, substance abuse prevention, and wellness.	
Hand Made Love: A Guide For Teaching About Male Masturbation by Dave Hingsburger (Video and Reading Material)	This book and video set discusses privacy, pleasure, and the realities of sharing living spaces with others. The narrator of the video talks about myths and suggests that masturbation can be a way of learning about sex, while the book discusses masturbation from the point of view of both health and pleasure.	Diverse City Press Inc. Phone/Fax: (877) 246 5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm
Under Cover Dick: A Guide For Teaching About Condom Use Through Video and Understanding by Dave Hingsburger (Video and Reading Material)	This book and video set provides clear direction regarding condom use. The video discusses disease transmission and demonstrates how to wear a condom, plus the book includes photographs of each step involved.	Diverse City Press Inc. Phone/Fax: (877) 246 5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm
Finger Tips: A Guide for Teaching about Female Masturbation by Dave Hingsburger and Sandra Haar (Video and Reading Material)	This book and video set is aimed at teaching women with developmental disabilities about masturbation. It also confronts typical myths about female sexuality. The book includes a step-by-step photographic essay about masturbation, and the joy of private time.	

Healthy Sexuality		
Title	Description	Contact
It's Perfectly Normal: Changing Bodies, Growing Up, Sex and Sexual Health written by Robie H. Harris; illustrated by Michael Emberley	This universally acclaimed classic by Robie H. Harris and Michael Emberley is a cutting-edge resource for kids, parents, teachers, librarians, and anyone else who cares about the well-being of "tweens" and teens. Providing accurate and up-to-date answers to nearly every imaginable question, from conception and puberty to birth control and AIDS, *It's Perfectly Normal* offers young people the information they need—now more than ever—to make responsible decisions and stay healthy.	Candlewick Press Phone: (800) 733-3000 Fax: (800) 659-2436 Mail: 99 Dover Street Somerville, MA 02144 www.candlewick.com/default.asp
Able to Live, Able to Love: A sexuality education resource guide for persons with intellectual disabilities and those who live and work with them by Anne Escrader with Elizabeth Moore; illustrations by Srividy Natarajan	This sexuality education resource has been planned, designed, and developed because the authors believe in taking a proactive approach towards disability and human sexuality. The authors understand sexual self-expression to be an important aspect of being human. The guide provides basic information on sexuality and relationships that persons with disabilities can work through on their own or with the support and assistance of parents, teachers, and others who live with them.	The Relationship, Sexuality and Safety Education Network of Wellington and Dufferin Counties Contact: Christine Rickards Phone: (519) 824-5544 ext. 776 Email: crickards@trellis.on.ca

Healthy Sexuality: Abuse Recognition		
Title	Description	Contact
Life Facts: Substance Abuse Refusal Training (Video and Reading Material)	This program provides lessons about drugs in daily living situations at home, in school, or in the community. The program teaches the facts of life about the dangers of substance abuse and chemical dependency, emphasizing how students can avoid drugs, by empowering them with refusal skills.	James Stanfield Phone: (800) 421-6534 Fax: (805) 897-1187 Email: orderdesk@stanfield.com Mail: James Stanfield Co., Inc. Drawer: WEB P.O. Box 41058 Santa Barbara, CA 93140 www.stanfield.com
No! How!!! co-written by Dave Hingsburger (Video)	This video involved people with disabilities in acting, writing, producing, and directing a film aimed at others with disabilities. From discussing disability to teaching boundaries and body parts, people with disabilities take the lead.	Diverse City Press Inc. Phone/Fax: (877) 246-5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm

Staff Education

Title	Description	Contact
Who Do We Serve? with David Hingsburger (Video)	This lecture deals with supporting people with intellectual disabilities who have committed sexual crimes. Who do we serve first in a community setting? Do we serve the individual first or do we serve the community?	Diverse City Press Inc. Phone/Fax: (877) 246-5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm
Behaviour Self! by Dave Hingsburger. (Book)	Dave writes about the importance of understanding behaviour messages from people with intellectual disabilities in a straightforward yet humorous fashion. This book gives insight to parents and staff with new ways on how to get the message right.	

Staff Education		
Title	Description	Contact
The Ethics of Touch (Video and Reading Material)	This training package looks at the delicate issue of touch. Those who provide direct care to people with intellectual disabilities are often asked to be in private places performing intimate services. From bathing to toileting to dressing, we are necessarily in close proximity to those we serve. Given this situation, it is imperative that staff be aware of how to provide these services while maintaining appropriate professional boundaries. How do we appropriately express affection toward those we serve? This video suggests new and healthy ways of helping people with disabilities fulfill their deepest needs.	Diverse City Press Inc. Phone/Fax: (877) 246-5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm
Power Tools: Thoughts About Power and Control in Service to People with Developmental Disabilities by Dave Hingsburge. (Book)	This book addresses the delicate issue of power within human services. Power is one of the most important issues that front-line care providers need to consider. *Power Tools* gets you thinking about who we are and the power that we have. The process of change involves three steps and two skills. *Power Tools* is written with humour, wit, and warmth. Please note that there is some language used in this book that may offend some readers.	Diverse City Press Inc. Phone/Fax: (877) 246-5226 Email: diversecitypress@bellnet.ca (or latourdcp@hotmail.com) Mail: 7654 Fifth Line, Angus, Ontario L0M 1B1 www.diverse-city.com/display.htm

Title	Description	Contact
Ethical Dilemmas: Sexuality and Developmental Disability edited by Dorothy M. Griffiths, Ph.D.; Debbie Richards; Paul Fedoroff, M.D.; and Shelley L. Watson, M.Ed.	Unique in its approach, *Ethical Dilemmas: Sexuality and Developmental Disability* addresses the critical issues and questions. It also provides recommendations and suggestions through extensively documented, researched, and expert consensus. Numerous case studies are used throughout to identify the issues and build the foundations for the many situations that occur within the lives of individuals who have disabilities.	NADD Press Phone: (800) 331-5362 Fax: (845) 331-4569 Email: info@thenadd.org Mail: 132 Fair Street Kingston, New York 12401 www.thenadd.org/index.shtml
Sexuality and the Developmentally Handicapped: A Guidebook for Health Care Professionals by William Rowe and Sandra Savage with Mark Ragg and Kay Wigle	Presents the knowledge, attitudes, and skills pertinent to responding to the sexual problems of intellectually handicapped persons, their families, and communities. Details fully documented cases, issues concerning the law, and resource materials available.	The Edwin Mellen Press Phone: (716) 754-2266 Fax: (716) 754-4056 Email: imiller@mellenpress.com Mail: P.O. Box 450 Lewiston, New York, 14092 mellenpress.com/index.cfm
Stress Management	A workbook to use with individuals with a developmental disability but could be a good tool for staff to use themselves in working through the management of stress.	Christine Rickards Behavioural Consultant Trellis Mental Health and Developmental Services Phone: (519) 824-5544 ext. 776 crickards@trellis.on.ca

Staff Education		
Title	Description	Contact
Practical Treatment Strategies for Persons with Intellectual Disabilities by Dr. G. Blasingame	This book is a result of a collaborative effort of several professionals in the field with their goal being to bring practical training to the professionals working with these issues and to change the lives of the individuals they support.	Wood 'N' Barnes Publishing Phone: (405) 942-6812 WOODBARNES.COM Mail: 2717 NW 50th Oklahoma City, OK 73112

Glossary

A

ABC data Descriptive data (antecedent, behaviour, consequence) that is evaluated to tell us why a behaviour occurs as oppose to how often a behaviour occurs.

abuse An action or behaviour that causes or is likely to cause physical injury or psychological harm to the recipient. This includes neglect.

active supervision A style of supervision in which individuals working with clients are not just observers and documenters of client activities, but also seek to provide ongoing support and instruction as the client encounters various life events.

antecedent In the ABC model, the precursory thought or event that results in a behaviour leading to a consequence.

B

baseline In behaviourism, the natural state of cognition or behaviour.

behaviour In the ABC model, the action or response one makes to the antecedent.

boundary Social rules around the type of talk, touch, and trust that is appropriate within a relationship.

C

consent Voluntary agreement or permission.

consequence In the ABC model, the result of the behaviour one chooses to engage in as a response to the antecedent.

D

debrief To meet after an event, project, or incident to discuss what happened, what went wrong, what went right, and what you can learn from the experience.

disclosure A process in which a person gives clear details of an event, either cognitive or behavioural. Persons who are victimized will "disclose" their experiences of abuse, while clients who offend in treatment will "disclose" their actions as a way to identify problems in thinking and behaviour.

F

functional Pertaining to the ways in which a person's intrisic characteristics combine with

experience to determine behaviour and perspective.

Functional Analysis/Analogue Assessment The process of determining what outcome a client is attempting to achieve by engaging in a certain behaviour.

H

hypothesis A working model of observed phenomena that attempts to make sense of what you observe.

M

media Any method of audiovisual representation of real-life persons or objects. These may include video, DVD, CD, tape, photography, or electronic storage devices (jump drive, SD cards, computer hard drives).

N

neglect When a caregiver fails to provide certain necessary aspects of healthy living. These can include food and shelter, warm positive regard, or attention to healthcare issues.

O

offending behaviour Legalistically, the breaking of laws; however "offending" is a more complex term that it immediately seems. From a social sense, it can be any time one person engages in behaviour that is offensive to others.

offensive behaviour Anything one does that causes others to be offended. This does not necessarily have to be something illegal.

outing journal A written record of a client's interaction with the community, which forms a powerful tool for evaluating client progress and success in managing situations in which they encounter risk or other difficulties.

P

potentially vulnerable person (PVP)/thing The objects of our clients inappropriate desire or interest. For clients with histories of abusing children, PVPs are children. Analogously, for clients with fetishistic interests, the fetish object is the potentially vulnerable thing.

preference A markedly greater sexual interest in one type of sexual person, object or activity. For instance, someone who prefers children is someone who would rather engage in sexual activities with children.

R

reinforcement In learning and behaviour, whenever one event or outcome influences the likelihood that the antecedent cognition or behaviour will be repeated. There is both positive and negative reinforcement.

reliability The level of consistency with which something is measured using a certain procedure.

risk assessment The process of evaluating the potential someone poses to engage in behaviour that places himself or others at risk for harm.

S

safety person An external contact such as a family member or friend that has been trained appropriately so that they are fully aware of the individual's potential risk factors and issues, and who uses this knowledge to help the supported individual manage any risk they may experience.

safety plan A written description of what a supported individual needs to do to stay safe in the community. scatter plot A way of graphically representing a person's behaviour in regard to particular areas of treatment or risk management interest. These plots allow us to look for patterns in behaviour and to formulate plans for behavioural change or risk management.

standardization An important means to ensure reliability, which requires that all persons performing a certain task do so in the same manner.

T

teachable moment Situations in which we have the opportunity to reflect on antecedents, behaviours, and consequences in a fashion that assists our client in better understanding these dynamics. These are also sometimes referred to as "a-ha!" moments, due their powerful potential for supporting change.

trigger Person, place, thing, or situation that puts us at risk to engage in a behaviour we are trying to curb. For example, a person who is trying to quit smoking will be triggered by seeing another person smoking, or even by the smell of cigarette smoke.

V

validity The relationship between the findings of an investigation or test and the real-life truth.

References

Abel, G. G., Becker, J. V., Cunningham-Rathner, J., Mittelman, M., & Rouleau, J. L. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law, 16,* 153–168.

Abel, G. G., Huffman, J., Warberg, B., & Holland, C. L. (1998). Visual reaction time and plethysmography as measures of sexual interest in child molesters. *Sexual Abuse: A Journal of Research & Treatment, 10,* 81–96.

Abracen, J., & Looman, J. (2005). Developments in the assessment and treatment of sexual offenders: Looking backward with a view to the future. *Journal of Interpersonal Violence, 20,* 12–19.

American Psychiatric Association (2000). *The diagnostic and statistical manual of mental disorders, 4th Edition, Text Revision.* Washington, DC.

Antonello, S. (1996). *Social skills development: Practical strategies for adolescents and adults with developmental disabilities.* Boston, MA: Allyn & Bacon.

Association for the Treatment of Sexual Abusers (ATSA) (2004). *Practice standards and guidelines for the evaluation, treatment and management of adult male sexual abusers.* Beaverton, OR.

Badgley, R.F. (1984). *Sexual offenses against children: Summary of the report of the committee on sexual offenses against children and youth.* Ottawa, ON: Supply and Services, Canada.

Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis, 1,* 91–97.

Barrett, M., Wilson, R. J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment, 15,* 269–283.

Blanchard, R., Klassen, P., Dickey, R., Kuban, M. E., & Blak, T. (2001). Sensitivity and specificity of the phallometric test for pedophilia in nonadmitting sex offenders. *Psychological Assessment, 13,* 118–126.

Blasingame, G. (1998). Suggested clinical uses of polygraphy in community-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research & Treatment, 10,* 37–45.

Blasingame, G. (2005). *Developmentally disabled persons with sexual behavior problems: Treatment, management, supervision,* 2nd ed. Oklahoma City, OK: Wood'n'Barnes.

Blasingame, G. (2006a, September). *Preliminary data on a tool for the developmentally disabled offender population: The Abel-Blasingame Assessment System for the Intellectually Disabled.* Paper presented at the 25th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Chicago, IL.

Blasingame, G. (2006b). *Working with forensic clients with severe and sexual behavior problems: Practical treatment strategies for persons with intellectual disabilities.* Oklahoma City, OK: Wood'n'Barnes.

Blasingame, G. (in press). Assessment, diagnosis, and risk management of sexual offenders with intellectual disabilities. In A. Phenix & H. Hoberman (Eds.), *Diagnosis, risk assessment, and management of sexual offenders.* New York: Springer.

Boer, D., McVilly, K., & Lambrick, F. (2007). Contextualizing risk in the assessment of intellectually disabled individuals. *Sexual Offender Treatment, 2,* 2.

Boer, D., Tough, S., & Haaven, J. (2004). Assessment of risk manageability of intellectually disabled sex offenders. *Journal of Applied Research in Intellectual Disabilities, 17,* 275–283.

Brownmiller, S. (1975). *Against our will: Men, women, and rape.* New York: Simon & Schuster.

Campbell, M., & Malone, R. P. (1991). Mental retardation and psychiatric disorders. *Hospital and Community Psychiatry, 42,* 374–379.

Cantor, J. M., Blanchard, R., Christensen, B. K., Dickey, R., Klassen, P. E., Beckstead, A. L., et al. (2004). Intelligence, memory, and handedness in pedophilia. *Neuropsychology, 18,* 3–14.

Carr, J. E., Nicolson, A. C., & Higbee, T. S. (2000). Evaluation of a brief multiple-stimulus preference assessment in a naturalistic context. *Journal of Applied Behavior Analysis, 33,* 353–357.

Cipani, E., & Schock, M. K. (2007). Functional behavioral assessment, diagnosis, and treatment. New York., NY: Springer Publishing Company.

Corne S., Briere J., & Esses L. (1992). Women's attitudes and fantasies about rape as a function of early exposure to pornography. *Journal of Interpersonal Violence, 7,* 454–461.

Curtiss, P. R., & Warren, P. W. (1973). *The dynamics of life skills coaching.* Prince Albert, SK: Saskatchewan NewStart Inc. (for the Training Research and Development Station Dept. of Manpower and Immigration).

Daily D. K., Ardinger, H. H., & Holmes, G. E. (2000). Identification and evaluation of mental retardation. *American Family Physician, 61,* 1059–1067, 1070.

DiClemente, C., & Prochaska, J. (1998). *Treating addictive behaviors: Applied Clinical Psychology* (2nd ed.). New York: Springer.

Fedoroff, J. P. (1993). Serotonergic drug treatment of deviant sexual interests. *Annals of Sex Research, 6,* 105–121.

Fernandez, Y. (2002). Phallometric testing with sexual offenders against female victims: Limits to its value. *Forum on Corrections Research, 14,* 7–12.

Finkelhor, D. (1984). *Child sexual abuse: New theory & research.* New York: Free Press.

Finkelhor, D., & Jones, L. M. (2004). *Explanations for the decline in child sexual abuse cases.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Finlay, W., & Lyons, E. (2002). Acquiescence in interviews with people who have mental retardation. *Mental Retardation, 40,* 1.

Fischer, L., & Smith, G. M. (1999). Statistical adequacy of The Abel Assessment for interest in paraphilias. Sexual Abuse: *A Journal of Research & Treatment, 11,* 195–205.

Fishback, W. P. (1896). *A manual of elementary law: Being a summary of the well-settled elementary principles of American law.* Indianapolis, IN: Bowen-Merrill.

Fisher, C. B., Cea, C. D., Davidson, P. W., & Fried, A. L. (2006). Capacity of persons with mental retardation to consent to participate in randomized clinical trials. *American Journal of Psychiatry, 163,* 1813–1820.

Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (2007). *Diagnostic manual-intellectual disability: A clinical guide for diagnosis of mental disorders in persons with intellectual disability.* Kingston, NY: National Association for the Dually Diagnosed.

Flynn, A., & Gravestock, S. (2010). Assessment, diagnosis and rating instruments. In N. Bouras & G. Holt (Eds.), *Mental health services for adults with intellectual disability: Strategies and solutions* (pp. 57–74). NY: Psychology Press.

Freedman, R. I. (2001). Ethical challenges in the conduct of research involving persons with mental retardation. *Mental Retardation, 39,* 130–141.

Frenzel, R., & Lang, R. (1989). Identifying sexual preferences in intrafamilial and extrafamilial child sexual abusers. *Annals of Sex Research, 2,* 255–275.

Freund, K. (1963). A laboratory method for diagnosing predominance of homo- or hetero-erotic interest in the male. *Behaviour Research & Therapy, 1,* 85–93.

Freund, K., & Blanchard, R. (1989). Phallometric diagnosis of pedophilia. *Journal of Consulting and Clinical Psychology, 57,* 1–6.

Freund, K., & Kuban, M. (1993). Toward a testable developmental model of pedophilia: The development of erotic age preference. *Child Abuse & Neglect, 17,* 315–324.

Freund, K., McKnight, C. K., Cibiri, S., & Langevin, R. (1972). The female child as a surrogate object. *Archives of Sexual Behaviour, 2,* 119–133.

Freund, K., & Watson, R. (1990). Mapping the boundaries of courtship disorder. *Journal of Sex Research, 27,* 589–606.

Freund, K., & Watson, R. (1991). Assessment of the sensitivity and specificity of a phallometric test: An update of "Phallometric diagnosis of pedophilia". *Psychological Assessment, 3,* 254–260.

Freund, K., Watson, R., & Dickey, R. (1991). Sex offenses perpetrated by men who are not pedophiles. *Journal of Sex Research, 28,* 409–423.

Freund, K., Watson, R., & Rienzo, D. (1988). Signs of feigning in the phallometric test. *Behaviour Research & Therapy, 26,* 105–112.

Frisbie, L. V., & Dondis, E. H. (1965). *Recidivism among treated sex offenders.* Sacramento: California Department of Mental Hygiene, Research Monograph #5.

Gannon, T. A., & Cortoni, F. (2010). *Female sexual offenders: Theory, assessment, and treatment.* Chichester, UK: Wiley Blackwell.

Gebhard, P., Gagnon, J., Pomeroy, W., & Christenson, C. (1965). *Sex offenders: An analysis of types.* New York: Harper & Row.

Griffiths, D., & Lunsky, Y. (2003). *Sociosexual Knowledge and Attitudes Assessment Tool (SSKAAT-R).* Wood Dale, IL: Stoelting Company.

Groth, A. N. (1978). Patterns of sexual assault against children and adolescents. In A. Burgess, A. N. Groth, L. Holmstrom, & S. Sgroi (Eds.), *Sexual assault of children and adolescents.* Lexington, MA: Lexington Books.

Groth, A. N., & Birnbaum, H. J. (1978). Adult sexual orientation and attraction to underage persons. *Archives of Sexual Behaviour, 7,* 175–181.

Hansen, K. J., & Kahn, T. J. (2006). *Footprints: Steps to a healthy life.* Brandon, VT: Safer Society.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66,* 348–362.

Hanson, R. K., Harris, A. J. R., Scott, T. L., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project.* [User Report 2007-05] Ottawa, ON: Public Safety Canada.

Hanson, R. K., & Morton-Bourgon, K.E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73,* 1154–1163.

Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sexual offenders.* [User Report 1999-02] Ottawa, ON: Department of the Solicitor General of Canada.

Hare, R. D. (2003). *Manual for the Hare Psychopathy Checklist—Revised.* Toronto, ON: Multi-Health Systems.

Helmus, L. (2009). *Re-norming Static-99 recidivism estimates: Exploring base rate variability across sex offender samples* (master's thesis). Available from ProQuest Dissertations and Theses database. (UMI No. MR58443).

Hingsburger, D. (1995). *Just say know! Understanding and reducing the risk of sexual victimization of people with developmental disabilities.* Angus, ON: Diverse-City Press.

Hingsburger, D., Chaplin, T., Hirstwood, K., Tough, S., Nethercott, A., & Roberts-Spence, D., (1999). Intervening with sexually problematic behavior in community environments. In: J. R. Scotti & L. H. Meyer (Eds.), *Behavioral intervention: Principles, models, and practices* (pp. 213–236). Baltimore, MD: Brookes.

Hingsburger, D., Griffiths, D., & Quinsey, V. (1991). Detecting counterfeit deviance: Differentiating sexual deviance from sexual inappropriateness. *Habilitation Mental Health Care Newsletter, 10,* 51–54.

Hoath, J., Wilson, R. J., Burns, M., Figliola, L., & Tough, S. (under review). *Sexual preference testing for intellectually-disabled persons who sexually offend: Issues, advisements, and an exploratory study.*

Horton, T., & Frugoli, T. (2001). *Healthy choices: Creative ideas for working with sex offenders with developmental disabilities.* Bloomington, IL. www.healthychoices4dd.com.

Howells, K. (1981). Adult sexual interest in children: Considerations relevant to theories of aetiology. In: M. Cook & K. Howells (Eds.), *Adult sexual interest in children.* New York: Academic Press.

Jespersen, A. F., Lalumière, M. L., & Seto, M. C. (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. *Child Abuse & Neglect, 33,* 179–192.

John Howard Society of Alberta (2001) Offender Registry. http://www.johnhoward.ab.ca/pub/offender.htm.

Kingston D. A., Firestone, P., Moulden, H. M., & Bradford, J. M. (2007). The utility of the diagnosis of pedophilia: A comparison of various classification procedures. *Archives of Sexual Behavior, 36,* 423–436.

Knight, R. A., & Prentky, R. A. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In W. L. Marshall, D. R. Laws, H. E. & Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender.* New York, NY: Plenum Press.

Krafft-Ebing, R. von (1886/1950). *Psychopathia sexualis: A medico-forensic study.* New York: Pioneer.

Lalumière, M. L., & Quinsey, V. L. (1996). Sexual deviance, antisociality, mating effort, and the use of sexually coercive behaviors. *Personality and Individual Differences, 21,* 33–48.

Langevin, R. (1993, February). *Brain abnormalities and genetic factors in homosexuality and in pedophilia.* Paper presented at "Sex Offenders & Their Victims III", Toronto, Ontario.

Langevin, R., & Lang, R. (1988). *Incest offenders: A practical guide to assessment and treatment.* Toronto, ON: Juniper Press.

Langevin, R., & Watson, R.J. (1991). A comparison of incestuous biological and step-fathers. *Annals of Sex Research, 4,* 141–150.

Laws, D. R., Hudson, S. M., & Ward, T. (2000). *Remaking relapse prevention with sex offenders.* Thousand Oaks, CA: Sage.

Laws, D. R., & Marshall, W. L. (2003). A brief history of behavioral and cognitive-behavioral approaches to sexual offender treatment: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment, 15,* 75–92.

Levenson, J. S., & D'Amora, D. A. (2007). Social policies designed to prevent sexual violence: The emperor's new clothes? *Criminal Justice Policy Review, 18,* 168–199.

Lindsay, W., Michie, A., Whitefield, E., Martin, V., Grieve, A., & Carson, D. (2006). Response patterns on the Questionnaire on Attitudes Consistent with Sexual Offending in groups of sex offenders with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 19,* 47–53.

Lindsay, W., Whitefield, E., & Carson, D. (2007). The development of a questionnaire to measure cognitive distortions in sex offenders with intellectual disability. *Legal & Criminological Psychology, 12,* 55–68.

Malamuth, N.M. (1981), Rape proclivity among males. *Journal of Social Issues, 37,* 138–157.

Marques, J. K.,Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research of Research and Treatment, 17,* 79–107.

Marshall, L. E., Marshall, W. L., Fernandez, Y. M., Malcolm, P. B., & Moulden, H. M. (2008). The Rockwood Preparatory Program for Sexual Offenders: Description and preliminary appraisal. *Sexual Abuse: A Journal of Research and Treatment, 20,* 25–42.

Marshall, W. L. (2005). Clinical and research limitations in the use of phallometric testing with sexual offenders. *Sexual Offender Treatment, 1,* 14–41.

Marshall, W. L., Kennedy, P., & Yates, P. M. (2002). Issues concerning the reliability and validity of the diagnosis of sexual sadism applied in prison settings. *Sexual Abuse: A Journal of Research & Treatment, 14,* 301–311.

Marshall, W. L., Kennedy, P., Yates, P. M., & Serran, G. (2002). Diagnosing sexual sadism in sexual offenders: Reliability across diagnosticians. *International Journal of Offender Therapy and Comparative Criminology, 46,* 668–677.

Marshall, W. L., & Laws, D. R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment, 15,* 93–120.

Martinson, R. (1974). Nothing works: Questions and answers about prison reform. *The Public Interest, 35,* 22–54.

Masters, W., & Johnson, V. (1966). *Human sexual response.* New York, NY: Bantam Books.

Mayer, A. (1988). *Sex offenders: Approaches to understanding and management.* Florida: Learning Publications.

McGrath, R., Livingston, J., & Falk, G. (2007). A structured method of assessing dynamic risk factors among sexual abusers with intellectual disabilities. *American Journal on Mental Retardation, 112,* 221–229.

Michie, A. M., Lindsay, W. R., Martin, V., & Grieve, A. (2006). A test of counterfeit deviance: A comparison of sexual knowledge in groups of sex offenders with intellectual disability and controls. *Sexual Abuse: A Journal of Research and Treatment, 18,* 271–278.

Miltenberger, R. (1998). Methods for assessing antecedent influences on challenging behaviors. In J. Luiselli & M. Cameron (Eds.), *Antecedent control.* Baltimore, MD: Paul H. Brookes Publishing Co.

Money, J. (1986). *Venuses penuses: Sexology, sexosophy, and exigency theory.* Buffalo, NY: Prometheus Books.

Morris, C. D., Niederbuhl, J. M., & Mahr, J. M. (1993). Determining the capability of individuals with mental retardation to give informed consent. *American Journal of Mental Retardation, 98,* 263–272.

Nafekh, M., Allegri, N., Stys, Y., & Jensen, T. (2009). *Evaluation report: Correctional Service Canada's Correctional Programs.* Ottawa, ON: Correctional Service Canada.

Olver, M. E., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale–Sexual Offender Version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19,* 318–329.

Orne, M. (1962). On the social psychology of the psychological experiment: With particular reference to demand characteristics and their implications. *American Psychologist, 17,* 776–783.

Pithers, W. D. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender.* New York: Plenum Press.

Rada, R. T., Laws, D. R., & Kellner, R. (1976). Plasma testosterone levels in the rapist. *Psychosomatic Medicine, 38,* 257–268.

Reyes, J., Vollmer, T., Sloman, K., Hall, A., Reed, R., Jansen, G., Carr, S., Jackson, K., & Stoutmimore, M. (2006). Assessment of deviant arousal in adult male sex offenders with developmental disabilities. *Journal of Applied Behavior Analysis, 39,* 173–188.

Rice, M. E., Harris, G. T., Lang, C., & Chaplin, T. C. (2009). Sexual preferences and recidivism of sex offenders with mental retardation. *Sexual Abuse: A Journal of Research & Treatment, 20,* 409–425.

Schlesinger, B. (1982). *Sexual abuse of children: A resource guide and annotated bibliography.* Toronto, ON: University of Toronto Press.

Skinner, B. F. (1971). *Beyond freedom and dignity.* New York: Knopf.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silence acceptance?* Baltimore, MD: Paul H. Brookes Publishers.

Tangney, J., Wagner, P., Fletcher, C., & Gramzow, R. (1992), Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology, 62,* 669–675.

Thornhill, R., & Palmer, C. T. (2000). *A natural history of rape.* Cambridge, MA: MIT Press.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14,* 139–153.

Tough, S. (2001). *Validation of two standard risk assessments (RRASOR, 1997; STATIC-99, 1999) on a sample of adult males who are intellectually disabled with significant cognitive deficits.* (master's thesis). University of Toronto, Toronto, ON, Canada.

Ward, T., & Stewart, C. A. (2003). The treatment of sexual offenders: Risk management and good lives. *Professional Psychology: Research and Practice, 34,* 353–360.

Williams, K. M. (undated). *Ethical challenges in the conduct of research involving persons with mental retardation.* ACFEI Continuing Education document.

Williams, S. M., Mallette, G., & Isaacs, W. (1993). *A descriptive study of gerontophiles: Men who assault older women.* Paper presented at the 12th annual meeting of the Association for the Treatment of Sexual Abusers, Boston, MS.

Wilson, R. J. (1998). Psychophysiological indicators of faking in the phallometric test. *Sexual Abuse: A Journal of Research & Treatment, 10,* 113–126.

Wilson, R. J. (1999). Emotional congruence in sexual offenders against children. *Sexual Abuse: A Journal of Research & Treatment, 11,* 33–47.

Wilson, R. J. (2009). Treatment readiness and comprehensive treatment programming: How do we ensure preparation for and commitment to change in persons who have sexually offended? In D. S. Prescott (Ed.), *Building motivation to change in sexual offenders.* Brandon, VT: Safer Society Press.

Wilson, R. J., Abracen, J., Looman, J., Picheca, J. E., & Ferguson, M. (2010). Pedophilia: An evaluation of diagnostic and risk management methods. *Sexual Abuse: A Journal of Research & Treatment.* First published on November 9, 2010 as doi:10.1177/1079063210384277.

Wilson, R. J., & Barrett, M. (1997, October). *Exhibitionism: The hub of the paraphilias?* Paper presented at the 16th Annual Conference of the Association for the Treatment of Sexual Abusers, Arlington, VA.

Wilson, R. J., Burns, M., Tough, S., Nethercott, A., Outhwaite, C., & Repp, A. (2007, November). *Clinical conundrums: Sexuality and the developmentally-delayed.* Symposium presented at the 26th Annual Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

Wilson, R. J., McWhinnie, A. J., & Wilson, C. (2008). Circles of Support & Accountability: An international partnership in reducing sexual offender recidivism. *Prison Service Journal, 138,* 26–36.

Wilson, R. J., & Pake, D. R. (2010). Treatment readiness: Preparing sexual offenders for the process of change. In M. Herzog-Evans (Ed.), *Transnational criminology manual.* Oisterwijk, Netherlands: Wolf Legal Publishing.

Wilson, R. J. & Yates, P. M. (2009). Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression & Violent Behavior, 14,* 157–161.

Yates, P. M., Prescott, D. S., & Ward, T. (2010). *Applying the Good Lives and Self-Regulation models to sex offender treatment: A practical guide for clinicians.* Brandon, VT: Safer Society.

Zuckerman, M. (1971). Physiological measures of sexual arousal in the human. *Psychological Bulletin, 75,* 297–329.

Notes