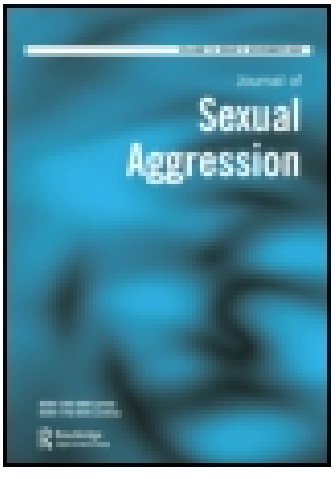

Journal of Sexual Aggression: An international, interdisciplinary forum for research, theory and practice
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/tjsa20

People with special needs and sexual behaviour problems: balancing community and client interests while ensuring effective risk management

Robin J. Wilson[a], David S. Prescott[b] & Michele K. Burns[c]
[a] Wilson Psychological Services LLC, Sarasota, FL, USA
[b] Becket Programs of Maine, Falmouth, ME, USA
[c] Trillium Health Partners, Peel Behavioural Services, Mississauga, Ontario, Canada
Published online: 20 Aug 2014.

To cite this article: Robin J. Wilson, David S. Prescott & Michele K. Burns (2014): People with special needs and sexual behaviour problems: balancing community and client interests while ensuring effective risk management, Journal of Sexual Aggression: An international, interdisciplinary forum for research, theory and practice, DOI: 10.1080/13552600.2014.943815

To link to this article: http://dx.doi.org/10.1080/13552600.2014.943815

Journal of Sexual Aggression, 2014
http://dx.doi.org/10.1080/13552600.2014.943815

Routledge
Taylor & Francis Group

People with special needs and sexual behaviour problems: balancing community and client interests while ensuring effective risk management

Robin J. Wilson,[1]* David S. Prescott[2] & Michele K. Burns[3]
[1]*Wilson Psychological Services LLC, Sarasota, FL, USA;* [2]*Becket Programs of Maine, Falmouth, ME, USA &* [3]*Trillium Health Partners, Peel Behavioural Services, Mississauga, Ontario, Canada*

Abstract *Deinstitutionalisation movements of the mid-1900s led to changes in policy and practice in the management of people with special needs (defined for this article as people with severe and persistent mental illness, intellectual disabilities and high levels of personality factors that interfere with treatment participation). Although the majority of clients with special needs receive care in community settings and interact more with family, friends and others in the community, some such clients require more rigorous case management. For clients who have offended, especially sexually, community-based services are scarce, and concerns regarding reoffence potential often supersede traditional understandings of diminished capacity. Recent reports suggest that jails and prisons have replaced hospitals as the institutions-of-choice for clients with special needs who engage in inappropriate conduct. This paper examines policies and practices regarding community risk management of people with special needs who have sexually offended. Vignettes are provided to illustrate how some clients and agencies have been affected, and suggestions are made to ensure best practices in risk management and public safety.*

Keywords *Special needs; offenders; civil commitment; sexual abuse; community; risk management*

The sexual abuse of women, children and other vulnerable people now attracts more community and legislative attention than virtually any other social health issue. Whereas stories in the media regarding sexual offending and paraphilias (e.g., paedophilia, sexual sadism) were relatively rare 50 years ago, today's newspapers and television newscasts often contain several such stories each edition. This has caused some to postulate that this is a problem growing out of control and that punishments for engaging in sexual abuse must be longer and stronger (Sample & Kadleck, 2008). However, perceptions of a rise in the incidence and prevalence of sexual abuse are not supported by epidemiological research (e.g., Finkelhor & Jones, 2006). Further, attempts to address sexual offending via judicial and legislative means have been met with mixed responses from a variety of stakeholders (e.g.,

*Corresponding author. E-mail: dr.wilsonrj@verizon.net

community, researchers, clinicians, policy-makers) and there have been few studies underscoring their relative utility (see Levenson, D'Amora, & Hern, 2007).

There is little question that sexual abuse has existed for as long as there have been people to be offenders and others to be victims. Why is it, then, that the study of sexual abuse is such a young area of inquiry? In many respects, we may find an answer to this question in the social upheaval of the 1960s (Prescott, Plummer, & Davis, 2010). During this tumultuous decade, focus was placed firmly on civil and individual rights, including the right to live a life free of abuse. By way of example, it was not until the early part of the 1960s that Kempe, Silverman, Steele, Droegemueller, and Silver (1962) described the "battered child syndrome". Unfortunately, this focus on battered children did not fully illuminate the difficulties associated with sexual abuse. Further, an early review of so-called *sexual psychopath* statutes (the precursors to today's sex offender civil commitment laws) by Swanson (1960) noted the extreme difficulties involved in assessment and treatment. Swanson (1960) recommended that, "The end result of such proceedings must always be 'effective treatment' and not 'effective punishment'". He went on to predict that, "It may take many decades before the idea of 'mental treatment' supplants that of punishment" (pp. 226–227). Subsequent decades of criminological research would find that punishment-only approaches to crime did not reduce re-offence (Aos, Miller, & Drake, 2006; Smith, Goggin, & Gendreau, 2002). Indeed, this is likely one of the few "answered" questions in our field—more punishment does not equal less crime.

It was not until Finkelhor's (1984) watershed publication, *Child Sexual Abuse*, that clinical, social and political focus shifted to this troubling area of human misbehaviour. In the 30 years since this pioneering work, the field of sexual offender assessment, treatment and management has grown significantly. Research into this area has become quite sophisticated, with several international meta-analyses (e.g., Hanson, Bourgon, Helmus, & Hodgson, 2009; Jespersen, Lalumière, & Seto, 2009) assisting us in better understanding the nature and consequences of the problem, as well as how best to identify those at highest risk to reoffend (Hanson & Morton-Bourgon, 2009). Treatment theorists (e.g., Marshall, Marshall, Serran, & O'Brien, 2011) have provided us with useful protocols to assist clients who have offended in changing the way they think and behave, so as to lessen their chance or recidivism upon release (Laws & Marshall, 2003; Marshall & Laws, 2003). These advances have also been recently applied to the assessment and treatment of people with intellectual disabilities (Blasingame, 2006, in press; Lindsay, 2009). Ironically, in some respects, the currently popular shift towards strength-based models (e.g., Self-Regulation Model, Good Lives model) has its origins in the Old Me/New Me formulation of Haaven, Little, and Petre-Miller (1990), which was first described as a treatment methodology for people with intellectual disabilities and sexual behaviour problems.

However, many practices without any empirical support—typically couched as measures taken to improve public safety—have also appeared in the past 20 years. These include the registration and notification of people who have abused, as well as restrictions on where people who have sexually abused can live. Sadly, an entire research literature has emerged showing the failure of these measures to actually reduce offending, and yet they remain in force (Levenson, 2007; Willis & Grace, 2008, 2009). One recent study found that, among juveniles, registration increases the number of plea bargains in the legal system, leading to questionable outcomes and accountability (Letourneau, Armstrong, Bandyopadhyay, & Sinha, 2013).

The focus of this article will be on clients who would not easily fit in traditional, mainstream or conventional models of treatment and risk management. For our purposes in this article, we consider "special needs" to encompass a variety of clinical and behavioural presentations that create challenges for providers and clients alike. Included in this are

intellectual and other cognitive processing disabilities, severe and persistent mental health conditions, highly entrenched antisociality (to the extent that it becomes a potent treatment interfering factor) and other less common presentations that cause lessened treatment responsivity. To date, there has been no empirical study of the effects of registration, notification or residence restrictions laws on clients with special needs or their communities. Clearly, however, this is a population that is easy for law-makers to overlook when creating statutes.

Deinstitutionalisation

The deinstitutionalisation movement of the 1950s and 1960s in the USA was a natural part of the civil rights movement. Similar movements were observed in the UK and Canada, among other nations; however, the implementation and subsequent coverage for deinstitutionalised patients was different to a degree, likely due to the presence of socialised health in the majority of those other nations. In the USA, the Community Mental Health Centers Act of 1963, enacted by the Kennedy administration, sought to establish community-based services as an alternative to institutionalisation of people with mental illness or intellectual disabilities.

Generally, deinstitutionalisation has been seen as a positive step forward in patients' rights; however, there have been drawbacks. Specifically, the success of the process hinges greatly on the degree to which the community actually picks up and maintains care for clients who would previously have been institutionalised. This is not simply about proper medical care, it is also about housing, support, and treatment beyond medication. The past several years have seen a resurgence in discussions related to patients' rights; particularly in regard to access to the community and the right to live unfettered by unnecessary restrictions (Wilson & Burns, 2011, p. 13, 138).

However, some of those formerly institutionalised, or those who previously would have been sent to institutions, might actually belong in institutions. Where there are clear threats to client safety, or where the client poses a threat to others, there should be some mechanism for addressing those risks, which may reasonably include commitment to a hospital or other similar facility. Not surprisingly, the mental health and intellectual disability fields have often been reluctant to establish long-term care facilities for clients of this sort, on the belief that "if you build it, they will come" and that we will once again be faced with the difficulties of increasing institutionalisation that we attempted to address some 50 years ago (Swanson, 1960). Is it possible to build a facility for people truly too dangerous to be free in the community without eventually populating it with people who are more socially problematic or discomforting than they are dangerous?

In attempting to answer this question, one need look no further than the primarily US example of sexual offender civil commitment (SOCC—see Brandt, Wilson, & Prescott, in press; Janus, 2006). While there are clearly some people who have sexually offended who are incapable of managing their behaviour in the community—hence, the need for SOCC—it would appear that many of those civilly committed to sexually violent predator facilities are unlikely to sexually reoffend (Duwe, 2014). It would not be unreasonable to question whether some of the people who have sexually offended now housed in civil commitment centres were sent there more because of the shocking nature of their offences or quirks in their social or physical presentation than because they actually presented a level of risk to reoffend worthy of commitment. Indeed, in the practical SOCC experience of two of the current authors (R.J.W. and D.S.P.), there appears to be an over-representation of people of limited cognitive ability, severe and persistent mental illness (SPMI), and/or physical abnormalities or deformities.

In today's society, without long-term care facilities, the slippery slope default position is to confine people with mental illness or intellectual disabilities who engage in inappropriate conduct to the only group of institutions that continue to exist—prisons. Indeed, in a 2010 report by the Treatment Advocacy Center in the United States (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010), the opinion is expressed that "it is thus fact, not hyperbole, that America's jails and prisons have become our new mental hospitals". This same report identifies that the proportion of US prison inmates with mental illness has almost tripled since the early 1980s, as the availability of hospital beds for seriously mentally ill people has decreased by a factor of 10 over the past 50 years (from one per 300 US population in 1955 to one per 3000 in 2005—see Torrey et al., 2010). In Canada, the percentage of offenders with mental health conditions has more than doubled over the past 15 years (Correctional Service of Canada, 2009), while the Prison Reform Trust (www.prisonreformtrust.org.uk, accessed 29 May 2014) in the UK reports that more than two-thirds of prison inmates—male or female—suffer from two or more mental health disorders.

As noted above, two of the groups of people most affected by deinstitutionalisation are those with intellectual disabilities and those with SPMI. Of note, these two conditions often co-occur (Cooper, Smiley, Morrison, Williamson, & Allan, 2007). It has long been known that people with intellectual disabilities and/or mental illness often have difficulty negotiating social relationships, and that these difficulties may extend to sexual conduct. People with special needs may have diminished capacities regarding age discrimination, ability to give or receive consent for sexual activities, experience sexual impulsivity or demonstrate poor sexual problem-solving (see review in Wilson & Burns, 2011). All of these increase the likelihood that someone might find themselves engaging in sexually offensive behaviour leading to official inquiry.

Traditionally, there has been recognition of the "special" nature of such clients, necessitating that we address their offending behaviour within the context of those diminished capacities and abilities. People with special needs who engaged in sexually or otherwise offensive conduct were often diverted from criminal justice proceedings and their needs were more likely to be addressed through clinical interventions, sometimes involving short or long-term commitment to hospital. Over the decades that the authors have worked with people with special needs who sexually offend, the numbers of clients being referred to criminal justice proceedings has increased. Beyond the fact that incarceration in prison has increased for people with special needs, all of the other measures of official control (e.g., registration, residency restrictions, public notification, etc.) are also now increasingly applied to this client group, not only with little regard for questions of effectiveness (see Levenson, 2007), but how such policies may actually make these clients more dangerous. For example, setting aside questions of empirical findings, there remain questions of how the vulnerabilities of clients with special needs come into play in settings such as civil commitment, where it is easy for others to exploit and/or victimise them. Likewise, how might registration and notification actually aggravate dynamic risk factors such as loneliness and lack of emotionally intimate relationships with adults (Mann, Hanson, & Thornton, 2010)?

It is possible that some of the increased criminal justice and correctional management of people with special needs who sexually offend is due to soaring levels of public and legislative intolerance of sexual offending. Disabled, mentally ill, or not, many community members would not be pleased to find out that the "special needs man" down the street had engaged in public masturbation or had made sexually inappropriate comments to teenagers.

Vignette—Bill's story

Bill (not his real name) was living in a group treatment home for people with intellectual disabilities and sexual behaviour problems with onsite staffing and security provided by a non-profit agency when he was observed watching children from the back yard of the home. His status as a person with sexual behaviour problems was discovered by neighbours after local police were contacted and made several "drive-bys" of the group home. The community posted notices in the neighbourhood and sidewalks were chalked with messages such as, "A sexual offender lives here". Previously having been able to go into the community for a variety of outings under supervision, Bill and his housemates experienced emotional trauma and social isolation due to being unable to leave the home for fear of being harassed. In fact, the group home residents became virtual prisoners in their own home, which traditionally had had a high degree of security anyhow. Ultimately, Bill and his peers were unable for a period to attend offsite treatment programming at a local hospital, which affected their progress. Bill began to see himself in such a negative light that he ultimately felt hopeless of ever being anything other than an offender and a "bad person". In spite of his disability, he was keenly aware that his status was negatively affecting his peers. His skills noticeably diminished over time while restricted to the group home. In terms of collateral damage, Bill's family was also ousted from their long-standing community, even though he rarely visited and, when he did so, Bill was always accompanied by trained staff and provided with eyes-on supervision.

Community risk management

Local and regional jurisdictions continue to grapple with how best to manage the risk of identified offenders in the community. Most Western nations now have national sexual offender registries, with varying degrees of public access (e.g., via the Internet). At the policy level, some regions have implemented specific prescriptions for community placement of people who have sexually offended. Such measures include community notification procedures, residency restrictions and monitoring and tracking technologies [e.g., Global Positioning Satellite (GPS); Vess, Day, Powell, & Graffam, 2013]. Although not all of these are used in every jurisdiction, it can be important for professionals to know of their use, as in some cases their usage has spread to other parts of the world (e.g., the polygraph is gaining currency in the UK—see Grubin, 2008; Wilcox & Sosnowski, 2005). Likewise, it can be important to consider their impact on people with special needs. For instance, in the authors' experience, people with high levels of disordered personality traits require additional time in treatment to address their ambivalence and concerns about risk-management strategies. Likewise, both intellectually disabled and mentally ill clients can require additional education regarding the importance of complying with these measures.

The containment model (English, 1998; English, Pullen, & Jones, 1996) represents an early and still popular approach to comprehensive community-based risk management of people with sexual offence histories in the USA. Perhaps the best-known implementation of this model is found in English's home state of Colorado where the primary triad of stakeholders includes probation, treatment and monitoring (i.e., polygraph) personnel. Secondary stakeholders (e.g., community groups, victim advocacy, faith groups) are included as individually determined, but not as part of the core group. As noted, the containment model is particularly popular in the USA; however, there are variations on this theme seen in other frameworks internationally. For example, multi-agency public protection arrangements (MAPPA) in the UK seek to involve a broader representation of stakeholders in the community risk management of sexual offenders. In Canada, models of "team supervision"

have attempted to include a broader representation of stakeholders (see Wilson, Cortoni, Picheca, Stirpe, & Nunes, 2009).

As noted, a UK variation on the containment theme is found in MAPPA (see Wood & Kemshall, 2007) and, as with containment, the intent is to ensure collaboration in managing offender risk post-release. MAPPAs are typically comprised of statutory agencies (law enforcement and probation), non-governmental organisations (NGOs; social service agencies providing treatment, advocacy, support—Quakers, Lucy Faithfull Foundation, Salvation Army) and community partner groups (victims' advocates, Circles of Support and Accountability [e.g., Circles-UK—see Hanvey, Philpot, & Wilson, 2011]). In the authors' estimation, while there are many smaller differences between supervision approaches, major differences between containment and MAPPA exist in the use of polygraphy in the USA and the inclusion of a broader sampling of non-statutory agencies in the UK.

In many jurisdictions, completing and providing non-deceptive results on regular polygraph evaluations is part and parcel of being allowed to maintain placement in the community. Of course, the use of the polygraph can have a dramatic effect on how clients understand and interface with approaches such as the containment model. Although a review of polygraph research is beyond the scope of this paper (see National Academy of Sciences, 2003), people with special needs who have sexually abused require special consideration prior to administration of polygraph examinations, particularly with respect to one's sexual history. For example, people with special needs can have memory deficits that place them at risk for fabricating victims in order to pass; it may make more sense to forego polygraph examinations until after the completion of a comprehensive assessment of each client. Further, even a number of polygraph examiners themselves have questioned to what extent the additional information provided actually aids treatment progress or improves the predictive validity of risk assessment measures (e.g., Cook, 2011). Of particular concern is the tendency—even susceptibility—of people with intellectual disabilities to answer questions how they believe the questioner might want them to respond (acquiescence bias), rather than answer with the truth (see Wilson & Burns, 2011). Blasingame (personal communication, 22 May 2010; see also 2006) suggests that such clients are suggestible and very easily led during interviewing. He noted further that, on occasion, clients with intellectual disabilities will admit to crimes they did not commit and, perhaps, even crimes that no one has done.

Other authors, such as Chaffin (2011) has challenged the field to demonstrate a cost–benefit ratio that will warrant the potential harm of the polygraph examination experience. He suggests that we should only use polygraphy if it can be proven to lead to better treatment outcomes, prevent future victimisation and protect abusers from all the consequences of abusing again. Currently, this research is lacking. Finally, Chaffin (2011) reminds professionals that:

> procedures to extract confessions seem to hold a particular sensitivity in the health care ethics literature, especially if the procedures are coercive or harsh. The World Medical Association (WMA, 1975) held that a breach could exist for health care providers by simply being present during harsh interrogations. (p. 316)

Given vulnerabilities of clients with special needs, and the often-compulsory nature of treatment, questions regarding what actually constitutes informed consent under these circumstances are worthy of consideration by all professionals.

A final consideration in using the polygraph has more to do with what treatment professionals are trying to accomplish. Is the goal to compel disclosure or to have clients develop the skills to be more honest and forthcoming? If the answer is the latter, how does the polygraph help or hinder this process? How do programmes know how effective they are when

the information is compelled? How is the therapeutic alliance affected when everything a client does with their therapist is ultimately subject to verification? Although there is no question that clients frequently engage in various acts deception in treatment, does the use of polygraph translate to clients as a fundamental form of distrust, further compromising professional attempts to build a genuine rapport? Perhaps most importantly, professionals will want to question whether the act of disclosing is a single event at the start of treatment or a process that unfolds across a treatment sequence (Ware & Mann, 2012).

In any event, a critical aspect of the containment model, MAPPA, polygraphy and most other approaches towards community risk management of sexual offenders is that they were developed and implemented first with people who had sexually abused, who do not have special needs and then quickly adapted to include this population. These models have therefore not taken into account the full extent of vulnerability among people with special needs who have offended sexually. While members of MAPPA or containment teams may view themselves as supportive, this is often not how they are perceived by people with special needs, who often have much higher rates of victimisation by caregivers than the general public and other people who come into contact with the law. Simply put, clients with special needs can be expert at appearing compliant in order to avoid what they believe to be certain punishment by authorities. Likewise, it can be easy for professionals to overlook just how powerful they are in the lives of these clients.

Given the potentially competing approaches of treatment, supervision and management, it is vital to explore the effect of multi-disciplinary approaches on the clients themselves. For example, there may be very real questions as to how clients with special needs perceive and understand the professionals around them. Is a given "team" of professionals really as cohesive as they seek to be? What do clients with special needs make of warm and empathic treatment approaches that are then counterbalanced by potentially intrusive supervision and management efforts? Or, therapeutic activities that do not appear therapeutic to them? Clearly, a question for those administering programmes and working at the front lines of community risk management is whether it is better to develop truly willing partners in risk management, or clients who do what they need in order to avoid problems with a supervising agent. It is likely the case that having a clear framework that takes into account both the relationships aspects of multi-disciplinary work as well as structural elements will go the furthest in building the safest communities.

Vignette—a community-based agency

Disability Services, Inc. (DSI—not their real name) has provided community-based residential and treatment services to people with special needs and behavioural concerns for many years. A plan to establish an additional group home was submitted to the municipality, which decided that a disclosure would need to be made to the local community due to the emotionally charged histories of this clientele. An uproar ensued and investigations were made of other properties already established and run by DSI, some of which were threatened with closure due to the clinical presentations of the clients who lived there. These presentations (mental illness, intellectual disabilities) were frightening to the local citizenry, despite evidence that they posed no greater risk to the community than other citizens (Monahan, 1981). At the time, no negative community events had been associated with any of DSI's homes but, nonetheless, fearful community members pressed the municipality for action. In the end, DSI chose another site for their home and scrutiny of their properties waned. In order to prevent future concerns of a similar nature, the municipality is now considering making it more difficult to place a group home in their community.

Treatment considerations

Treatment programmes for people who have sexually abused are most effective when they adhere to the principles of risk, need and responsivity (Andrews & Bonta, 2010; Hanson et al., 2009). Although responsivity is often thought of as the efforts of professionals to tailor services to the individual style of each client, we have argued elsewhere (Wilson & Prescott, in press) that professionals can also consider responsivity to include efforts to build the capacity of the client to engage fully in the treatment process. This can take place via efforts to explore motivation to change, clarify areas of ambivalence, evoke specific areas of the client's life that they would like to change and efforts at collaborative (as opposed to prescribed) goal-setting. This last point is particularly important for clients with special needs, who have often experienced previous treatment efforts in their life as venues where they do as they are told and try to avoid mistakes.

A central question for treatment providers to ask is whose needs each therapeutic activity is actually meeting? In the authors' experience, many treatment programmes resort to treatment plans that address broad and overly vague goals in the interest of saving time ("Mr. A will work hard in treatment"). Very often, treatment plans can be written in language with which it is difficult to connect at an emotional level ("Mr. B will reduce his deviant sexual fantasies"). Likewise, other programmes can seek to address every possible risk factor; this can take place through overly diligent efforts to have clients disclose detailed autobiographical accounts that describe how each risk factor in their life may have been present at various times. Setting aside issues related to memory problems and learning disabilities among clients with special needs, providing thorough treatment to every aspect of a client's life and current functioning may provide a sense of safety to professionals, but doing so can violate each of the principles of risk (which holds that mismatching of service intensity can actually increase risk), need (which emphasises providing treatment only for relevant treatment goals related to future crime) and responsivity (which reminds us that we can lower client motivation by providing unnecessary treatment and not focusing on that which is both relevant and meaningful for the client).

Clients with special needs can be particularly sensitive to feeling misunderstood (Wilson & Burns, 2011). Careful treatment planning that elicits what is relevant and meaningful to the client is therefore particularly important for people with special needs and challenging behaviours; clients cannot and will not become invested in a treatment plan that they do not view as a good fit for them. It can be all too easy for clinicians to revert to assigning treatment goals onto challenging clients who do not want them or whose behaviour is signalling discord between the therapist and themselves (Miller & Rollnick, 2013). This discord is often accompanied by the professional's belief that a client needs to "get their act together". In many cases, the therapist also believes that it can be effective to prescribe goals now and secure buy-in later. This rarely works (Prescott & Miller, in press). Instead, providers may be more effective when they work painstakingly to build client motivation, engagement and other areas of client responsivity (Hanson & Morton-Bourgon, 2009). Many clinicians worry that engaging in lengthy discussions about treatment goals will take more time than they have. However, when one considers the high stakes of treatment and treatment failure (which can itself elevate risk; Hanson & Bussière, 1998), it may be more accurate to say that clinicians have little choice but to engage in these discussions.

A key activity in treatment planning, goal-setting and the building of responsivity among clients with special needs is in establishing "approach goals". These are goals that the clients find relevant, desirable and will work towards rather than away from (Yates, 2009; Yates, Prescott, & Ward, 2010). The creation of approach goals is different with each client, both by definition and in accordance with the responsivity principle (Hanson & Morton-Bourgon,

2009). In clients with special needs, part of conceptualising goals might include the use of art (drawing, collage) that represents what this goal means to the client and, literally, how that part of their future appears to them. This sort of exercise has been a critical part of the Old Me/New Me construct of Haaven et al. (1990), in which clients create collages from magazine images to depict who they used to be and who they want to be going forward. The central idea is to match criminogenic treatment needs and understanding of them to meaningful areas of the client's life. A fundamental consideration is that the therapist and client can always return to revisit these goals over time and with the benefit of an improved therapeutic alliance and hindsight.

With the establishment of approach goals, treatment can proceed. Where cognitive-behavioural treatment (CBT) is the method of choice in many studies (Hanson et al., 2002), it is not always a straightforward process for people with special needs and problematic sexual behaviour (Wilson & Burns, 2011). Adapted forms of CBT can be helpful with people with intellectual disabilities (i.e., mild and borderline intelligence levels) and severe mental disorders (e.g., Tough, 2001), professionals will want to ensure that their adaptations are meeting the needs of their clients. This is a responsivity concern. Many possible problems can take place. For example, one has to question the utility of a CBT approach when the client's ability to do "C" is compromised by his clinical presentation. In such cases, the principles of applied behavioural analysis (see Baer, Wolf, & Risley, 1968; Carr, Nicholson, & Higbee, 2000; Cipani & Schock, 2007) may be of assistance. In particular, collecting, charting and analysing behavioural data during community outings and other important social events can provide excellent understanding and direction regarding how well a client is incorporating approach goals into his daily living (see Wilson & Burns, 2011).

Although it makes perfect sense that changing one's thoughts and behaviours can enable one to lead a safer and more fulfilling life, careful attention is required in making sure that clients with special needs and sexual offending histories fully grasp treatment concepts and apply them to their lives. This can frequently take place through experiential methods whose aim is to deepen the impact of treatment activities and their meaning to the client (Bergman & Hewish, 2003; Longo, Prescott, Bergman, & Creeden, 2012; Wilson & Prescott, in press). Other research involving wraparound techniques with people at high risk to sexually reoffend suggests that celebrating milestones (e.g., months of sobriety, amount of time successfully free in the community, etc.) can have a dramatic effect on "forward thinking" and planning for success (see Wilson, McWhinnie, Picheca, Prinzo, & Cortoni, 2007; Wilson, McWhinnie, & Wilson, 2008). Ultimately, experiential and strength-based methods do not replace activities that adhere to the risk and need principles. Rather, experiential methods adhere to the responsivity principle; this is particularly crucial in considering treatment methods for clients with special needs.

Developmental adversity: a key consideration in treatment and supervision

Recent studies (Levenson, Willis, & Prescott, 2014; Reavis, Looman, Franco, & Rojas, 2013) have found significant levels of trauma and adverse childhood experiences in the backgrounds of people who have sexually abused. While historical treatment approaches have not included a focus on trauma (e.g., Salter, 1988), such findings provoke the question of how clients who have sexually offended can be expected to change their lives for the better in the absence of treatment that help them move beyond their own histories. Historically, many programmes have taken the stance that clients should address their victimisation only after complete acceptance of their own abusive behaviours. In many cases, professionals have viewed statements regarding adverse childhood experiences with suspicion, as if being made more as an excuse than a treatment need. Newer research on the effects of trauma suggest that understanding the effects of one's past, building a better life and managing risk should occur

concomitantly (Ford, Chapman, Connor, & Cruise, 2012; Levenson et al., 2014; Prescott, 2012; Reavis et al., 2013; Simons, 2007). After all, many of the abuse-related thought processes and interactional styles that these clients present with in treatment have their roots in childhood adversity.

Implications for community risk management

It can appear perfectly reasonable to expect people who have sexually abused to participate in treatment and adhere to supervision strategies or face the consequences. Supervision strategies will often include such measures as registration, notification, residency restrictions, electronic monitoring and submission to polygraphy and other compliance procedures (e.g., voice recognition). Decades of research into the therapeutic alliance (e.g., Bordin, 1979; Prescott & Miller, in press) and therapeutic processes (Marshall, 2005) demonstrate the importance of engaging clients through warm, empathic and guiding approaches—not those which engender a climate of distrust. This is especially the case for clients with special needs, who often hold core beliefs about the world as a hostile, dangerous place where one has to fight to earn respect, get even, etc., and the harm caused to others is easy to overlook (see Ward & Keenan, 1999).

We are not suggesting that people with special needs should necessarily get a "free pass" or that they should somehow be exempted from attempts to hold them accountable for their behaviour while ensuring public safety. Indeed, it has been our experience that the system sometimes fails to give such clients meaningful consequences, the end product being that they fail to learn that their behavioural choices can lead to negative outcomes. What we are saying, however, is that there must be a reasonable middle ground between doing little or nothing and sending such clients to jail or civil commitment centres or maintaining them on unreasonable supervision schemes. There must be a realistic appraisal of the client's criminogenic risks and his clinical presentation. By example, for those clients in residential care with professional staff supervision at all times in the community, what benefit is achieved in having them submit to GPS monitoring, unannounced visits by police (potentially threatening the continued existence of the entire residential and treatment environment) or regular polygraph evaluations?

Professionals working with people with special needs who have sexually abused often have to change the way they think, not only about their clients, but about themselves. For example, professionals often believe that they are fundamentally different from the people they supervise; after all, they are professionals and their clients are "sex offenders". However, the discussion of approach goals above serves as a reminder that all human beings seek to attain states of being that are roughly similar, such as competence, autonomy and relatedness with others (Ryan & Deci, 2000), as well as a sense of meaning and purpose in life (Emmons, 1999) and other common life goals (Yates et al., 2010; Yates & Prescott, 2011).

While assessments can help define the needs of an individual, knowledge of similarities shared among all humans can help professionals find ways to develop a working alliance as well as an excellent treatment/case plan (Prescott & Miller, in press). Beyond this, it is our belief that professionals must again take into account the differences between themselves and clients with special needs. This can be a lifetime of work and is well beyond the scope of this paper; although many professionals describe vacillating between experiencing their clients as naive and more clever than they are themselves. Without this effort by the clinician, however, researchers have questioned aloud whether low levels of empathic understanding are not actually "toxic" to treatment (Moyers & Miller, 2013).

Ultimately, once the risks and needs of clients with special needs have been established and frameworks have been put in place to account for them, we recommend that 80% of the efforts exerted on such clients be focused on adhering to the responsivity principle. Prizing the differences between people while recognising their inherent worth, and the fact that we all ultimately share similar goals, can be an excellent place to start in building genuinely willing partners in change (Miller & Rollnick, 2013; Prescott & Miller, in press).

Conclusion

Whether they have sexually abused or not, people with special needs have long history of being misunderstood and mistreated by others, including their own caregivers. It is difficult to identify a single policy, including registration, notification, residence restrictions or civil commitment, that has been designed to accommodate them. Methods exist to tailor treatment or supervision services to meet their needs in adherence to the responsivity principle remain in short supply despite advances in other areas of our field. Ultimately, each agency and professional is obliged to question to what extent they are making sense to their clients and lead to meaningful engagement of a prosocial process of change. Towards this end, working with people with special needs requires that we first look at our own limitations.

Acknowledgements

The views and opinions expressed in this paper are not necessarily those of the Becket Family of Services or Peel Behavioural Services, Trillium Health Partners. The authors wish to thank Leanne Baldwin for her review of an earlier draft of this paper.

References

Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Cincinnati, OH: Anderson.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not*. Olympia: Washington State Institute for Public Policy.

Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behavior analysis. *Journal of Applied Behavior Analysis*, *1*(1), 91–97. doi:10.1901/jaba.1968.1-91

Bergman, J., & Hewish, S. (2003). *Challenging experience: An experiential approach to the treatment of serious offenders*. 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, NY: Springer.

Blasingame, G. (2006). *Practical treatment strategies for forensic clients with severe and sexual behavior problems among persons with developmental disabilities*. Oklahoma City, OK: Wood'N' Barnes Books/Safer Society Press.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*, 252–260.

Brandt, J., Wilson, R. J., & Prescott, D. S. (in press). Doubts about SVP programs: A critical review of sexual offender civil commitment in the US. In B. Schwartz (Ed.), *The sex offender*, *Vol. 8*. Kingston, NJ: Civic Research Institute.

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. doi:10.1901/jaba.2000.33-353

Chaffin, M. (2011). The case of juvenile polygraphy as a clinical ethics dilemma. *Sexual Abuse: A Journal of Research and Treatment*, *23*, 314–328.

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

Cook, R. D. (2011). The sexual history polygraph examination: Is it time for change? *ATSA Forum*, *23*.

Cooper, S.-A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *British Journal of Psychiatry*, *190*(1), 27–35. doi:10.1192/bjp.bp.106.022483

Correctional Service of Canada. (2009). *The changing federal offender population highlights (2009)*. Ottawa, ON: Author.

Duwe, G. (2014). To what extent does civil commitment reduce sexual recidivism? Estimating the selective incapacitation effects in Minnesota. *Journal of Criminal Justice*, *42*, 193–202. doi:10.1016/j.jcrimjus.2013.06.009

Emmons, R. A. (1999). *The psychology of ultimate concerns*. New York, NY: Guilford.
English, K. (1998). The containment approach: An aggressive strategy for the community management of adult sex offenders. *Psychology, Public Policy, and the Law*, *4*, 218–235. doi:10.1037/1076-8971.4.1-2.218
English, K., Pullen, S., & Jones, L. (1996). *Managing adult sex offenders. A containment approach*. Lexington, KY: American Probation and Parole Association.
Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York, NY: Free Press.
Finkelhor, D., & Jones, L. (2006). Why have child maltreatment and child victimization declined? *Journal of Social Issues*, *62*, 685–716. doi:10.1111/j.1540-4560.2006.00483.x
Ford, J. D., Chapman, J., Connor, D. F., & Cruise, K. R. (2012). Complex trauma and aggression in secure juvenile justice settings. *Criminal Justice and Behavior*, *39*, 694–724. doi:10.1177/0093854812436957
Grubin, D. (2008). The case for polygraph testing of sex offenders. *Legal and Criminological Psychology*, *13*, 177–189. doi:10.1348/135532508X295165
Haaven, J., Little, R., & Petre-Miller, D. (1990). *Treating intellectually disabled sex offenders: A model residential program*. Orwell, VT: Safer Society Press.
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. doi:10.1037/0022-006X.66.2.348
Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior*, *36*, 865–891. doi:10.1177/0093854809338545
Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *14*, 169–194.
Hanson, R. K., & Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 188 prediction studies. *Psychological Assessment*, *21*(1), 1–21. doi:10.1037/a0014421
Hanvey, S., Philpot, T., & Wilson, C. (2011). *A community-based approach to the reduction of sexual reoffending: Circles of support and accountability*. London: Kingsley.
Janus, E. S. (2006). *Failure to protect: America's sexual predator laws and the rise of the preventive state*. Ithaca, NY: Cornell University 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 and Neglect*, *33*, 179–192. doi:10.1016/j.chiabu.2008.07.004
Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemueller, W., & Silver, H. K. (1962). The battered-child syndrome. *JAMA: The Journal of the American Medical Association*, *181*(1), 17–24. doi:10.1001/jama.1962.03050270019004
Laws, D. R., & Marshall, W. L. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offenders: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment*, *15*, 75–92.
Letourneau, E. J., Armstrong, K. S., Bandyopadhyay, D., & Sinha, D. (2013). Sex offender registration and notification policy increases juvenile plea bargains. *Sexual Abuse: A Journal of Research and Treatment*, *25*, 189–207. doi:10.1177/1079063212455667
Levenson, J. S. (2007). The new scarlet letter: Sex offender policies in the 21st century. In D. S. Prescott (Ed.), *Knowledge and practice: Challenges in the treatment and supervision of sexual abusers* (pp. 21–41). Oklahoma City, OK: Wood 'N' Barnes.
Levenson, J. S., D'Amora, D. A., & Hern, A. L. (2007). Megan's law and its impact on community re-entry for sex offenders. *Behavioral Sciences and the Law*, *25*, 587–602. doi:10.1002/bsl.770
Levenson, J. S., Willis, G., & Prescott, D. S. (2014). Adverse childhood experiences in the lives of male sex offenders: Implications for trauma-informed care. *Sexual Abuse: A Journal of Research and Treatment*. First published on May 28, 2014 as doi:10.1177/1079063214535819
Lindsay, W. R. (2009). *The treatment of sex offenders with developmental disabilities*. Chichester: John Wiley.
Longo, R. E., Prescott, D. S., Bergman, J., & Creeden, K. (2012). *Current perspectives and applications in neurobiology: Working with people who are victims and perpetrators of sexual abuse*. Holyoke, MA: NEARI Press.
Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment*, *22*, 191–217.
Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research & Treatment*, *17*(2), 109–116.
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.
Marshall, W. L., Marshall, L. E., Serran, G. A., & O'Brien, M. D. (2011). *Rehabilitating sexual offenders: A strength-based approach*. Washington, DC: American Psychological Association.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford.

Monahan, J. (1981). *The clinical prediction of violent behavior* [Reprinted as Predicting violent behavior: An assessment of clinical techniques]. Thousand Oaks, CA: Sage.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, *27*, 878–884. doi:10.1037/a0030274

National Academy of Sciences. (2003). *The polygraph and lie detection*. Washington, DC: Author.

Prescott, D. S. (2012). Where we are and where we need to be: Assessment and treatment of the past, present, and future. In R. E. Longo, D. S. Prescott, J. Bergman, & K. Creeden (Eds.), *Current perspectives and applications in neurobiology: Working with young persons who are victims and perpetrators of sexual abuse* (pp. 55–86). Holyoke, MA: NEARI Press.

Prescott, D. S., & Miller, S. D. (in press). Improving outcomes one client at a time: Feedback-informed treatment with adults who have sexually abused. In B. Schwartz (Ed.). *The sex offender*, *Vol. 8*. Kingston, NJ: Civic Research Press.

Prescott, D. S., Plummer, C., & Davis, G. (2010). Recognition, response, and resolution: Historical responses to rape and child molestation. In K. L. Kaufman (Ed.), *The prevention of sexual violence: A practitioner's sourcebook* (pp. 1–19). Holyoke, MA: NEARI Press.

Reavis, J., Looman, J., Franco, K., & Rojas, B. (2013). Adverse childhood experiences and adult criminality: How long must we live before we possess our own lives? *The Permanente Journal*, *17*(2), 44–48. doi:10.7812/TPP/12-072

Ryan, R. M., & Deci, E. L. (2000). Self-determination and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68–78. doi:10.1037/0003-066X.55.1.68

Salter, A. (1988). *Treating child sex offenders and victims*. Thousand Oaks, CA: Sage.

Sample, L. L., & Kadleck, C. (2008). Sex offender laws: Legislators' accounts of the need for policy. *Criminal Justice Policy Review*, *19*(1), 40–62. doi:10.1177/0887403407308292

Simons, D. A. (2007). Understanding victimization among sexual abusers. In D. S. Prescott (Ed.), *Knowledge and practice: Challenges in the treatment and supervision of sexual abusers* (pp. 56–90). Oklahoma City, OK: Wood 'N' Barnes.

Smith, P., Goggin, C., & Gendreau, P. (2002). *The effects of prison sentences and intermediate sanctions on recidivism: General effects and individual differences* (User Report 2002-01). Ottawa, ON: Solicitor General Canada.

Swanson, A. H. (1960). Sexual psychopath statutes: Summary and analysis. *The Journal of Criminal Law, Criminology, and Police Science*, *51*, 215–235. doi:10.2307/1141192

Torrey, E. F., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More mentally ill persons are in jails and prison than hospitals: A survey of the States*. Alexandria/Arlington, VA: National Sheriffs Association/Treatment Advocacy Center.

Tough, S. E. (2001). Validation of two standardized risk assessments (RRASOR, 1997; Static-99, 1999) on a sample of adult males who are developmentally disabled with significant cognitive deficits. *Masters Abstracts International*, *39*(06), 1626B. (UMI No. MQ58817).

Vess, J., Day, A., Powell, M., & Graffam, J. (2013). International sex offender registration laws: Research and evaluation issues based on a review of current scientific literature. *Police Practice and Research*, *14*, 205–218. doi:10.1080/15614263.2012.680719

Ward, T., & Keenan, T. (1999). Child molesters' implicit theories. *Journal of Interpersonal Violence*, *14*, 821–838. doi:10.1177/088626099014008003

Ware, J., & Mann, R. E. (2012). How should "acceptance of responsibility" be addressed in sexual offending treatment programs? *Aggression and Violent Behavior*, *17*, 279–288. doi:10.1016/j.avb.2012.02.009

Wilcox, D. T., & Sosnowski, D. E. (2005). Polygraph examination of British sexual offenders: A pilot study on sexual history disclosure testing. *Journal of Sexual Aggression*, *11*(1), 3–25. doi:10.1080/13552600410001667797

Willis, G. M., & Grace, R. C. (2008). The quality of community reintegration planning for child molesters: Effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, *20*, 218–240.

Willis, G. M., & Grace, R. C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior*, *36*, 494–512. doi:10.1177/0093854809332874

Wilson, R. J., & Burns, M. (2011). *Intellectual disability and problems in sexual behaviour: Assessment, treatment, and promotion of healthy sexuality*. Holyoke, MA: NEARI Press.

Wilson, R. J., Cortoni, F., Picheca, J. E., Stirpe, T. S., & Nunes, K. (2009). *Community-based sexual offender maintenance treatment programming: An evaluation*. (Research Report R-188). Ottawa, ON: Correctional Service of Canada.

Wilson, R. J., McWhinnie, A. J., Picheca, J. E., Prinzo, M., & Cortoni, F. (2007). Circles of support and accountability: Engaging community volunteers in the management of high-risk sexual offenders. *Howard Journal of Criminal Justice*, *46*(1), 1–15. doi:10.1111/j.1468-2311.2007.00450.x

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., & Prescott, D. S. (in press). Understanding and responding to persons with special needs who have sexually offended. In K. McCartan (Ed.), *Sexual offending: Perceptions, risks and responses*. Basingstoke: Palgrave-MacMillan.

Wood, J., & Kemshall, H. (2007). *The operation and experience of Multi-Agency Public Protection Arrangements (MAPPA)*. London: Home Office.

World Medical Association (1975, October). *Declaration of Tokyo*. Tokyo: Author. Retrieved July 23, 2014, from http://www.wma.net/en/30publications/10policies/c18/index.html

Yates, P. M. (2009). Using the good lives model to motivate sexual offenders to participate in treatment. In D. S. Prescott (Ed.), *Building motivation to change in sexual offenders* (pp. 74–95). Brandon, VT: Safer Society.

Yates, P. M., & Prescott, D. S. (2011). *Building a better life: A good lives and self-regulation workbook*. Brandon, VT: Safer Society Press.

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 Press.