Ensuring Responsive Treatment Options for Persons with Special Needs and Problematic Sexual Behavior

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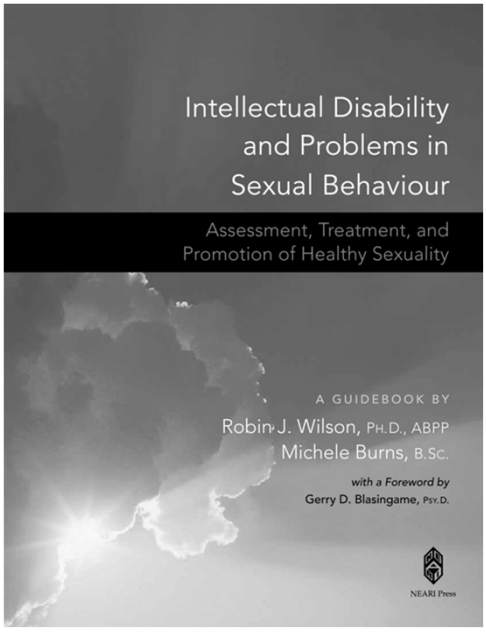
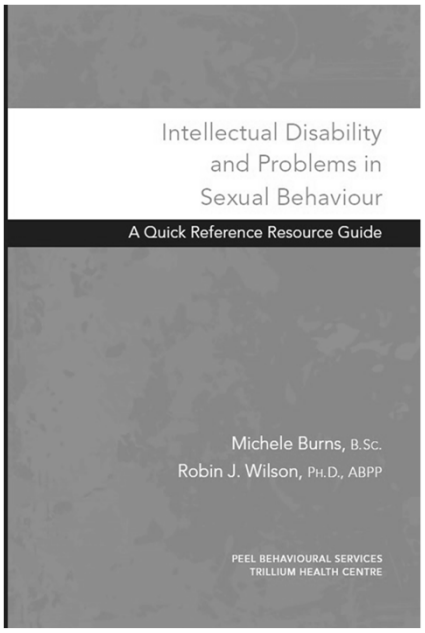
Disclaimer

- During this presentation, there will be a few pictures of books I authored or co-authored.
- I certify that I receive no remuneration from the sale of these books.
- All proceeds of their sale go back into the clinics where they were produced and are used to support persons-in-care, or are given as scholarships for students interested in working with folks with IDD / SN.





Who are we talking about?

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

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

Judge Trueman

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

Special Needs and Crime

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

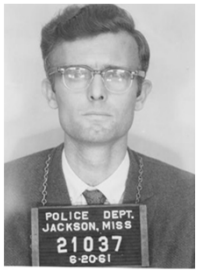
Special Needs and Sexual Offending

A judge in Canada observed:

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

Effective Interventions

Nothing Works?

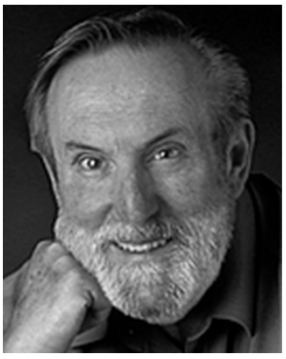


Martinson (1974)

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

Andrews, Bonta, Gendreau

What Works?



Sanction vs. Human Service

Several very large-scale meta-analyses

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

All arrived at the same conclusion:

- Punishment alone will not reduce bad behavior

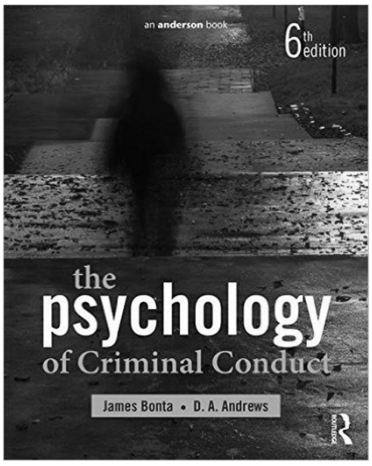
An answered question?

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

Smith et al. 2002, p.19

Bonta & Andrews (2017)

Psychology of Criminal Conduct



Andrews & Bonta – "Big 4"

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

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

Overarching Risk Factors

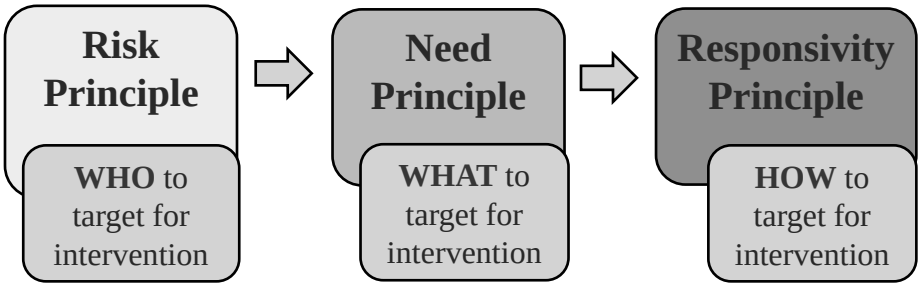
Added to these were four additional factors to comprise the Central-8 risk domains:

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

RNR Principles

Bonta & Andrews, 2017

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



Responsivity

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

Responsivity Assessment

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

- IQ testing and misidentification
- Trauma (?)
- Stages of change
- Motivation
- And ???

Treatment Focus

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

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

Assessment

Behavioral Difficulties

- Children with special needs tend to be impulsive, uninhibited, overly friendly, inquisitive, demanding of affection and physical contact, intrusive, insensitive to social cues, and have poor social skills.
- It's not hard to see how some of these – without proper attention and guidance – could ultimately lead to problems in later life.

Difficulties for our clients

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

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

Areas of Focus

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

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

Attention/Hyperactivity/Perseveration
- Does the client have issues with focus?

Areas of Focus

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

Socio-Sexual And Social Skills
- Inappropriate courtship skills, social skills, interactional skills?

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

Areas of Focus

Sexual Knowledge

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

Learning History

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

Areas of Focus

Structure

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

Modeling

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

Medical and Psychiatric Issues

Medical

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

Medication

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

Psychiatric

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

Hypersexuality

- Excessive sex drive

Counterfeit Deviance

Counterfeit Deviance has been theorized to apply to some people with SN, in which the their behavior looks "deviant," but may not be when you consider the circumstances.

– Dave Hingsburger

(Makes a great argument for employing Applied Behavioral Analysis)

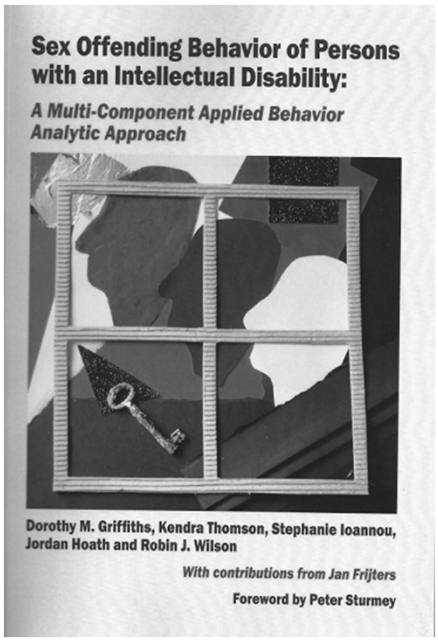
Consequential Learning

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

Applied Behavioral Analysis

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

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



Morning Routine — Visual Schedule

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

Week Of : _____

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

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: _____

Outing Journal

Part 1

To be completed before going on the outing:

1. What are your plans for today? What will you do? Where will you go?
2. What are the risks? Will there be any dangerous situations?
3. How will you use SRT (Self-Regulation Techniques) to make sure everyone is safe?

Part 2

To be completed upon return from the outing:

4. How did your day go? Did you follow your Safety Plan? Did you use any SRT strategies, and if yes, which ones?
5. Circle the picture that best represents your outing today.

Individual's signature: _____

Safe Person's signature: _____

Formal Risk Assessment

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

Dynamic Risk & Special Needs

Clearly, persons with special needs and behavioral problems are at a disadvantage in regard to most, if not all, dynamic risk variables

- Differential diagnosis and individualized case planning can be difficult
- Many tools identify difficulties in prediction with special needs clients

ARMIDILO-S

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

www.armidilo.net

Who can we use this on?

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

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

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

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

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

Treatment & Supervision

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

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

Rights

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

I agree…

…but would note that these rights include:

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

Points to Consider

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

Marshall, 2005

- Warm
- Empathic
- Rewarding
- Directive

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

Agents of Change

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

balanced, self-determined* lifestyle.

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

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

Responsivity

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

Treatment & Special Needs

Tough (2001)

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

The intent of treatment and supervision

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

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

Treatment of Persons with Behavior Problems

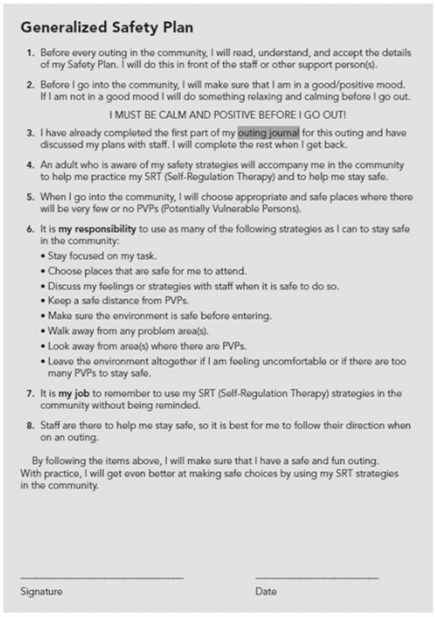
- Current effective practice requires…
  - Adherence to principles of risk, need, responsivity
  - Assessment of risk factors/criminogenic needs
  - Cognitive(?)-behavioral interventions
  - Treatment that specifically addresses identified risk factors/criminogenic needs
  - Post-treatment maintenance/follow-up programming
  - A focus on wellness

Treatment & Supervision

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

And, I can't emphasize this enough:

Responsivity, Responsivity, Responsivity



Generalized Safety Plan

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

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

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

_____ _____

Signature Date

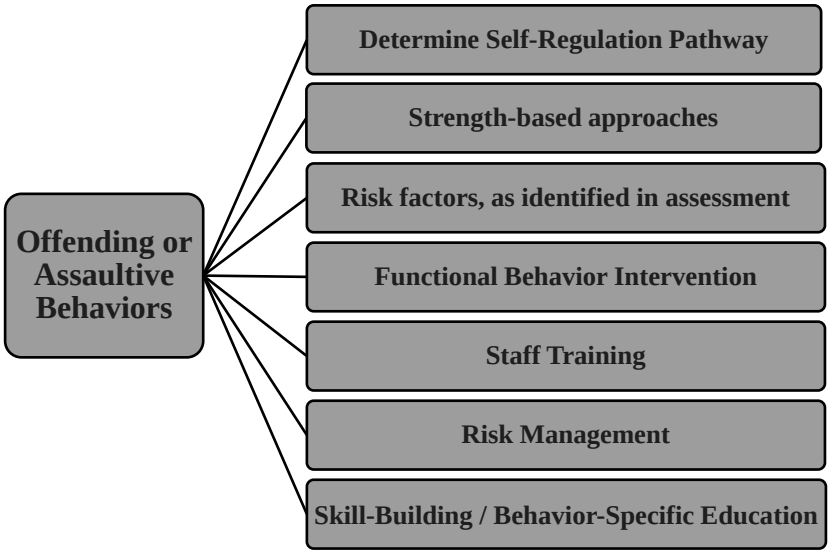
Effective programs

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

Stages of Change

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

Treatment Programs



Program Delivery

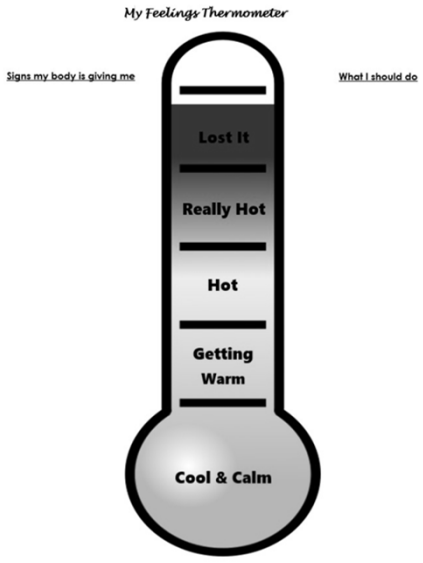
Treatment Components

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

Modifying Interventions

Treatment modifications include:

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



Treatment & Supervision

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

Treatment & Supervision

Responsivity

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

A little more behavioral than cognitive?

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

Rise of Strength-based Approaches

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

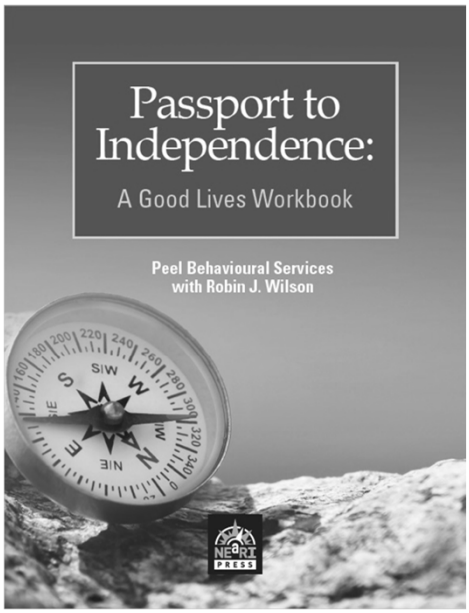
Strength-based Approaches

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

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

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

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



Good Lives Model
General Principles and Assumptions

- GLM is a popular modality in sexual violence prevention
- Clients are goal directed and are predisposed to seek a number of primary "goods"
- **Primary goods** are actions, experiences, activities that are important and beneficial to human beings and that are sought for their own sake
- They are objective and based in human nature
- Instrumental or secondary goods provide concrete ways (i.e., means) of securing these goods

Primary Human Goods

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

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

Prevention — The other side

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

Prevention — The other side

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

Challenges

Promoting healthy sexuality while maintaining safety

Meeting Sexual Needs

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

– Gerry Blasingame

Promoting Healthy Sexuality

- Historically, society has reacted with fear and disgust when confronted with sexuality in persons with special needs
- Even experienced professionals have shared negative feelings and beliefs about sexuality and special needs presentations
  - Commonly heard statements such as “Oh gross! Do you need to do that here?”, “Do you have to do that?”, “Stop that, it’s not normal.”

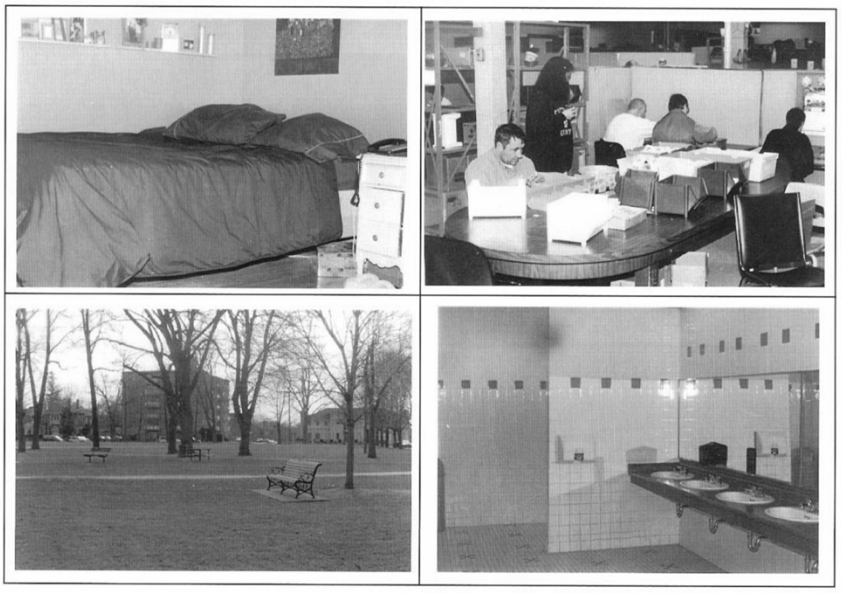
Promoting Healthy Sexuality

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

Challenges

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

Location Laminate D



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

Media Contracts

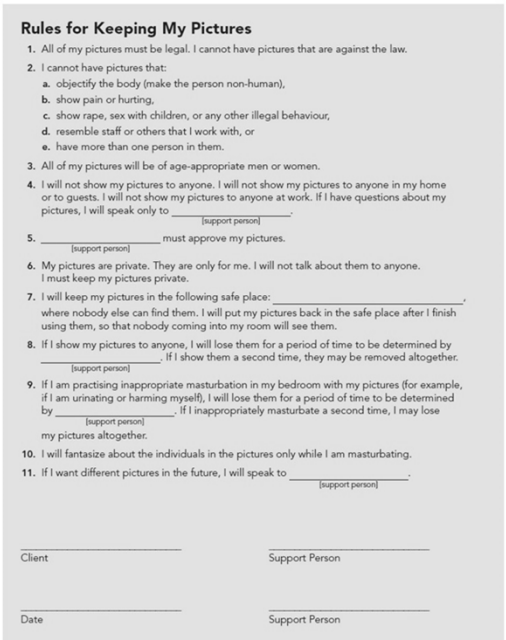
- All forms of media must be reviewed for appropriate content dependent on the needs of the client
- TV, internet, video games, books, magazines, newspapers, catalogues, Play Station 3, Wii systems, iPods, etc.
- TV programs need to be monitored for type of individuals in the media, (e.g., children,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

Media Contract

- There is a need for consistency among ***all*** team members. Family members also need to be on board with media contracting when clients are at home and when selecting gifts/outings.
- If clients go home for weekend visits, staff must conduct a search of their possessions when returning to the group home to ensure content is appropriate (on a variety of levels).
- When living in a group home there needs to be media rules to ensure the safety of all.
  - What one client has, they all potentially have.

Pornography

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



Rules for Keeping My Pictures

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

_____ Client

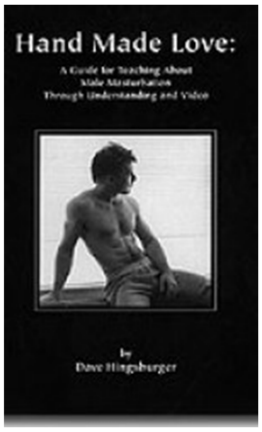
_____ Support Person

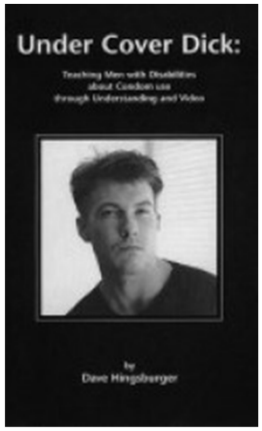
_____ Date

_____ Support Person

Dave Hingsburger

Diverse City Press





Challenges

What if your client's sexual practices are ***unusual*** or ***abnormal***?

An incredibly brief summary …

Tips to Maximize Case Management Efficacy

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

The safest "offender" …

Gwen Willis (2012)

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

Closing Thoughts

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

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

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