Vermont
Best Practices Manual

Assessment, Treatment, and Risk Management with Individuals with Developmental Disabilities and Problematic Sexual Behaviors

2017

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A decade has passed since publication of the first edition of the Vermont Best Practices manual in 2005. As in the earlier version, the framework and approaches contained in this updated manual are the efforts of many dedicated people who have worked to make our communities safer while demonstrating respect for persons with developmental disabilities and problematic sexual behaviors.

Among the original contributors, we single out a special thanks to Gail Falk who coordinated the editing and publication of the first edition of this manual. Her wise and compassionate voice is still ever present throughout this document.

Robert McGrath and Edward Riddell updated, revised, and edited this second edition of the manual. Gratitude and appreciation is extended to the many other people who contributed to the revision process by reviewing and critiquing chapters. These include Heather Allin, Jared Bianchi, Walter Coble, Georgia Cumming, Jessica Dorr, Tonya Mason, Chuck Medick, and Elizabeth Walters. As well, we thank James Haaven for his inspiration and leadership in the field and his generosity in reviewing the earlier and current versions of this manual and providing many helpful comments.

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PART ONE

INTRODUCTION AND TERMINOLOGY

INTRODUCTION

In the past we would not have needed a manual about community supports for persons with developmental disabilities who have problematic sexual behaviors (DD/PSB). Many were committed for life to institutions such as Brandon Training School. A few were locked up for long sentences in jails. The majority were sent home by a perplexed legal system to families and communities who had few, if any, supports. Often, the offending did not stop, there were more victims, and the cycle continued.

This manual reflects our belief that persons with DD/PSB can live and receive treatment safely in their communities. It also reflects our belief that the best methods for support and treatment are not self-evident - that many approaches have been tried, and some have proven much more useful and effective than others. We do not think we have all the answers, and we need to keep reassessing our practices. So this updated manual should still not be seen as the last word but rather the current word.

We have written this manual in hopes that it will be useful to service coordinators, support staff, mental health professionals, victim advocates, community correctional services specialists, correctional officers, guardians, lawyers, judges, families, and others. We hope it will help the reader sort through questions and dilemmas that arise when different systems and values collide. Our focus is on the practical considerations that arise in everyday work with persons with DD/PSB. This is not intended to be a manual for therapists, although we hope therapists will find it useful. The manual was written by Vermonters for Vermonters, but we hope it will be helpful to people doing similar work and facing similar dilemmas in other places.

A few words about terminology:

- We have chosen to use the term "person with developmental disabilities who has problematic sexual behaviors (DD/PSB)" for several reasons.

    - First, it is "**person**" first language. It emphasizes the person first not the disability. Each person is an individual, and terms must not blind us to each person's unique personality and traits.

- Second, we use the term "**developmental disabilities (DD**)" because it is a broad term that includes several neurodevelopmental disorders that are a focus of this manual. These disorders include intellectual disabilities (ID) and autism spectrum disorder (ASD), both of which are explained further in Chapter 1.

- Third, we use the term "**problematic sexual behavior (PSB)**," rather than the narrower term "sexual offense." PSB is sexual or sexually motivated behavior that involves others and may cause harm to them. Such behavior is usually, but not always, illegal. It includes forced or threatened sexual contact; sexual or sexually motivated acts involving a person under the legal age of consent or who is otherwise unable to provide consent; use of the Internet or other technology to produce or secure sexual images involving minors or others who have neither provided nor are able to provide consent; and solicitation of or communication with a minor for sexual purposes (Association for the Treatment of Sexual Abusers, 2014). This broad definition accounts for the fact that many individuals who have DD/PSB have not been adjudicated for their behavior. Thus, they have not committed a sexual offense in the eyes of the law. In a few places, however, we do use the terms sex offense and sex offender when referencing research studies, Vermont statutes, or agency protocols that use these terms.

- We refer to individuals who have DD/PSB as "he" or "him." We are well aware that females do commit sexually abusive acts (Gannon & Cortoni, 2010), but the vast majority of individuals we work with are male, and the use of a single pronoun keeps the writing simpler.

- We refer to victims as "she" or "her" for the same set of reasons. We are well aware that men, particularly men with DD, are victims.

- We alternate references to staff, caregivers, correctional officers, lawyers, and family between "he" and "she" in recognition of the fact that individuals in these roles are fairly equally divided between male and female.

CHAPTER 1:
WHAT IS "DEVELOPMENTAL DISABILITY"?

DEFINITION

Developmental disabilities (DD) are a group of conditions that cause impairment in the areas of physical development, learning, language, or behavior areas (Centers for Disease Control and Prevention, 2016). These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime. People with developmental disabilities have difficulty learning and performing daily life skills. DD includes intellectual disabilities (ID) and autism spectrum disorder (ASD).

Developmental disabilities have many causes. The most common are:

- Genetic disorders (such as Down Syndrome).
- Prenatal exposures and birth injuries (such as umbilical cord accidents, fetal alcohol syndrome, or maternal disease during pregnancy).
- Childhood illness or metabolic disease (such as meningitis and phenylketonuria).
- Traumatic brain injury (TBI) before age 18.

PREVELANCE

Developmental disabilities, when broadly defined, are common and have been reported in about 1 in 6 children in the United States in 2006–2008 (Boyle et al., 2011). Of course, the prevalence of specific and narrowly defined developmental disorders is much smaller. For example, using definitions contained in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (American Psychiatric Association, 2013), the prevalence of intellectual disabilities among the general population is approximately 1%. Similarly, the prevalence of autism spectrum disorder, which sometimes co-occurs with ID, is also approximately 1% (American Psychiatric Association, 2013).

LEGAL AND PROFESSIONAL DEFINITIONS OF DEVELOPMENTAL DISABILITIES

The term developmental disability has different meanings in different laws. The federal Developmental Disabilities Act, written in the 1970s, contains a broad definition of developmental disability that includes all physical and mental disabilities that substantially limit a person's functioning during childhood and adolescence.

In Vermont law, the term developmental disability includes the terms **intellectual disability (ID)**, **Autism Spectrum Disorder (ASD)**, and **pervasive developmental disorder (PDD)**.

Vermont's **Developmental Disabilities Act of 1996** (18 V.S.A. §8721 et seq.) uses the term developmental disability because in 2014 the State of Vermont's Respectful Language law was signed and banned the use of other diagnostic terms that have a negative stigma towards people who receive developmental disability services. This language change is also consistent with the American Psychiatric Association (2013), which has dropped the term "mental retardation" used in earlier versions of its diagnostic and statistical manuals and adopted the more internationally accepted term "intellectual disability." Intellectual disability is the equivalent term for the *ICD-10* diagnosis of "intellectual developmental disorders." We respect and adhere to the law by using the term "developmental disabilities" in this manual.

Among individuals receiving services from DAIL for sexual behavior problems, most have been diagnosed with an intellectual disability, but a sizable minority has been diagnosed with autism spectrum disorder.

Intellectual Disability

In the DSM-5, a person may be diagnosed with an intellectual disability by meeting three diagnostic criteria (p. 33):

> **Criterion A:** Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

Criterion B: Deficits in adaptive functioning that result in failure to meet developmental socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

Criterion C: Onset of intellectual and adaptive deficits during the developmental period.

In DSM-5, the severity of intellectual disability is defined on the basis of an individual's adaptive functioning and not his IQ scores. This is because adaptive functioning determines the level of supports that an individual will require. Individuals with ID have full-scale IQ scores that are approximately 70 or below.

Autism Spectrum Disorder

In the DSM-5, a diagnosis of autism spectrum disorder (ASD) now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. In the DSM-5, a person may be diagnosed with autism spectrum disorder (ASD) by meeting five diagnostic criteria (pp. 50-51):

Criterion A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Criterion B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g, strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).

4. Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Criterion C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

Criterion D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

Criterion E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual

disability, social communication should be below that expected for general developmental level.

A more detailed description of Vermont's definition of developmental disability is contained in **Chapter 12: The Vermont Developmental Services System**. Most of the suggestions and recommendations in this manual will also be useful for people who are working with individuals with cognitive impairments which affect the person's ability to learn but are not as severe as a severe or profound intellectual disability, such as individuals with a mild intellectual disability disorder diagnosis.

CHARACTERISTICS OF PEOPLE WITH DD

Generally, people with DD have serious difficulty learning how to do things that most people their age are able to learn. However, all people with DD are capable of learning new skills. People with DD typically think in categories rather than using inductive or deductive reasoning. Thus, teaching concepts through labels and concrete situations works better than teaching abstract concepts.

SOME PEOPLE WITH DD ARE FUNNY AND FUN, PATIENT AND CARING; SOME ARE SHORT-TEMPERED AND IMPATIENT. SOME ARE TRUTHFUL, AND SOME ARE NOT; MOST, LIKE THE REST OF US, ARE TRUTHFUL MOST OF THE TIME BUT NOT ALWAYS.

Some people with DD have physical disabilities; most do not. Some people with DD have psychiatric disabilities; most do not. Some people with DD are funny and fun, patient and caring; some are short-tempered and impatient. Some are truthful, and some are not; most, like the rest of us, are truthful most of the time but not always.

Some people with DD have great difficulty expressing thoughts and feelings in words; others may have good verbal and social skills but lack cognitive understanding. In general, people with DD have trouble with complex ideas or situations, and with reasoning, analysis, and judgment. In some ways, an individual's good verbal skills can present difficulty in that he may act as if he understands a situation when he does not.

Often, to get along in society, many people with DD have learned:

- to act or say they understand when they do not
- to be acquiescent (nod agreement, go along, fake understanding, say “yes”)

It is common for adults with DD to have trouble:

- getting and keeping a job.
- reading and writing and doing school work.
- knowing the value of money.
- budgeting.
- planning.
- understanding and predicting consequences.
- initiating new sequences of thought and behavior.
- living independently.
- developing social networks.
- taking care of personal hygiene and health care.

“Mental age” is an outdated concept sometimes used to describe people with DD. Avoid falling into this trap. An adult, for example, with an IQ of 60 does not have the emotions and feelings of an eight-year-old, even though he or she may read or do math on a third-grade level. Society often expects adults with intellectual disabilities to act childlike, and people may be surprised or upset that a person with DD has adult feelings of sexuality, anger, caring, anxiety, and the like.

“MENTAL AGE” IS AN OUTDATED CONCEPT SOMETIMES USED TO DESCRIBE PEOPLE WITH DD. AVOID FALLING INTO THIS TRAP.

People with DD usually develop sexual drives and feelings at the same ages as other individuals. However, they typically have less knowledge about sex and often have trouble picking up and giving subtle social cues.

In general, people with DD in American society must face discrimination, stigma, or disadvantage on account of disability. For example, being called the "R-word” is a common insult in our society. Most adults are reluctant to identify themselves as having an intellectual disability and resist being given that label. People with DD develop their own individual emotional responses and coping skills in reaction to these adversities.

People with DD are almost always in special education during their school years. The public tends to think that everyone in special education has an intellectual disability or a developmental disability, but this is not true. Nearly 90 per cent of students in special education have impairment other than intellectual disabilities, such as specific learning disabilities, attention deficit disorder (ADD), hearing impairments, and speech and language impairments.

VULNERABILITY TO ABUSE

Individuals with DD are vulnerable to being abused by others. Experiencing abuse however does not cause sexual offending behavior in the vast majority of people (e.g., Jespersen, Lalumiere, & Seto, 2009). Still, it is essential to understand a person's abuse history and its emotional impact in designing and carrying out treatment and supervision. In working with individuals with DD/PSB, it is important to keep in mind that there is a good chance they have been victims of abuse at some point in their lives.

Children with DD are far more likely to be sexually and physically abused and neglected than other children (Blasingame, 2005; Sullivan & Knutson, 2000). As well, adults with DD experience high rates of physical and sexual abuse (Harrell, 2015; Sobsey, 1994). Some of the reasons are that they:

- may not realize that they have a right to refuse sexual advances.
- may not be able to physically resist sexual advances.
- may not understand that sexual abuse is abusive or illegal and fail to report it when it occurs.
- may experience a range of emotional reactions that may inhibit reporting abuse (e.g., fear, anger, guilt, shame, confusion, arousal, or even concern for the perpetrator).
- often are taught to be compliant with authority figures and/or to trust them to do the right thing.
- may not have been taught risk reduction skills.
- may not be able to communicate to others what has happened to them.
- may not be believed or taken seriously enough when they do report abuse.

Some people who have been abused have enduring problems as a result, such as:

- sleep disturbance.
- post-traumatic stress symptoms.
- poor self-esteem.
- depression.
- anxiety.
- hyper-vigilance.
- difficulty in adult relationships and sexual functioning.

THE RELATIONSHIP BETWEEN DEVELOPMENTAL DISABILITIES AND SEXUAL OFFENDING

Developmental disabilities do not **cause** sexual offending. There is no definitive study that shows that people with DD are either more likely or less likely than others to offend sexually. However, the majority of prevalence studies do suggest that persons with DD/PSB are over-represented in the criminal justice system (Jones, 2007; Guay, Ouimet, & Proulx, 2005; Petersilia, 2000). It is not known however whether these findings indicate that individuals with DD, compared to individuals without DD, are at slightly higher risk to commit sexual offenses or whether those that do are simply more likely to be detected. Regardless, most people with DD are law-abiding citizens. A small proportion are offenders and need to have legal constraints for the protection of society.

The U.S. Supreme Court has said that people with intellectual disabilities may be less able than others to consider the consequences of their actions and to control their actions. The court referred to problems with "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others' reactions." Atkins v. Virginia, 536 U.S. 304 (2002).

People with DD often lack sexual knowledge and misperceive social boundaries and rules. Some people with DD may engage in behavior that is perceived as deviant, but actually reflects the individual's lack of understanding of social rules. For these individuals, the label of "sex offender" is misleading. Social skills training and support for positive social relationships is of paramount importance for these individuals.

Other individuals with DD have offense related sexual arousal and are drawn to sexually abusive behavior for the same reasons as other people who commit sex offenses and will need specialized treatment and supervision for their sexually abusive behavior

PART TWO

LEGAL ROLES AND ISSUES

UNDERSTANDING THE LEGAL FRAMEWORK

Understanding the legal framework within which persons who sexually abuse others are supervised is essential for professionals who work with this population. Part Two of this manual covers the following legal topics, which pertain to some persons with DD/PSB.

- **Sexual offenses in Vermont**. The laws are described with citations to the Vermont statutes.

- **Competency to stand trial**. This important issue is central to whether an individual will face (1) criminal charges or (2) commitment under Act 248.

- **Presentence investigations and sentencing**. This is a summary of the sentencing process and the alternate sentences that are available after a person has pled guilty or has been convicted of a crime.

- **Sex offender registration laws**. The Vermont law on sex offender registration is explained.

- **Act 248**. This section reviews the rules for Act 248, Vermont's commitment law for offenders with intellectual disabilities who have been found incompetent to stand trial.

- **Guardianship**. The rules and roles of guardianship are described in this section.

- **Lawyer's roles**. Persons with DD/PSB and those who work with them may interact with a number of different lawyers. This section explains the roles of various lawyers who commonly interact with persons with DD/PSB who have been arrested, charge, or convicted of a crime.

CHAPTER 2:
SEXUAL OFFENSES IN VERMONT

Sexual offenses in Vermont fall into several categories:

- Sexual assault and aggravated sexual assault
- Lewd and lascivious conduct
- Sexual activity with a vulnerable adult by a caregiver
- Any of the following offenses where the victim is a child:
    - Kidnapping if sexual assault occurs or is threatened
    - Lewd and lascivious conduct with a child
    - Prostitution-related offenses
    - Possession of child pornography
    - Internet solicitation of a child under 16
    - Use of a child in a sexual performance

Some offenses are **felonies**, meaning that the offender can be subject to imprisonment for a period greater than two years, and some are **misdemeanors**, meaning potential imprisonment of two years or less. A discussion of different charges follows.

THE SEXUAL ASSAULT OFFENSES

The sexual assault offenses, found at Chapter 72 of Title 13 of the Vermont Statutes Annotated, carry some of the most serious penalties. The threshold requirement for a conviction for sexual assault is that a "sexual act" has occurred. A **sexual act** is contact between "the penis and the vulva, the penis and the anus, the mouth and the penis, the mouth and the vulva, or any intrusion, however slight, by any part of a person's body or any object into the genital or anal opening of another." 13 V.S.A. §3251(1). Thus, a conviction for sexual assault means that the person has engaged in at least one of these forms of contact with the victim.

There are different types of sexual assault depending on other factors present in addition to the sexual act, as listed below. Maximum sentences for these felonies vary from 20 to 35 years.

- Any sexual act with a person under the age of 16 (except if the parties are married and the act is consensual). 13 V.S.A. §3252(c). This is commonly called "statutory rape" and does not apply if both parties are under the age of 16. cite. It is a strict liability crime, meaning that it is no defense that the offender did not know the victim's age or that he made a reasonable mistake about the victim's age.

- Any sexual act with a person under the age of 18 where the offender occupied a position of authority over the child, either by law or by relationship to the child. 13 V.S.A. §3252(d).

- Any sexual act with a person who does not consent to it, or who is compelled to participate by threats or coercion or through fear that any person will suffer imminent bodily injury. 13 V.S.A. §3252(a)(1).

- Any sexual act accomplished by using intoxicants or drugs to substantially impair the other person's ability to resist, without that person's knowledge or against her will, for example, by covertly using "date rape" drugs to make the victim compliant. 13 V.S.A. §3252(b).

An **aggravated sexual assault** may incur a more severe penalty than a basic sexual assault. Sentences generally range from 10 years to life. 13V.S.A. § 3253(b)-(c). A person convicted of aggravated sexual assault has committed sexual assault accompanied by one or more aggravating factors. *See* 13 V.S.A. § 3253(a). These aggravating circumstances include: causing or threatening serious bodily injury; being assisted or joined by another person in the assault; being armed with a deadly weapon at the time of the offense; kidnapping the victim; having a previous conviction for sexual assault; being 18 years or older when the victim is under the age of 13; subjecting the victim to repeated, non-consensual sexual acts as part of a scheme or plan.

LEWD AND LASCIVIOUS CONDUCT

Unlike the sexual assault offenses, lewd and lascivious conduct does not require the State to prove that a specific type of "sexual act" occurred. The statute prohibits "open and gross lewdness and lascivious behavior," 13 V.S.A. 2601, that is, sexual conduct involving at least one unwilling participant or viewer. Acts which may constitute lewd and lascivious conduct, but not sexual assault, include: exposing one's genitals to an unwilling viewer; fondling an unwilling person's genitals where there is no intrusion into the body; fondling an unwilling person's breasts; public masturbation; and so on. The act is a crime even if it is not done in a public place, so long as the offender does not disguise or conceal his actions. No more than one witness is required, and this witness may be the victim. Lewd and lascivious conduct is a felony.

LEWD AND LASCIVIOUS CONDUCT WITH A CHILD

This provision prohibits the willful and lewd commission of any lewd or lascivious act upon or with the body, or any part or member thereof, of a child under the age of 16 years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of the perpetrator or of the child. 13 V.S.A. §2602. Fondling the genitals or breasts of a child, even through clothing, is considered lewd and lascivious behavior. In fact, the offender need not have touched the child. For example, causing the child to masturbate constitutes a lewd act committed "with" the body of the child.

SEXUAL EXPLOITATION OF CHILDREN

Vermont statutes prohibit possessing child pornography, including electronically, of “sexual conduct by a child or of a clearly lewd exhibition of a child's genitals or anus.” 13 V.S.A. §2827(a). Using a child under the age of 16 in a sexual performance, including exhibiting a child's genitals, or promoting any photograph, film, or visual recording of sexual conduct by a child is also considered illegal.
13 V.S.A. §2822;. 13 V.S.A. §2824.

SEXUAL ABUSE AND EXPLOITATION OF VULNERABLE ADULTS

Vermont law protects "vulnerable adults" from sexual abuse and exploitation by caregivers. Individuals 18 years or over with developmental disabilities are considered to be vulnerable adults. A **vulnerable adult** includes any person with a developmental disability whose ability to protect himself from abuse, neglect or exploitation and to care for himself is impaired due to a mental, physical, or developmental disability. 33 V.S.A. §6902(14).

Any sexual activity with a vulnerable adult by a caregiver who works at a care giving facility or in a program is considered criminal sexual abuse. 33 V.S.A. §6902(1)(D). **Sexual activity** includes any act that could constitute a sexual assault or lewd and lascivious behavior, unless it is appropriate medical care or personal hygiene. 33 V.S.A. §6902(11). For example, a nurse aide who fondles the breasts of nursing home residents could be considered an offender, whereas a nurse aide who engages in routine perianal cleaning would not be an offender. It does not matter whether the offender's care giving services were volunteered or paid. Neither does the location of the activity make any difference. Exceptions exist for consensual sexual activity between a vulnerable adult and that person's care giving spouse, or for consensual relationships between vulnerable adults and caregivers hired, supervised, and directed by them. 33 V.S.A. §6902(1)(D).

SEXUAL OFFENSES IN VERMONT FALL INTO SEVERAL CATEGORIES:

- SEXUAL ASSAULT AND AGGRAVATED SEXUAL ASSAULT
- LEWD AND LASCIVIOUS CONDUCT
- SEXUAL ACTIVITY WITH A VULNERABLE ADULT BY A CAREGIVER
- ANY OF THE FOLLOWING OFFENSES WHERE THE VICTIM IS A CHILD:
    - KIDNAPPING IF SEXUAL ASSAULT OCCURS OR IS THREATENED
    - LEWD AND LASCIVIOUS CONDUCT WITH A CHILD
    - PROSTITUTION-RELATED OFFENSES
    - POSSESSION OF CHILD PORNOGRAPHY
    - INTERNET SOLICITATION OF A CHILD UNDER 16
    - USE OF A CHILD IN A SEXUAL PERFORMANCE

Chapter 3:
Competence to Stand Trial

Every adult is presumed to be competent. Thus, any person, regardless of diagnosis of intellectual disability disorder, may be charged with a crime and arrested. However, it is unconstitutional to put an individual on trial for a crime if the person cannot understand and participate meaningfully in the trial process. A person who cannot understand and participate meaningfully is termed **incompetent to stand trial**.

"The test of competency to stand trial is whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding – and whether he has a rational as well as factual understanding of the proceedings against him." *State v. Cleary*, 2003 VT 9, ¶11, 175 Vt. 142, 824 A.2d 509 (2003).

Some people with intellectual disabilities are competent to stand trial and some are not. Incompetence to stand trial can arise from many disabilities, including mental illness, physical illness or disability, intellectual disability, or another developmental disability. No diagnostic label or IQ score alone proves that a person is competent or incompetent to stand trial.

Typically, a request to evaluate an individual's competence to stand trial is made by the defense lawyer, usually in the early stages of a criminal prosecution. However, a request for a competency evaluation can be initiated at any stage of a case by the judge, defense attorney, or the state's attorney if she feels the defendant is not grasping the situation.

The competency evaluation is completed by a **forensic psychiatrist** - a doctor with special, advanced training in assessing whether or not a person is competent to stand trial. There are only a few forensic psychiatrists in Vermont.

When the court orders an evaluation, it asks the Department of Mental Health (DMH) to arrange the evaluation. Usually, the evaluation can be completed on an outpatient basis but, occasionally, the evaluation is conducted at Vermont Psychiatric Care Hospital (VPCH) or a prison if the court thinks the individual is

too dangerous to be released. A competency evaluation for a person with DD should include an up-to-date psychological assessment of the individual's cognitive functioning. The DMH will include this in the evaluation if asked to do so.

In assessing competence to stand trial, the evaluator is trying to determine whether or not the person has enough understanding of the process that it is fair to put the person on trial. Typically, a forensic evaluation consists of a face-to-face interview with the individual and a review of any records provided by the prosecutor, defense attorney, or facility where the individual is housed. Since it is helpful for the evaluator to have as much background information about the person as possible, those who have information should contact the evaluator and offer to provide relevant information.

ACCORDING TO THE AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (COMMENTARY TO STANDARD 7-4.1), FUNCTIONAL COMPETENCE TO STAND TRIAL CONSISTS OF FIVE COMPONENTS. PARAPHRASED HERE, THEY ARE:

1. A PERCEPTION OF THE PROCESS NOT DISTORTED BY MENTAL ILLNESS OR DISABILITY. THIS INCLUDES AN UNDERSTANDING OF THE ROLES OF THE JUDGE, THE PROSECUTOR, THE DEFENSE ATTORNEY, AND THE JURY.
2. AN ABILITY TO CONSULT RATIONALLY, GIVING AND RECEIVING INFORMATION, WITH HIS ATTORNEY.
3. THE ABILITY TO RECALL AND RELATE FACTS RELATING TO THE ALLEGED OFFENSE.
4. THE CAPACITY TO TESTIFY IF APPROPRIATE.
5. AN ABILITY TO CONSULT WITH COUNSEL AND UNDERSTAND THE PROCEEDINGS IN LIGHT OF THE SEVERITY OF THE CHARGES AND THE COMPLEXITY OF THE CASE.

While the legal standard for determining competency to stand trial is clear, the practical application of this standard varies widely, and there can be strong disagreement about whether an individual with DD is or is not competent to stand trial.

The Vermont Supreme Court has said that, "a competency determination can require special help or services to enable the defendant to meet the constitutional competency standard." In re. J.M., 172 Vt. 61, 69, 769 A.2d 656, 663 (2001). Accommodations for people with cognitive impairments include having frequent breaks, intermittent inquiries to confirm a defendant's comprehension of the proceedings, involvement of support people, and careful phrasing of questions.

In summary, the range of the need for and the outcome of evaluating competency to stand trial is wide. Some people with developmental disabilities may be found competent to stand trial after an evaluation by experts and a hearing by the court, and the criminal proceedings against them continue. Other people with developmental disabilities are found, after evaluation and hearing, to be incompetent to stand trial, and the criminal proceedings against them cease. Either their case is dismissed or the state seeks civil commitment under what is commonly known as Act 248. Act 248 will be discussed in more detail in **Chapter 7: Act 248**.

CHAPTER 4:
PRESENTENCE INVESTIGATION

If a person is found competent to stand trial, the case will move toward a decision. There may be a trial before a judge or jury, or the individual may decide to plead guilty. Trial procedures and plea bargains are outside the scope of this manual.

In a criminal prosecution, if the individual is convicted by the judge or jury, enters a plea of guilty, or does not contest his guilt, the next phase is to determine the sentence. Particularly in sex crimes where the person's mental health or capacity is an issue, the sentencing process often includes a **Presentence Investigation (PSI).** Strategies for conducting and writing a PSI have been well detailed by Cumming and McGrath (2005) and Purvis, Ward, and Shaw (2013). A PSI is usually completed for any serious felony case. The purpose of the PSI is to provide information about the defendant to the judge to assist in disposition. A PSI should be done routinely before sentencing a person with DD/PSB in order to provide the background and perspectives of key people, including the victim, and to explore the impact of the person's developmental disabilities.

Typically, the judge orders a PSI, although the prosecutor or the defense attorney may also request one. Sometimes the court will order a **psychosexual evaluation** (see Chapter 14: Assessment and Psychosexual Evaluations).

The PSI report is written by a **Correctional Services Specialist (CSS)**, an employee of the Department of Corrections (DOC) (see Chapter 13: Supervision by Department of Corrections). It includes detailed information about the perspectives of the person who was victimized and the defendant's:

- criminal history.
- Department of Children and Families (DCF) history.
- Department of Disabilities, Aging, and Independent Living (DAIL) history.
- family and personal history.
- education history.
- marital and relationship history.
- employment and financial history.
- substance use and misuse history.
- medical and mental health history.
- prior periods of community supervision and/or incarceration.

For a person with DD/PSB, the PSI report should include information about developmental and special education services that he is receiving, has received, or could be eligible to receive. The report should detail any support, assistance or accommodations the person with DD/PSB will need:

- to complete daily living tasks.
- to benefit from treatment (including the need for a specialized program or group for individuals with DD/PSB).
- to comply with conditions of community supervision (such as keeping track of dates, transportation, reading written materials, communication assistance).

PSIs sometimes fail to include information about a person's developmental disability. **A defendant has a right to submit information about his crime, background or disabilities to the CSS who is completing the PSI, and to make sure that the CSS talks with people who understand the person's disabilities.** Sometimes public defenders may be unaware of the importance of this information.

DS staff should assist the client in conveying information about the disability to the public defender so that the client and his attorney can make an informed decision about what information to present to the CSS.

At the end of the report, the CSS assesses the information and, if requested by the court, may make a sentencing recommendation. The PSI should include an opinion about the defendant's amenability to specialized sex offender treatment, the level of risk to the victim and to the community (see Chapter 14: Assessment and Psychosexual Evaluations), and special conditions needed to address the specific needs and risks of the defendant. Whether or not a recommendation for incarceration is made, the PSI should identify specific DOC programs that the person would likely be referred to and the minimum length of sentence required to be eligible for those programs.

The PSI is typically submitted to the court at least two weeks prior to sentencing. The PSI is a confidential document, which is initially shared only with the judge, the state's attorney, the defense attorney, and the CSS who will be supporting the individual once he is sentenced. The defendant may read the report in the presence of his attorney. The person's therapist and any other treatment providers may receive a copy of the PSI if the offender or his guardian authorizes the CSS to release it.

The PSI will be relied upon by the judge and by Corrections. It is essential that the information be accurate. If the defendant disagrees with any facts reported in the PSI, he or his attorney must raise the objection before sentencing. The judge will decide whether or not the information objected to is accurate. If the judge decides the information is inaccurate, it will be stricken from the report. If the defendant or his attorney is dissatisfied with the PSI, the defense attorney may object to portions or submit a **defense PSI** to the court.

CHAPTER 5:
SENTENCING

Judges typically craft sentencing decisions to achieve one or more of the following five sentencing goals: punishment, deterrence, rehabilitation, incapacitation, and restitution.

1. **Punishment.** Fair punishment is considered proportionate to the seriousness of the offense. In Vermont Statutes, specific offenses and the range of penalties for them are clearly delineated.

2. **Deterrence.** Deterrence is intended to send a message that criminal behavior will be detected and punished. Its intent is to discourage people from breaking the law.

3. **Rehabilitation.** The goal of rehabilitation is to treat an individual's problems that contributed to his offending behavior and help him develop attitudes and skills to live a crime free life.

4. **Incapacitation.** Incapacitation is intended to control risk by limiting an individual's ability to commit crimes. Incarceration and varying levels of community supervision can act to reduce a person's access to potential victims (e.g., children) or activities (e.g., drinking alcohol) that may place him at increased risk to reoffend.

5. **Restitution.** Restitution requires the person who has committed a crime to make amends to the victim and the community. This can include financial restitution, written or verbal apologies, and community service work.

To achieve one or more of the five sentencing goals, Vermont courts have five alternatives to use in sentencing (13 V.S.A. §7030):

1. Deferred sentence
2. Probation
3. Supervised community sentence (SCS)
4. Sentence of imprisonment
5. Pre-approved conditional re-entry (formerly called furlough)

DEFERRED SENTENCE

A deferred sentence will rarely be used in the context of a sex offense. It requires the written agreement of the prosecutor. With the prosecutor's agreement, upon adjudication of guilt and after the filing of a PSI report, the court may defer sentencing and place the defendant on probation. The supervision for an offender under a deferred sentence is similar to probation supervision. The offender will check in with an assigned Correctional Services Specialist (CSS). The offender is likely to be required to comply with the same types of special conditions listed below in the section on Probation.

If the defendant complies with the terms of probation and the deferred sentence agreement for a specified period (no longer than five years), the defendant's criminal record is expunged at the end of the period and the defendant is released from the conditions. This means that there is no record anywhere that the person was arrested or convicted. If, on the other hand, the defendant violates the conditions during the deferral period, the court imposes the sentence.

PROBATION

In probation, all or part of the offender's term of imprisonment is suspended and the offender is released into the community under the supervision of the Department of Corrections, subject to conditions set by the court. Probation may be an appropriate disposition for persons who appear to be at relatively low risk to sexually reoffend. In general, probation would not be recommended for individuals at high risk to reoffend.

Probation conditions may serve to address one or more of the five sentencing goals listed earlier; punishment, deterrence, rehabilitation, incapacitation, and restitution. Probation conditions however typically place an emphasis on managing an individual's risk factors for sexual reoffending, such as using alcohol, drugs, and pornography and being in locations where potential victims (for example, children) tend to be present.

For an offender with developmental disabilities, the conditions should be written in language he can understand, and should be tailored to the specific risks and capacities of the individual. It is important to keep the list short enough for the offender to focus on the important issues.

The following is a list of **probation conditions** that may apply. They should be used selectively as they pertain to the particular offense and the particular offender. Each probation condition must be reasonably related to the individual's offense. State v. Cornell, 2016 VT 47 (2016).

- You shall live where your probation officer directs.
- (If alcohol/drug use has a relation to offending behavior) You shall not purchase, possess, or consume alcoholic beverages/regulated drugs.
- (If alcohol use is not related to offending behavior) You shall not consume excessive amounts of alcohol.
- (For offenders who have abused alcohol or drugs) You shall submit to alcosensor/urinalysis testing as requested by your probation officer.
- (For offenders who have abused alcohol or drugs) You shall attend and participate in alcohol/drug counseling as directed by your probation officer.
- You shall not purchase or possess pornographic materials.
- You shall not operate a motor vehicle; or you shall not operate a motor vehicle after dark, except for purposes of verified employment, unless in the company of a responsible adult.
- You shall report your weekly schedule to your probation officer.
- You shall be at home every night after ___ p.m.
- You shall not hitch-hike.
- You shall not pick up hitch-hikers.
- You shall not make contact with the victim, or any members of the victim's family, unless approved by your probation officer.
- (for offenders with child victims) You shall not intentionally make contact with any child without permission and prior approval of your probation officer.
- You shall not purchase or possess firearms.
- You shall participate meaningfully in a sex offender treatment program approved by your probation officer. (Insert name of program)

- You shall contribute $____ per week to pay for the cost of therapy required by the victim.
- You shall pay $____ per week to the victim or the Victim Compensation Program for expenses the victim had as a result of the offense.

Under certain circumstances, the court may modify conditions of probation during the period of probation. If the offender violates probation, the court, following a hearing, may (1) continue the probationer on the existing sentence; (2) warn the probationer that future violations could result in revocation of probation; (3) change the conditions of probation; or (4) revoke probation and impose part or all the sentence which was suspended, to be served incarcerated or in a supervised community setting.

SUPERVISED COMMUNITY SENTENCE

A supervised community sentence (SCS) is a form of imprisonment to be served outside the walls of a correctional facility. The Parole Board, not the court, has the authority over these cases. It may be served through half-way houses, day centers, community work programs, residential treatment centers, individual and group counseling, house arrest, electronic monitoring, and intensive supervision. SCS conditions are similar to but typically more restrictive than probation conditions, although typically less restrictive than conditional re-entry conditions. For the court to impose such a sentence, it must have a recommendation from the Department of Corrections. If the offender commits a crime or violates a term of his supervised community sentence, he may be arrested and held in jail pending hearing.

A supervised community sentence provides the statutory basis for a creative partnership between Corrections, the Parole Board, and developmental services to tailor programs to the specialized needs of offenders with developmental disabilities.

IMPRISONMENT

The court may sentence an offender to a term of imprisonment with a minimum and a maximum term of duration, for example, five to ten years. Offenders convicted after 2001 no longer receive good time off their minimum sentences. In

other words, the minimum imposed by the judge is the actual minimum, and the offender cannot reduce the minimum sentence further by good behavior.

As part of the sentence, all or part of the term of imprisonment may be suspended, and the offender placed on probation. When only part of the term of imprisonment is suspended, with the offender to serve the rest, it is called a **split sentence**. For example, if someone receives a five to ten-year sentence but is only required to serve three years in jail, he is serving a split sentence. Usually, for an individual convicted of sex offenses, a split sentence includes a probation requirement for the individual to complete the incarcerated portion of sex offender treatment prior to release to probation. If the person does not complete the sex offender treatment while incarcerated (due to his own fault or behavior) the court may find a probation violation prior to release to the community, followed by re-sentencing and increased jail time to complete the incarcerated treatment program.

An **indeterminate sentence** sets a minimum and maximum time to serve (for example, a minimum of five years and a maximum of ten years). Indeterminate sentences with a low minimum and a high maximum are frequently used with individuals who have committed sexual offenses. This provides:

- the opportunity for early release on conditional re-entry for those who engage honestly in treatment.
- long periods of correctional supervision and mandated outpatient follow-up treatment.
- long-term public protection from individuals who have no interest in treatment because these individuals may continue to be incarcerated until the maximum release date.

CONDITIONAL RE-ENTRY AND PAROLE

After an incarcerated individual has served his minimum term of imprisonment, he is eligible for supervised community release through **conditional re-entry** (formerly referred to as “furlough”) and **parole**. Some sentences have a minimum term of zero. These individuals are eligible for conditional re-entry or parole immediately after sentencing.

Conditional re-entry is a more frequent means of release than parole for individuals convicted of sex crimes in Vermont. Individual convicted of sex offenses are

sometimes initially returned to the community on conditional re-entry, and are granted parole any time from six months to one or more years following release.

Conditional re-entry and parole are granted with specific conditions, which are monitored by Department of Corrections field staff (for more details, see Chapter 13: Supervision by Department of Corrections). The period of Corrections supervision and the ability to enforce specific conditions ends at the expiration of the maximum term of the individual's sentence.

IMPACT OF SEX OFFENDER TREATMENT ON A SENTENCE

As earlier noted, an individual's participation in sex offender treatment can impact the length of his prison sentence, and upon release, his period of community supervision.

The Department of Corrections has four prison sex offender treatment programs, which are delivered primarily in a group format. Placement in a program is based on an individual's risk and treatment needs. In general, individuals who are deemed low risk for sexual reoffending are placed in an approximately 6-month program; moderate risk individuals in a 12-month program; and high risk individuals in a 24-month program. Individuals with DD/PSB who do not have the ability to participate in one of these three programs, due to intellectual or other disabilities, can be placed in the DOC's "adapted" program for individuals with special needs. Individuals who cannot function in any group treatment setting are provided individual treatment services.

Per DOC policy, an individual is eligible to begin prison-based sex offender treatment shortly before his minimum release date, so that if he successfully participates in treatment, he will be eligible for release on his minimum release date. Take, for example, an individual who received an **indeterminate sentence** with a minimum of five years and a maximum of ten years. If he were assessed as needing the high risk 24-month program, he would begin that program about 24 months before he reached the end of his 5-year minimum sentence, and if he successfully completed treatment would be eligible for release at his minimum release date.

If an offender remains in denial of his offense, or refuses his designated prison treatment program, DOC will not recommend him for parole, and release planning will not occur until six (6) months prior to his maximum release date.

If an individual who has successfully completed prison-based sex offender treatment is released to the community on probation or parole, he will continue in the DOC community-based sex offender treatment program. Successful completion of probation or parole is generally contingent on successful completion of sex offender treatment.

CHAPTER 6:
SEX OFFENDER REGISTRATION LAW

Registration laws require a convicted sex offender to register certain identifying information in a public place, even after the offender has completed his sentence. Registration laws were enacted throughout the country after publicity of the 1994 sexual assault and murder of a young girl named Megan Kanka in New Jersey. Soon thereafter, a federal law, referred to as **Megan's Law**,[1] was also enacted. It requires each state to have a system for sex offender registration and community notification but gives considerable latitude to the states to determine what is required.

Sex offender registration is primarily a law enforcement tool to assist police in tracking the whereabouts of sex offenders. Other goals of registration are:

- to deter offenders from committing future crimes.
- to provide law enforcement with an additional investigative tool.
- to increase public protection.

VERMONT SEX OFFENDER REGISTRY

Vermont's sex offender registration law creates a registry of sex offenders maintained by the **Vermont Criminal Information Center (VCIC)** at the Department of Public Safety. This is a separate and distinct registry from the registries maintained by the Department of Aging and Independent Living (DAIL) and the Department for Children and Families (DCF), which are discussed at the end of this chapter. (The VCIC also has an additional role that we will explain at the end of the chapter as well.) Until 2004, the sex offender registry was confidential. Very limited disclosure was permitted except to police officers and prospective employers. The 2004 amendments to the law established Internet posting of information about many sex offenders and increased the authority of police officers to release information about registered sex offenders to people in the community.

[1] Megan's Law is a part of the Jacob Wetterling Crimes Against Children and Sexually Violent Offenders Registration Act. See the Glossary for more information.

OFFENDERS REQUIRED TO REGISTER

The registration requirements apply to "**sex offenders**," which is defined in the Vermont registry law as a person who was convicted after July 1, 1996 of committing or attempting to commit a sexual offense; or who was in prison in Vermont for a sexual offense after July 1, 1996; or who was under community supervision by the Department of Corrections for a sexual offense after July 1, 1996. **Sexual offenses** include:

- sexual assault and aggravated sexual assault
- lewd and lascivious conduct
- sexual activity with a vulnerable adult by a caregiver
- any of the following offenses where the victim is a minor:
    - kidnapping if sexual assault occurs or is threatened
    - lewd and lascivious conduct with a child
    - prostitution-related offenses
    - possession of child pornography
    - Internet solicitation of a child under 16
    - use of a child in a sexual performance

Any sex offender convicted or released from prison in another state on or after July 1, 1996 and who moves to Vermont must register, as well as any non-resident sex offender who is working or going to school in Vermont. A person convicted of **statutory rape** (based solely on the age of the victim) is **not** required to register if the **perpetrator was younger than 18** at the time of the crime.

THE REGISTRATION LAW DOES NOT APPLY TO OFFENDERS COMMITTED UNDER ACT 248 OR TO JUVENILES (EXCEPT FOR JUVENILES WHO WERE TRIED AS ADULTS).

A person whose conviction of a sex offense is reversed and dismissed is not required to register for that conviction, and any information about the conviction contained in the registry should be removed and destroyed. If any information about that conviction has been provided to any person or agency, that person or agency is required to remove and destroy the information. If the person has more than one entry in the registry, only the entry related to the dismissed case is expunged.

Individuals who have not registered with the Vermont Sex Offender Registry but who are required to do so by law may call (802) 241-5400 or write the registry at the address below to obtain registration forms.

Vermont Sex Offender Registry
Vermont Crime Information Center
45 State Drive
Waterbury, Vermont 05671-1300
Tel: (802) 241-5400
Fax: (802) 241-5552
Email: DPS.SOR@vermont.gov

INFORMATION REQUIRED BY THE REGISTRY

A sex offender is required to provide the registry with the following information:

- Name
- Date of birth
- General physical description
- Current address
- Social Security number
- Fingerprints
- Current photograph
- Current employment
- Current postsecondary school (if any)

The Department of Corrections also gives the registry:

- The name, address, and phone number of the Department of Corrections office monitoring the offender.
- Documentation of any treatment or counseling received.

The Department of Corrections notifies the registry when an offender leaves a correctional facility and also notifies the offender of his responsibility to keep his information at the registry up to date.

UPDATES AND DURATION OF REQUIRED REGISTRY INFORMATION

Offenders who are required to register must:

- notify their probation officer of any change of address, employment, or school **within three days** of the change for as long as they are being supervised in the community by the Vermont Department of Correction.
- after they are discharged from Department of Corrections supervision, notify VCIC of any change of address, employment, or school **within three days**
- register **within three days** of moving out of state with the sex offender registry in the new state (and also notify VCIC of the change of address).
- complete an annual update form sent by VCIC **within ten days** of receipt (The form is sent at the time of the offender's birthday.)

A sex offender must continue to comply with the registration requirements for **ten years** from the date he is discharged from the supervision of the Vermont Department of Corrections, unless he is subject to Lifetime Registration. VCIC will notify the registrant when he is no longer required to report.

Lifetime Registration applies to:

- individuals who have at least one prior conviction for an offense that would require them to register in Vermont or another jurisdiction of the United States and are convicted in Vermont of a subsequent offense after September 1, 2001.
- individuals who have been convicted of sexual assault or aggravated sexual assault after September 1, 2001.
- individuals who have been determined by a court to be a Sexually Violent Predator. An offender determined by a court to be a **Sexually Violent Predator** must update his information every **90 days**

If a Lifetime Registrant believes he is no longer dangerous, he can petition the court to be removed from the registry.

USES AND NOTIFICATION OF REGISTRY INFORMATION

The law requires the Department of Public Safety to notify the victim when the offender is released from prison and any time the sex offender changes address, and **if** the victim requests the information **and** such disclosure is necessary to protect the victim or the general public.

VCIC passes along registration information to local law enforcement. The information may then be used by the local officials only for law enforcement purposes, except as follows:

- VCIC, the Department of Corrections, **or** local law enforcement officials may release limited registry information to a member of the public if the person requesting the information is asking about a specific offender and has a legitimate concern about public safety of herself or another person. When a person requests information, the law enforcement agency will verify her identity and keep a record of who called and the information that was released. The identity of any victims will not be provided under any circumstances. Law enforcement officials may release more extensive information about sex offenders who are subject to Internet posting (see the section to follow entitled "Internet Posting of the Sex Offender Registry").

- Law enforcement may proactively notify members of the community who are likely to encounter a registrant. Law enforcement may also conduct broader notifications in consultation with VCIC and the Department of Corrections.

- DS agencies and others may obtain information from the registry if there is a specific reason for making the request, such as concern that a person who one of their clients is spending time with may be a sex offender.

INTERNET POSTING OF THE SEX OFFENDER REGISTRY

Internet posting of information about sex offenders began in 2004 in Vermont and can be found at http://www.dps.state.vt.us/cjs/s_registry.htm. The information posted on the Internet includes most registry information, including the town of residence **but not the street address**. The Internet posting includes a digital photograph of the offender.

Sex offenders whose information is posted on the Internet include those who:

- were convicted of aggravated sexual assault or kidnapping and sexual assault of a child.
- have more than one conviction for sexual assault or lewd and lascivious conduct with a child.
- have an outstanding arrest warrant for failure to register.
- have been found by a court to be a Sexual Predator.
- have not complied with sex offender treatment.
- are designated by the Department of Corrections as "high risk."[2]

Information on the Internet registry is organized and available by search by the sex offender's name and by the county of residence. To use the registry, a member of the public must register as a user by providing his name and address and must agree that the information is confidential and only to be used to protect personal or community safety. It is a crime to use registry information to injure or harass a sex offender.

OTHER REGISTRIES IN THE STATE OF VERMONT

The Vermont Sex Offender Registry is separate and distinct from the registries maintained by the Department of Aging and Independent Living and the Department for Children and Families. Briefly:

- The Department of Aging and Independent Living maintains the Adult Protective Services (APS) Registry, a registry of individuals who have been found, in an administrative investigation by Adult Protective Services, to have abused, neglected, or exploited a vulnerable adult. It is confidential, except for reports disclosed to law enforcement agencies, certain state agencies, certain employers, and, under very limited circumstances, members of the public. 33 V.S.A. §6911.

- The Department for Children and Families (DCF) maintains a registry of individuals who have been found in an administrative investigation by DCF (or its predecessor SRS) to have abused or neglected a child. The registry contains a record of substantiations from investigations that happened any

[2] The Department of Corrections has developing rules for deciding who is a "high risk" offender, which are detailed in Vermont Department of Corrections Policy #255.01.

time from 1992 to the present. The registry is confidential except for reports to employers, including developmental services programs, for the purpose of checking the background of prospective and current employees who may work with children or vulnerable adults. 33 V.S.A. §309. Background checks can also be conducted for volunteers who may be working with children or vulnerable adults.

A person who is on the DCF registry will have trouble getting employment, or even doing volunteer work, for an organization where they may have contact with children or vulnerable adults. Occasionally, the registry information is incorrect or the person no longer poses any danger to vulnerable children and adults. DCF offers an appeals process (called "expungement") to individuals who believe their information should be removed from the registry. To start the appeals process, the person who is on the registry writes a letter to the district director of the DCF district office involved. The letter should include details about the substantiation as well as the person's name, address, and daytime telephone number.

In addition to maintaining the sex offender registry, the VCIC is the repository of *all* criminal record information generated by criminal justice agencies statewide. VCIC consolidates and verifies arrest, prosecution, sentencing, and correctional information provided by other agencies into a criminal history format that documents a subject's contacts with the criminal justice system in Vermont.

The VCIC criminal history repository contains:

- identifying information (e.g., Name, Date of Birth, Place of Birth etc.)
- criminal justice information for crimes for which probable cause has been found by a Vermont District Court
    - date of Arrest, Arresting Agency, and Case Number
    - date of Arraignment, Docket Number, and Court
    - charge(s) and Pleas
    - case Disposition
    - sentence Information

Note that the following information is **NOT** included in the VCIC repository:

- charges that were never arraigned.
- motor Vehicle Offenses such as DWI, DLS, C&N, Vehicular Homicide which were arraigned prior to September 1, 1995.
- charges that were arraigned in Family Court, the Traffic Ticket Bureau or the Municipal Ordinance Bureau.
- records of juveniles unless the juvenile was prosecuted in District Court as an adult.
- out-of-state charges.
- charges that were expunged.

Developmental services (DS) agencies and schools have access to VCIC to check the criminal background of a prospective employee. In addition, other organizations whose employees or volunteers provide care for vulnerable populations are now authorized to receive Vermont and out-of-state criminal record checks for purposes of employment screening.

CHAPTER 7:
ACT 248

Act 248 is Vermont's civil commitment law for people with intellectual disabilities who have been found to be a danger to the community and who cannot be sent to prison. Act 248 is located in the Vermont statutes at Title 13, Section 4823 and Title 18, Sections 8839 – 8846.

Act 248 was adopted in 1987 to address a hole in the law. At that time, Vermont law authorized civil commitment of an individual with an intellectual disability only if the person was a danger to himself. Thus, when criminal charges were dismissed against an individual found incompetent to stand trial on the basis of an intellectual disability, the court had no option but to let him go free. If a person did not agree to treatment, he could not be held, and the public could not be protected from repeat offenses. Act 248 provided a way for courts to protect public safety by committing individuals found incompetent to community programs that have the legal responsibility to protect public safety.

APPLICABILITY OF ACT 248

To be committed under Act 248, a person must be a person in need of custody, care and habilitation, which is defined as a person who:

- has an intellectual disability (see definition Chapter 1: What is "Developmental Disability"?)
- present a danger of harm to others, that is, be a person who has engaged in ANY of the following:
    - sexual assault
    - lewd and lascivious conduct with a child
    - inflicting or attempting to inflict serious bodily injury upon another person, and:
- for whom appropriate custody, care, and habilitation can be provided by the Commissioner in a designated program.

Act 248 is used only for people who have been found incompetent to stand trial because they can't understand or participate meaningfully in the trial process, or

they are not responsible for their crime because they didn't understand it was wrong. Individuals who are competent to stand trial go through the usual criminal process even if they have developmental disabilities. Additionally, Act 248 is limited to people with a diagnosis of an intellectual disability disorder. Individuals who do not have an intellectual disability disorder but have other disabilities may be found incompetent to stand trial but they cannot be put under Act 248.

People can be put under Act 248 only if they have committed one of the acts listed as a "danger of harm to others." For example, a person who has committed arson or theft or stolen a car cannot be put under Act 248 unless there was some element to the crime that involved inflicting serious bodily injury. The term "sexual assault" is broad and includes attempted sexual assault and sex with a person who did not give consent and sex with a person under age 16 (see Chapter 2: Sexual Offenses in Vermont).

PROCEDURES

Typically, cases proceed as follows:

1. An individual is found incompetent to stand trial and the psychiatrist/psychologist who wrote the evaluation for competency confirms the person has an intellectual disability.

2. The state's attorney files a petition in District Court asking the judge to put the person under Act 248.

3. The court orders the Commissioner of the Department of Aging and Independent Living (DAIL) to complete an evaluation of the person.

4. If a sexual offense is involved, DAIL requests an evaluation of the person that includes:
   - a psychological assessment to determine whether the person has an intellectual disability.
   - a psychosexual evaluation to determine whether the person presents a danger of harm to others and to assess the nature of the risk.
   - recommendations for custody, care, and habilitation of the person.

   Usually, DAIL asks the designated developmental services agency for the county where the person lives to conduct the evaluation, but the Department

may select a different evaluator if there is a conflict of interest, a history of having served the individual, or if specialized knowledge is needed for the evaluation.

5. DAIL submits the evaluation to the court. If the accused and his lawyer disagree with the evaluation, they can ask the court for time to obtain a second evaluation from a different evaluator. The accused may also argue that he should not be put under Act 248 because he has not committed the act of which he is accused. In these situations, there is a hearing where the State's Attorney presents witnesses to support the state's case, and the lawyer for the accused may cross-examine the witnesses or put on witnesses who support the accused's version of events.

6. The court reviews the evaluation(s) and evidence, if any, decides whether or not to put the person under Act 248, and determines the specific conditions to include in the court order. Often, at this stage, the state's attorney, the attorney for DAIL, and the public defender agree upon and submit a proposed order to the judge for signature.

THE COURT ORDER

The court order places the person in the custody of the Commissioner of DAIL. At this point, the Developmental Disabilities Services Division (DDSD) is responsible for designating an agency to provide care, custody and habilitation to the person. DDSD generally selects the designated agency (DA) for the county where the person lives but may select a different agency if it is better suited to provide the necessary services. DDSD might also select another agency in order to provide a safe distance from the victim or because of intense community hostility.

A DDSD Public Safety Specialist serves as the **Commissioner's representative**. This person provides monitoring and oversight to assure that the court order is carried out. In special cases, such as when DDSD Public Safety Specialist has a conflict of interest in a case, a Guardian from the Office of Public Guardian (OPG) may serve the Commissioner's representative.

Most court orders include:

- an order to the person under custody to participate in treatment.
- an order to the person under custody to live where his treatment team decides.
- authorization for DAIL and/or the designated agency to make disclosures as necessary to protect public safety.
- authorization for DAIL to search the person's room or residence.
- an order to the person under custody not to drive a car, consume alcohol, or possess any weapon.
- an order permitting the person under custody to be arrested and returned to the program if they elope.

Court orders may include orders specific to the individual, such as:

- an order to have no contact with the victim or her family.
- an order to abstain from going to a particular town or school.

In some areas of supervision of the person under custody, the court order may give discretion to the Commissioner. For example, the order may allow the Commissioner to make any disclosures deemed necessary for community safety. However, in this example, although the final decision lies with the Commissioner, in practice the Commissioner's representative will arrive at a decision through consultation with the Collaborative Team.

Please note that an order under Act 248 is **not the same as a guardianship order**. An Act 248 order gives **DAIL** the authority to make decisions that affect public safety and the person's treatment for the offense, but the Department does not have authority to make decisions in areas unrelated to treatment and safety—such as medical care or financial matters. If the person under Act 248 has a guardian, the Act 248 order supersedes the guardian's authority in areas relating to public safety and treatment but the guardian retains authority in other areas, such as assuring that the individual receives proper health care. If the person under Act 248 does not have a guardian, he continues to make his own decisions about medical treatment and financial matters.

JUDICIAL REVIEW

A person under an Act 248 order may challenge the order 90 days after the date the judge signs the order (or any time thereafter).

If the individual does not ask for a review of the order, DAIL must file a request for review with the court within a year from the date the judge signed the order. Toward the end of each year, the Commissioner's representative must write an annual review, which summarizes the individual's progress and activities throughout the year, and assesses the person's continuing dangerousness. Based on the Annual Review, if the Department believes that the individual is no longer dangerous, it will ask the court for the Act 248 order to be terminated. If the Department believes that the person is still dangerous, it will ask the court to continue the order for another year as written or with modifications.

Current practice is for the review to be conducted in Family Division of the Superior Court in the county where the person currently resides. The Family Court appoints a lawyer for the individual. Ordinarily, this is a lawyer with Vermont Legal Aid's Disability Law Project (DLP). An Assistant Attorney General represents the Department.

In many cases the Department's attorney and the person's attorney agree on the continuation of the order or modifications and present them to the judge as an agreed ("stipulated") order. If the Department's attorney and the person's attorney can agree on the order, there may not need to be a hearing. If there is disagreement, there will be a hearing, and the Department is responsible for presenting witnesses to prove that the person under Act 248 is still dangerous. If the court finds that the person is still a "person in need of custody, care, and habilitation," the court will renew the Act 248 order, or modify it. If the court finds that the person is no longer in need of custody care and habilitation, it will terminate the order.

NOTICE TO LAW ENFORCEMENT

When the Department receives an order putting a person under Act 248, it sends a copy of the order to local law enforcement officials (i.e., state police, town police, sheriff) with a letter stating:

- the person is under Act 248 supervision.
- the person's address and the name of the service coordinator for the designated agency.
- the authority of the law enforcement agency to arrest and return a person to the program if he violates the court order.

The purpose of the letter is to provide for quick cooperation with law enforcement if the person is missing, or presents a danger to others. The Department revises and resends the letter every time there is a change of the person's address or there is a new Act 248 order. It is the responsibility of the designated agency to assure that the Commissioner's representative is notified of any address change so that law enforcement officials can be updated.

If a person is missing from the program or presents a danger to others, an immediate call to local law enforcement officials should be made advising them of the situation and requesting assistance. This call can be made either by staff of the designated program or by the Commissioner's representative. To date, designated programs have experienced excellent cooperation from law enforcement in the rare situations where such calls have had to be made.

(See sample letter to law enforcement at the end of this chapter.)

RESPONSIBILITIES OF THE DEVELOPMENTAL SERVICES AGENCY

The designated developmental services agency is responsible for providing care, custody, and habilitation to the person under custody as provided in the Act 248 order. Funding for supervision and support is authorized under Act 248 by the DAIL System of Care Plan (see Chapter 12: The Vermont Developmental Services System). Services also must be consistent with the DDAS Quality Services Guidelines (see Chapter 12: The Vermont Developmental Services System)

The treatment team for a person under Act 248 includes the Collaborative Team (as for other sexual offenders; see Chapter 11: The Collaborative Team) and his assigned Commissioner's representative.

In general, the treatment team has broad authority to design supervision and treatment. The responsibilities of the developmental services agency are to:

- Assure community safety. This includes protection and respect for past victims.
- Assure safety of the person under Act 248.
- Reduce or eliminate the risk of future reoffending through treatment and training.
- Increase the person's skills, independence, sense of self-worth, and ability to be a productive citizen of Vermont.

Of these goals, assuring (1) safety and (2) treatment designed to reduce the person's dangerousness are paramount.

One way for an individual to get off an Act 248 order is to demonstrate that he is now competent to stand trial and to face the original criminal charges. If this is a goal for the individual, assisting him to learn the skills he needs to be found competent should be an important part of the program that the developmental services agency provides.

VIOLATION OF ACT 248 ORDER

If a person who is under an Act 248 order violates the court order, the treatment team, including the Commissioner's representative, should meet to determine the degree of violation and how to change the program as a result of the violation. The team should respond in an individual manner, based upon assessment of the particular situation.

EXAMPLES OF CHANGES INCLUDE THE FOLLOWING:

- REDESIGN OF THE PROGRAM.
- CHANGE OF RESIDENCE.
- MORE INTENSIVE THERAPY OR SUPERVISION.
- MORE RESTRICTIONS TO PROTECT PUBLIC SAFETY.

SENDING THE PERSON TO JAIL IS NOT AN OPTION, UNLESS THE PERSON ON ACT 248 IS ARRESTED FOR A NEW CRIME OR CURRENTLY UNDER DOC SUPERVISION.

If the designated agency no longer feels able to provide safe custody, care and habilitation to the individual, the agency should notify the Department, which may select a different agency to provide services or notify the court of the safety concern.

SAMPLE LETTER TO LAW ENFORCEMENT

January 2, 2017

Station Commander
Vermont State Police
US Route 2
103 South Main Street
Waterbury, VT 05671-2101

Washington County Sheriff's Department
P. O. Box 678
Montpelier, VT 05601-0678

RE: ACT 248 Commitment of ****

Gentlemen:

Please be advised that **** is under commitment to the custody of the Commissioner of Department of Aging and Independent Living. The commitment Order was issued pursuant to 18 V.S.A. §§8839-46, which provides a mechanism to commit individuals with developmental disabilities who present a danger of harm to others to community-based programs of treatment supervised by the Commissioner. A copy of the Order is attached.

Please be advised that, while the information contained in the court Order is public, other information in this letter is confidential under the law. Please do not share information not in the court Order with anyone other than law enforcement. If you have any questions about the confidentiality of this information, please contact this office.

**** now resides at *** Street, ***, Vermont. He is supervised by Upper Valley Service. His case manager is ***, who can be reached at (802) ***-****.

Please note that the Order provides that this program is a designated program and if Mr. **** elopes from the program, he may be arrested by a law enforcement officer and returned to the program or custody of a treatment team member pursuant to 18 V.S.A. §7105.

The purpose of this letter is to notify you of the existence of the Order and provisions regarding elopement. Should the Department require your assistance in regard to an elopement, we will contact you. If you have any questions regarding this arrangement, please contact me at (802) ***-**** or after hours at (800) 642-3100. Thank you for your attention to this matter.

Sincerely,

Commissioner's Representative
Department of Aging and Independent Living

/Enclosure

cc: ****, Case Manager
****, AAG

CHAPTER 8:
GUARDIANSHIP

Parents are automatically considered the guardian for a child under 18 except when parental rights have been terminated or turned over to someone else. When a person turns 18, the law assumes that the individual is independent of his parents and is able to make decisions for himself. A person does not have to prove himself capable of making decisions upon turning 18; the law assumes capability.

This means that an individual who is 18 years or older is presumed to be capable of, among other things, signing a contract or lease, hiring and consulting with a lawyer, deciding where to live and work, consulting with a doctor or dentist and making medical decisions, and deciding who will see confidential records. The individual's parents are no longer legally responsible for taking care of him or paying his expenses, nor are they entitled to see their son's confidential records without his consent unless they are his guardian.

Vermont law provides for court-ordered guardianship because some people with developmental disabilities will be exploited or neglected if they do not have a person to support them in decision-making.

A LAWYER OR DEVELOPMENTAL SERVICES AGENCY SHOULD NOT RELEASE INFORMATION VERBALLY OR IN WRITING ABOUT A PERSON OVER 18 TO THE PERSON'S PARENTS WITHOUT CONSENT UNLESS THE PARENTS HAVE BEEN APPOINTED TO BE GUARDIAN BY A COURT.

PUBLIC AND PRIVATE GUARDIANSHIP

Vermont has two kinds of guardianship for adults with developmental disabilities:

- Private guardianship
- Public guardianship, Office of Public Guardian (OPG)

Private guardians are usually family members or friends appointed and supervised by the Probate Court. **Public guardians** for people with developmental disabilities are usually appointed by Family Court; they are staff of the DAIL Office of Public Guardian.

In both kinds of guardianship, the guardian's authority is detailed in the order of guardianship. **Guardianship orders** are public information; a copy may be obtained from the court where the order originated. The Developmental Services Agency working with a person who is under guardianship should have a copy of the guardianship order in the case file for reference.

AUTHORITY OF GUARDIANS

The authority of the guardian depends on the powers granted to the guardian by the court, which may include the ability to:

- approve and monitor the person's residence.
- select and monitor treatment and service providers.
- apply for public benefits.
- approve major sales and purchases by the person.
- approve contracts, such as leases, employment contracts, or credit card applications.
- consent to medical and dental treatment.
- approve an application for a license, such as a driver's license (Note: individuals who are under guardianship are barred by federal law from purchasing a gun).
- provide financial management (for private guardianships only).
- secure legal rights.

Guardians are responsible for listening to the wishes and preferences of the person for whom they are guardian. The guardian helps the person live the life he chooses for himself. When a person is able to make a decision or take an action for himself, the guardian should not interfere. **One of the most difficult tasks of being a guardian is to recognize when a person is able to and should make his or her own decisions.**

Guardians are responsible for monitoring and taking action to ensure that a client is not exploited, neglected, or abused; that his health and welfare is protected; and that his legal and human rights are secure.

GUARDIANSHIP AND PERSONS WITH DD/PSB

Serving as guardian for a person with DD/PSB can present enormous role conflicts. Respecting a person's desire to live the life they choose can come into direct conflict with keeping the person from legal jeopardy or from hurting someone.

To be effective, a guardian must develop knowledge about best practices in the supervision and treatment of persons with DD/PSB. Service providers should offer training and orientation activities to guardians and should not assume that the guardian is already familiar with the principles of supervision and treatment of persons with DD/PSB.

The guardian must have a solid understanding of the individual's risk of reoffending. Thus, the guardian will need assistance in learning about best practices in evaluating individual risk. When a person has had a psychosexual evaluation, the guardian should understand (1) how the assessment was conducted and (2) the results of the assessment (see Chapter 14: Assessment and Psychosexual Examinations). The guardian, no less than program staff, will base decisions upon the assessment results. The guardian should meet with the evaluator and receive an in-depth explanation of the results. This meeting can be held with the person evaluated present or separately. If the guardian believes the assessment results are not valid, the guardian is responsible for seeking a new assessment.

When appropriate, a guardian should serve as the person's advocate to maximize services or benefits. For instance, supervision and treatment programs for individuals who have committed sexually abusive acts often involve curtailment of rights and privileges that are taken for granted by most American citizens. The guardian must skillfully evaluate whether or not the curtailment of rights proposed for an individual are based on solid clinical practice and are justified to manage the individual's risk of reoffending. In addition, a guardian is responsible for assessing whether or not the person's treatment program is effective. If the guardian does not think the treatment program is effective, the guardian should seek to improve it or request a different treatment program.

A treatment program should always include the person's guardian as part of the Collaborative Team. If the program feels there is a conflict of interest, this should be brought to the attention of the court that appointed the guardian (or, in the case of a Public Guardian, to the attention of the program director).

THE GUARDIAN'S ROLE AND THE COURT'S ROLE

If an individual with DD/PSB has been adjudicated and is in the custody of Corrections, many decisions that would otherwise belong to the guardian or the individual are decided by court order or the Department of Corrections. Any specific condition stated in a court order supersedes the authority of a guardian. For instance, if a court order states that a person must live in Washington County, the guardian cannot move him to another county.

Most decisions that are related to the person's rehabilitation, supervision, and treatment are made by the Corrections Department for people under their custody. However, the guardian can still make decisions in areas they have been granted authority by the court, such as medical treatment and finances, which are not determined by Corrections. For instance, a doctor at the Correctional Facility may recommend a psychotropic drug to help a person control his anxiety. The guardian must determine that the potential benefits of the medicine outweigh the risks and consent to the administration of such a medicine.

Similarly, an Act 248 order gives the Commissioner of DAIL the authority to make decisions that affect public safety and the person's treatment for the offense, but the Department does not have authority to make decisions in areas unrelated to treatment and safety--such as medical care or financial matters. If the person under Act 248 has a guardian, the Department's authority supersedes the guardian's authority in areas relating to public safety and treatment but the guardian retains authority in other areas granted by the court, such as assuring that the individual receives proper health care.

CHAPTER 9:
LAWYERS' ROLES

Several different attorneys may be involved with a person with DD/PSB over time. While the lawyers involved and the judge are usually clear about each attorney's role, the jobs and responsibilities of the various lawyers may be confusing to the person with DD/PSB, the family, the person who was victimized, the guardian, and the developmental services program staff. This section details the responsibilities of the different lawyers who may be involved with a person with DD/PSB or with one of his cases.

STATE'S ATTORNEY

When a person is accused of a crime, the State's Attorney is responsible for prosecuting the case, that is, to bring forward to the court the facts that show that the person is guilty. She must represent the perspective of the person who was victimized and the interests of society in protecting itself against crime and punishing crime. If there is not enough evidence to show that the person is guilty, the State's Attorney must notify the court; the State's Attorney should never knowingly take part in the prosecution of an innocent person.

Developmental services staff should keep in mind that the interest of the State's Attorney may be adverse to that of the accused individual. Confidential information should not be released to the State's Attorney without consent from the individual, his guardian, or his attorney (see Chapter 19: Confidentiality and Release of Information).

If an individual is found incompetent to stand trial, the State's Attorney files a petition in District Court requesting commitment under the mental health commitment laws or under Act 248 and handles the state's side of the case until the order is signed; otherwise, the case is dismissed.

The State's attorney usually represents the state's position in delinquency petitions or on a petition for custody by the Department for Children and Families (DCF) or when someone has been accused of abusing or neglecting a child.

If a petition for a public guardian has been submitted for an individual, the State's Attorney is responsible for filing the petition in Family Court and presenting the petitioner's side of the case to the court.

VICTIM ASSISTANT AND VICTIM REPRESENTATIVES

The Victim Assistance Program was created by the Vermont Legislature. The program supports crime victims while their cases move through the criminal justice system. The Victim Advocate is responsible for helping crime victims understand the court process and supporting victims through that process. Victim Advocates are located in each county's State's Attorney's Office and in the Attorney General's Office. In general, the Victim Advocate is not an attorney, but works with the State's Attorney or Attorney General. The Victim Advocate provides support to the victim, makes certain that the victim knows what is happening in the case, and helps the victim's voice to be heard. (See Chapter 10: Respect and Protection for Victims for more information.)

Sometimes the victim will have her own lawyer. The **Disability Law Project**, which is discussed later in this section, may represent a victim with developmental disabilities in a criminal case if it believes the victim needs specialized representation. Additionally, it may represent the victim to seek a restraining order.

OFFICE OF THE ATTORNEY GENERAL

Occasionally a lawyer on the staff of the Vermont Attorney General assumes the responsibilities for prosecuting a case instead of the State's Attorney. This may occur in cases involving:

- Medicaid fraud or abuse/neglect of a person while the person was receiving Medicaid-funded services.
- high-profile cases of child abuse or abuse of an elderly or disabled person.

Developmental services staff should keep in mind that the interest of the Attorney General may be adverse to that of the accused individual. Confidential information should not be released to the Attorney General without consent from the individual, his guardian, or his attorney.

Lawyers from the Attorney General's office also represent DAIL in Act 248 annual reviews. Lawyers for DAIL are authorized to receive confidential client information for people who are committed to the Department under Act 248 or who are under the Department's guardianship.

PUBLIC DEFENDER

Public defenders are available in each county to provide representation to people accused of a crime who but cannot afford to hire a lawyer. The person accused of a crime is referred to as "the accused" or "the defendant." Some public defenders are on the staff of the Vermont Defender General; others are in private practice and receive state funding to represent indigent defendants. Public defenders cannot choose their clients; they are appointed by the court on a case-by-case basis.

The public defender is responsible for explaining to the accused person the criminal process (what will happen next) and the person's options at any given point. If the public defender has difficulty communicating with her client or thinks the person does not understand, she may ask the court for a competency evaluation. Sometimes a defendant may want to have someone he knows well sit in on the interview to help with communication. Some public defenders welcome this support and others believe it interferes with the privacy of confidential attorney/client communication.

If the defendant has had a competency evaluation, the public defender represents the person at the competency hearing. If there is a petition for Act 248, the public defender represents the person at the initial commitment hearing (but not at the annual review).

The public defender's sole allegiance is to the accused person. While she may accept suggestions about what is in the best interest of the accused person, ultimately, the public defender will make the decision together with the defendant. The public defender may realize that the client is a dangerous person but protecting public safety is not the public defender's job.

VERMONT LEGAL AID/DISABILITY LAW PROJECT

The Disability Law Project (DLP) is a part of Vermont Legal Aid that specializes in the legal rights of people with disabilities.

Staff attorneys for the DLP represent people under Act 248 who want to challenge their order, and/or who are up for their annual order review. The staff attorney assists the person to understand the Act 248 Family Court review process and represents the person in the process. The DLP attorney will meet privately with the person with DD/PSB, and may need assistance from program staff to devise a safe setting for the meeting. The person with DD/PSB decides whether or not to challenge the continuation of the Act 248 order in consultation with his DLP attorney. If the person with DD/PSB wants to challenge the Act 248 order, the DLP attorney may request an independent evaluation of the person.

DLP attorneys may ask developmental services program staff about the program or services for a person under Act 248. Staff should remember that the DLP attorney represents the individual's liberty interests and may not have the same interests as the program staff. With authorization from the individual (or guardian), DLP attorneys are entitled to review the records of a person they represent and speak with developmental services staff.

DLP attorneys also represent people with DD/PSB in public guardianship cases in Family Court, as well as in many private guardianship cases. The DLP attorney meets with the person with DD/PSB, explains the guardianship process to him, and determines whether or not the person wants a guardian. Sometimes DLP employs a paralegal for the interview process. It is the DLP attorney's responsibility to represent the person's wishes, even if others disagree as to what is the individual's best interest.

If a client lacks the ability to comprehend what his attorney is telling him and to make decisions, and the DLP attorney cannot communicate well enough with the client to determine his wishes, the attorney will ask the court to appoint a **guardian ad litem**. This is a volunteer who investigates the case and makes a recommendation to the lawyer and the court about what would be in the best interest of the individual.

Staff attorneys for the DLP may assist public defenders when defendants with disabilities need accommodations in the court procedure or when a disability has a bearing on the criminal case. They may also represent persons with DD/PSB who

are under supervision of Corrections to get accommodations in programming when necessary, often in conjunction with the Prisoners' Rights Office.

The Disability Law Project gives free representation to Vermonters with disabilities in a wide range of cases where they need a lawyer to protect their rights, such as special education, public benefits, discrimination, and parental rights. Developmental services staff and guardians should assist people who want to talk confidentially to a lawyer to contact the Disability Law Project.

CONFLICT OF INTEREST

If the Public Defender or Vermont Legal Aid has previously represented someone on the other side of the case (such as the victim or a member of the victim's family), they are responsible for notifying the court that they have a conflict of interest. The court will appoint a private attorney to take the place of the Public Defender or Vermont Legal Aid if there is a conflict.

PART THREE

RESPECT AND PROTECTION FOR VICTIMS

CHAPTER 10:
RESPECT AND PROTECTION FOR INDIVIDUALS WHO HAVE BEEN SEXUALLY VICTIMIZED

It is important for staff and others who support people with DD/PSB to model and demonstrate respect for victims and their families. Two important goals of programs that work with persons with DD/PBS are the safety and protection of individuals who have been sexually victimized, and the prevention of future victimization. These circumstances present particular challenges for staff, as they must be able to consider the needs of victims, as well as the needs of the person with DD/PSB who engaged in the abusive behaviors.

While persons who have been victimized need to be protected from further acts of violence, they also require support and guidance in dealing with the physical, emotional, psychological, and at times financial consequences of the sexual abuse they have experienced. In addition, persons who have suffered sexual abuse may also need assistance and support in developing a comprehensive safety plan, including access to information about the status and whereabouts of the person with DD/PSB, and the prevention of contact, if so desired or as stipulated by court order.

INDIVIDUALS WITH DD/PSB AS VICTIMS

In working with a person with DD/PSB, it is important to keep in mind the significant likelihood that at some point in his life, the individual that committed abusive acts may have also been a victim of abuse. To be clear, experiencing abuse does not *cause* sexually assaultive behavior in the vast majority of people (Paolucci et al., 2001; Salter et al., 2003; Whitaker et al. 2008). While treatment focuses on the sexually abusive behaviors, effective treatment depends upon the understanding and integration of the abusing individual's own abuse history, including psychological and emotional impacts, in the design and implementation of any treatment and supervision plan. (For more information on victimization of persons with DD/PSB, see Chapter 1: What is "Developmental Disability"?)

VICTIM SERVICES

People who support persons with DD/PSB benefit from being aware of statewide and regional victim service providers. In Vermont, victim services can be broadly divided into three basic categories, as follows:

1. **Victim advocates in the Prosecutors' Offices**. The State's Attorney in each county, and the Vermont Attorney General, each has at least one Victim Advocate. Victim advocates provide victim support and guidance throughout the criminal justice process, and act as liaison between victims and the State's Attorneys and other criminal justice agencies. Victim advocates also help victims to better understand their rights, and provide assistance in navigating the complexities of the criminal justice system. Advocates also provide victims with information and updates regarding their case, as well as support and assist victims as they prepare for testimony and/or complete Victim Impact Statements. Victim advocates are also instrumental in helping victims access additional resources and services, such as Victim's Compensation, registration with the Vermont Automated Notification System (VANS) program, and applying for protection orders.

   In Vermont, victim advocates have differing levels of confidentiality. State-based victim advocates are NOT CONFIDENTIAL. Victims need to be aware that information they share with State Advocates can be shared with the State's Attorney, Attorney General, and may even be compelled to share with defense council and the court.

2. **Victim Services Specialists in the Department of Corrections**. Victim Services Specialists (VSS) are employed by the Department of Corrections (DOC), and like State's Attorney's Advocates, they also act as victim liaisons between victims and the DOC. VSS works with crime victims when the offender is in the custody or under the supervision of the DOC. VSS provide ongoing support and information to victims throughout the supervision process. In addition to providing victims with offender case updates, VSS also provide victims with information about opportunities where they may provide input or directly participate in DOC processes, such as at parole board hearings. VSS also help victims identify needs, and coordinate related services with other partner agencies and community-based victim service providers. As post-adjudication victim providers, DOC VSS are also able to provide specialized restorative-justice based services for victims, such as the Apology Letter Bank and the Victim-Offender Dialogue program. In addition to direct service with

victims, VSS also provide consultative services to DOC casework staff, assisting with the integration of victim-informed best practices. The DOC Victim Services Unit also houses and manages the VANS program, which provides offender custody status information to registered victims—providing a critical piece of a victim's on-going safety plan.

3. **Local Domestic Violence and Sexual Assault Programs**. Local, community-based, non-profit sexual assault and domestic violence centers in Vermont provide voluntary, confidential crisis services, along with other forms of support and information, to victims of sexual assault and violence. Information shared with center advocacy staff *is CONFIDENTIAL*. Victims can receive therapy, assistance with protection orders, and other legal and support services from these programs without first having to report the crime to the police, or become involved in a criminal prosecution. Most community victim service providers adhere to a victim empowerment model, meaning they promote victim choice and resourcefulness by providing, facilitating and supporting victims of violence to access services and make choices, thereby building their own individual capacity for self-efficacy and autonomy.

In addition to these three programs, there are **specialized support programs for victims with disabilities**. These include:

- **Adult Protective Services (APS)**. An office within DAIL. APS staff investigate complaints of abuse, neglect, and exploitation of vulnerable adults. As part of their investigation, they often intervene to protect the victim and prevent future abuse. 1-800-564-1612 or 1-800-241-0512.

- **Green Mountain Self-Advocates (GMSA)** – Statewide self-advocacy network run and operated by people with developmental disabilities. It can provide peer support to victims of sexual abuse. 1-800-564-9990 (in VT) or 1-802-229-2600, or gmsavt.org.

- **Deaf Victims Advocacy Services** – Provides a rich summary of resources. 1-802-661-4091 or www.dvas.org.

- **Vermont Communication Support Project** – Provides communication assistance to people with developmental disabilities whose communication deficits interfere with their access to the justice system. 1-888-686-8277 or www.disbilitiyrightsvt.org. More information on Communication Specialists (CSs) appears later in this chapter.

COLLABORATION AMONG VICTIM SERVICES AND PROGRAMS FOR INDIVIDUALS WITH DD/PSB

A victim-centered approach to supervision and treatment of people with DD/PSB is vital. The trauma suffered by the victim should be addressed as part of the treatment program for the person who used abusive behaviors. This practice places a high value upon each individual victim's self-identified needs and interests. Developing a collaborative relationship between victim assistance programs and programs for people with DD/PSB can be a helpful partnership in this regard.

Victim advocates, in particular, often occupy a uniquely valuable position. Usually, it is the victim advocate that has built a trusting relationship with the victim and has the most comprehensive information regarding victim's needs and desires. With a victim's express permission, advocates can be a helpful resource in integrating the victim's needs into the case management process. When appropriate, and in harmony with the victim's wishes, victim advocates may be helpful in coordinating victim involvement. In adjudicated cases, **Victim Impact Statements** can also be a useful tool to include, as they often detail the level of trauma experienced by the victim and provide unique insight into both the victim's needs as well as their individual definition of justice. Victim Impact Statements are discoverable by defendants upon submission to the state's attorneys' office. They become public documents if they are filed with the court.

The victim's need for privacy and safety is a paramount concern. The acquisition of specific offense information and details must be obtained in the most victim-sensitive and trauma-informed way possible. For example, using an offending individual's self-disclosures, coupled with documents that are publically available (e.g., police affidavits) can form a strong foundation in an individual's comprehensive case plan and do not require contacting the victim. In this way, those working with persons with DD/PSB may be able to create a responsive and relevant plan that prevents future harm, while simultaneously respecting and supporting the needs of the person that has been most harmed, the victim.

Part of treatment may include some type of apology to the victim. This is sometimes referred to as a "**clarification**." Individuals whose cases have been adjudicated, and who are in custody or under the supervision of the DOC are able to submit letters to the Apology Letter Bank, where they will be securely housed in case the victim requests such communication. DOC VSS provides additional specialized restorative-justice based services for victims, such as the Victim-

Offender Dialogue program. In any case, the person with DD/PSB or members of his treatment team should not contact the victim about whether to have or how to handle an apology or a victim-offender dialogue. These services should be provided only at the victim's request. Ideally, a victim advocate, such as a DOC VSS or a victim's therapist, would help facilitate such services.

The victim perspective should be kept in mind whenever any decisions are made about case management, especially in areas concerning the level and type of supervision. For instance, if a victim is a client in the same agency where the person with DD/PSB is being served, a victim-centered approach is meant to ensure that the victim is not exposed to incidental contact or confronted by the abuser. Case managers of both parties need to be made aware of this possibility, and treatment teams should use extreme caution in scheduling appointments at agency offices. In this case, the agency must first and foremost protect the rights of the victim to not have contact with the person that has caused them harm. The "right" to be in the agency is forfeited by the person who has committed the abusive acts if the victim also receives supports from the agency. Similarly, if the victim is a staff member, he or she shall retain the right to remain free from unwanted/unanticipated contact with the person who has caused them harm, even at the workplace.

NOTIFICATION OF VICTIMS

Victims in Vermont have the right to be notified when an offender is being released from custody, or when there is a change in an offender's custody status. This information is provided in order to maintain the victim's safety. (For limitations upon disclosure, see Chapter 20: Disclosure for Safety and Treatment.)

Release or custody change notification is provided through VANS, the Vermont Automated Notification System, a program of the Vermont Department of Corrections. Victims who are registered in VANS are often contacted by DOC casework or Victim Services staff prior to the offender's release date in order to provide them with an opportunity to share any concerns they may wish to have considered as part of the release planning process.

Victims are able to decide how they wish to receive VANS notifications - by phone and/or email. In certain limited circumstances, notification will take place in person.

For more information about VANS registration and notifications, please visit the Vermont Department of Corrections Victim Services webpage: www.doc.state.vt.us/victim-services or call (888) 810-1847.

VICTIMS' EXPERIENCES WITH THE JUDICIAL PROCESS

TESTIFYING

Following are some of the common difficulties any victim may face when involved in the criminal justice system:

- Remembering the details of the crime
- Fear of testifying in front of the defendant
- Embarrassment over being a victim
- Fear of what people will think of them
- Family pressures about testifying
- Rage
- Anger at the criminal justice system and how they have been treated
- Confusion about what is happening at any given time in the case
- Transportation problems
- Loss of wages from work
- Fear around safety
- Multiple delays in proceedings
- Loss of autonomy
- Ambivalence about testifying
- Re-experiencing trauma

In addition to the difficulties just mentioned, victims with DD may have the additional difficulties because of their developmental delays:

- They may be especially vulnerable, easily manipulated or tricked.
- They may not be able to recall specific details, such as the time of day or exact location of the crime, or even general details, such as the date, month, or town where the crime occurred.
- They may be unable to recall details previously disclosed, relate information accurately or in a chronological order, or may become easily confused or frustrated while providing testimony.
- They may not have verbal abilities.

- They may not be able to read or write.
- They may find it difficult to understand what is happening in the criminal justice system.
- They may feel that they are disappointing legal counsel or support persons in attendance and begin to "shut-down."
- The defense attorney may easily confuse them.
- Most important, they may not be aware that they have been victimized. (Depending on the level of disability, some people have many caretakers who have to put their hands on them during the course of helping them. There may be confusion about sexual touch or little or no knowledge of sexuality).

Many prosecutors have not received specific training, and thereby do not know how to interview victims with DD. Victim testimony therefore may be confusing and make the case presentation more challenging. The prosecutor may assume that a jury will not believe a victim because he or she cannot "get the facts straight," or may fear that the defense attorney will easily confuse or coax the victim to say something that is not true. Victim advocates or a victim's attorney can be instrumental in identifying needs and coordinating the services of a Communication Specialist to assist with victim communication throughout criminal proceedings, or to make other court-related accommodations.

COMMUNICATION SPECIALIST (CS)

A Communication Specialist, provided by the Vermont Communication Support Project, is qualified to assist a victim with communication during the interview process, depositions, court testimony and proceedings. A CS provides services analogous to those provided by an ASL interpreter for a person with a hearing impairment. The CS has training and experience in communication with persons with DD in order to effectively assist victims in relaying what happened, and understanding the court process and what is being said to them. The CS restates the question or information in a way that the victim can understand. The CS will not change the victim's story.

VERMONT COMMUNICATION SUPPORT PROJECT

Provides communication assistance to people with DD whose communication deficits interfere with their access to the justice system. 1-888-686-8277.

The court usually appoints a CS upon the request of one of the parties and a finding that it is necessary, although a formal court appointment is not necessary for a CS to provide services to a victim. Sometimes, several meetings with the victim are necessary to ensure that she is knowledgeable about what is being said and what is happening. This way, she can participate fully and make her wishes known. Once appointed, a CS should be available to accompany the victim at all proceedings in which the victim's presence is required. To make a referral, contact the Vermont Communication Support Project at 1-888-686-8277.

A comprehensive list of Vermont victim resources is made available through the Vermont Center for Crime Victim Services and available online at: www.ccvs.state.vt.us/resource-directory.

PART FOUR

SUPERVISION SYSTEMS: SEPARATE ROLES; COLLABORATIVE ACTION

CHAPTER 11:
THE COLLABORATIVE TEAM

PURPOSE OF THE COLLABORATIVE TEAM

A Collaborative Team consists of the key individuals who interact with the person with DD/PSB. They work to meet his needs and to protect the community. The team is critical for both supervision (to protect the public) and treatment.

Supervision and treatment are closely intertwined; one cannot work well without the other. Supervision without treatment may simply restrict the individual and not provide him with the chance of learning new skills or of lowering the risk of reoffending. When treatment is added to the mix, an opportunity is created for the person to learn and practice new social skills and healthy ways of thinking about sexuality. Treatment without supervision creates risk for the community. The person with DD/PSB cannot be expected to behave appropriately without supervision until he has learned and incorporated risk management skills into his daily life. And change is not easy. It can take time.

THE PERSON WITH DD/PSB SHOULD ATTEND TEAM MEETINGS AND IS CONSIDERED A PART OF THE TEAM. THIS TEAM SHOULD BE VIEWED AS SUPPORTING THE NOTION OF COMMUNITY SAFETY, WITH PERSON WITH DD/PSB BEING ONE PART OF THE TEAM, RATHER THAN JUST BEING HIS SUPPORT TEAM.

SOMETIMES, THE PERSON WITH DD/PSB WILL ATTEND JUST PART OF THE MEETING EITHER BECAUSE OF SHORT ATTENTION OR BECAUSE OTHER TEAM MEMBERS NEED TIME TO DISCUSS AN ISSUE WITHOUT HIM BEING PRESENT.

MEMBERS OF THE TEAM

A Collaborative Team should include any of the following key people who work with the person with DD/PSB:

- Developmental Services Program (DSP) services coordinator
- Legal guardian
- Community access worker
- Employment consultant and/or job coach
- Home provider (HP)
- Therapist
- Psychiatrist
- Correctional Services Specialist (CSS)
- Special education/school representative
- Department for Children and Families (DCF) caseworker

Family members and victim representatives may be included in the team. The clinical director of the DS agency (if one exists) should be on the team if the person's treatment or supervision presents particularly complex issues.

Ideally, this team should be created prior to the transition of the person with DD/PSB to the agency. Regular meetings should be held to ensure a smooth and comprehensive transition. The team's mission or purpose is documented in the Individual Support Agreement (ISA), written by the offender and the team.

When the team first forms, there should be discussion about ground rules, such as sharing (or confidentiality) of information with individuals outside the group, expectations about attendance and being on time, meeting times and length, responsibility for notes or minutes, and communication between meetings.

Like any well-functioning team, the team needs a facilitator who is responsible for seeing that the views of all members are voiced and heard and helping the team to move on if it gets stuck on a particular subject. Without a facilitator, it is most common for the most extroverted or forceful members of the team to dominate the conversation, and the valuable knowledge and opinions of other team members are lost. The facilitator is typically responsible for making sure that there is agreement about the agenda, keeping the meeting to the agreed-upon time frame, and summarizing decisions of the team. The role of facilitator can be assumed by a single person or rotated among the group.

All information should be shared among team members (see Chapter 13: Supervision by the Department of Corrections for reasons why this is important). In addition to keeping the person with DD/PSB and the community safe, sharing information can be useful in meeting the needs of the person in ways not related to offending, e.g., obtaining the skills needed to perform a job, learning how to read, and improving social skills. If the person with DD/PSB is in school, team members should be willing to attend Individualized Education Program (IEP) meetings. They should also be willing to attend any meetings in a correctional center when the individual is transitioning out into the community.

THE INDIVIDUAL SUPPORT AGREEMENT

It is critical for members of the team to come to agreement about the basic mission and goals of the team. For a person with DD/PSB who is receiving developmental services, the Individual Support Agreement (ISA) offers a systematic way for the team to discuss and agree upon goals and supports.

The ISA details the goals of the person with DD/PSB, which, ideally, should include participation in treatment without further offenses. Supports and outcomes should be defined clearly and listed on the ISA.

The ISA mechanism drives the team, along with input from the therapist working with the person with DD/PSB. The whole team, including the person with DD/PSB, must work to develop the ISA. This way, all members will be invested in the plan and offer their full support. Without full support, there is a good chance that the team will fail in its mission. (For more information on the ISA, see Chapter 12: The Vermont Developmental Services System.)

WHAT MAKES AN EFFECTIVE TEAM?

A team is effective when all members:

- share all information.
- work as a member of a team.
- understand that protection of the community is the responsibility of the team.
- are comfortable in working with persons with DD/PSB and holding them accountable for their behavior.
- are comfortable discussing sex.
- are reasonably comfortable with their own and others' sexuality.
- are knowledgeable about sexual abusing behaviors.
- are knowledgeable about a victim-centered approach and how to apply it.
- maintain objectivity.
- cope with stress.
- set boundaries.
- are assertive.
- are flexible.
- are willing and available to engage in required training.
- understand the legal requirements for the person with DD/PSB and the team (for instance a court order, statutory registration, legal duty to warn, mandated reporting).

FREQUENCY OF MEETINGS

Meetings should be scheduled regularly. The frequency of meetings will depend upon the risk level of the person with DD/PSB. In the case of an individual who is at high risk, meetings of core team members typically are held at least once per month. All members should be held to a high standard of attendance at meetings. It is imperative that the person with DD/PSB knows that all team members support the plan and take the responsibility seriously.

Strict attendance also means that all members will have the same information at any given time. There is a risk that the person with DD/PSB may manipulate the situation, or "split" the team, if they realize that any team member is not "in the loop."

DEALING WITH CONFLICTING VALUES

Reconciling the conflicting values of team members can be difficult, but is necessary. As mentioned, members should be comfortable with their own (and others') sexuality and in openly discussing sexual matters. They must understand that the two most important items the team must confront are community safety and services to reduce reoffense risk. Team members who cannot understand or accept this point of view may need to be replaced. It is important to present a supportive, unified, solid front when working with the person with DD/PSB.

The issue of open sharing of lapse behavior through the team process can be particularly difficult because it may lead to sanctions or a return to prison. Often a family member, shared living provider (SLP), guardian, or the person with DD/PSB himself will withhold information, which would lead to sanctions. At other times, they may withhold information simply because they are unsure of the consequences of sharing the information. From the beginning, teams should discuss why sharing all information is crucial for treatment and community safety and which types of lapse behavior will lead to which consequences. The risks of sharing information about lapse behavior should be acknowledged. This issue should be revisited periodically.

Self-evaluation and a willingness to look at one's own beliefs, feelings, and behaviors should be a regular part of the team's business. Team members will deal routinely with a variety of emotionally charged issues when addressing offending tactics, such as attempted domination and intimidation, anger, aggression,

depression, and self-defeating behaviors as well as contending with dysfunctional families, victim issues and ongoing risk assessment. Team members should be aware that sometimes teams working with persons with DD/PSB mirror some of the same dysfunctional behaviors the person may exhibit, such as splitting and manipulation. It is crucial for each team member to take good care of himself physically and emotionally.

DEALING WITH DIFFICULT TEAM MEMBERS

The skills and expectations for effective team members are very high. Frequently, important members of the team (i.e., family members, shared living providers, the offender) lack the experience or skills to be effective team members. For these individuals, coaching before and outside of the team meetings is essential.

The coaching role is typically assumed by the service coordinator or CSS, but it may be assumed by the therapist or another team member. Coaching may consist of explaining basic principles of treatment and supervision for persons with DD/PSB, which are new to this person but well-known to other team members. Coaching may also involve role playing, assisting the team member to verbalize thoughts and feelings, discussing in advance issues that may arise at the meeting, or providing the team member with direct feedback about why certain behavior is disruptive or distracting. Within the meeting, the inexperienced team member may be partnered with a more experienced team member who will provide coaching during the meeting.

If a professional member of the team, such as the service coordinator, school representative, or CSS, is not cooperating with the expectations and ground rules for team members, another member of the team should assume responsibility for giving the person feedback and offer coaching. If the professional member does not respond and his or her conduct continues to divide or distract the team, the team member's supervisor should be approached. If the therapist is not following the expectations and ground rules for the team, team members should give the therapist feedback; if the therapist is not willing or able to change, a different therapist should be chosen.

CHAPTER 12:
THE VERMONT
DEVELOPMENTAL SERVICES SYSTEM

The Developmental Disabilities Services Division (DDSD) plans, coordinates, administers, monitors, and evaluates services for people with developmental disabilities (DD) and their families in Vermont. DDSD is part of the Department of Disabilities, Aging and Independent Living (DAIL). The main office of DDSD is in the State Office Complex in Waterbury, Vermont.

Developmental Service Programs (DSP) services and supports are developed and delivered in accordance with the Vermont Developmental Disabilities Act of 1996. All DSP services for people with DD are provided in local communities throughout the state. Services include intake and assessment, service coordination, residential supports, community supports, work supports, clinical services, communication supports, crisis supports, respite and family supports.

DAIL designates one **Designated Agency (DA**) in each county of the state as responsible for ensuring these services are available. Some DAs serve more than one county and constitute a geographic service region.

The responsibilities of a DA include the following:

- Receiving and acting upon referrals and applications for services.
- Informing applicants and service recipients of their rights.
- Assuring an individualized person-centered service plan is developed for each recipient, i.e., an Individual Support Agreement (ISA).
- Responding to consumer satisfaction information, complaints and grievances.
- Providing crisis services for any eligible person in the geographic area.
- Evaluating and addressing training needs.
- Developing a comprehensive services network and assuring the capacity to meet the needs and desired outcomes of eligible people in the region.
- Monitoring data and reporting it to DAIL.

In addition, there are four **Specialized Service Agencies (SSAs)** that provide specialized, comprehensive services to selected individuals but do not have broader regional responsibilities. Some persons with DD/PSB receive supervision and support from DAs and others receive support from SSAs. Once a person is receiving services, there is no difference in services, funding, or oversight between an SSA and a DA. There are ten DAs, four SSAs and one contracted provider in Vermont. All of these are private, non-profit providers. (See the list of Vermont Developmental Service Agencies in Appendix A.)

A person with a developmental disability and/or his family may also choose **self-managed supports**, wherein the person or family manages the funds to pay for necessary supports with the oversight of the local DA and monies being passed through a fiscal intermediary. Self-managed supports are not suitable for sex offenders.

APPLYING FOR SERVICES

Any person who believes he or she has a developmental disability, or is a family member or guardian of a person with DD, may apply for developmental services programs. A one-page application form must be completed (available from DAIL) and filed at the DA for the geographic area where the person with DD resides (see provider map in Appendix B). The DA will help any applicant who needs assistance in completing the form.

Upon receiving a completed application, the DA screens the paperwork for any emergency needs. If there is no emergency, the DA conducts an assessment to answer the following questions:

- Does the person have a developmental disability as defined by law?
- What does the person need?
- Does the person's situation meet the criteria for receiving services or funding defined in the System of Care Plan (see next section)?
- What are the financial resources of the person?

The DA should give a written decision on the application within 45 days (or earlier if there is an emergency).

ELIGIBILITY FOR DEVELOPMENTAL SERVICES IN VERMONT

Eligibility for receiving developmental services is defined in the Developmental Disabilities Act of 1996[3] and in regulations of the Department.[4] For adults, a person must (1) have a developmental disability and (2) be a resident of Vermont.

To "have a developmental disability," a person must have **intellectual disability** or a **pervasive developmental disorder**, which occurred before age 18, and also substantial deficits in adaptive behavior which occurred before age 18. These terms are defined in greater detail in the regulations.

A person has a developmental disability if he or she has:

- a full scale IQ of 70 or below on a standard IQ test for adults **or**
- a diagnosis of pervasive developmental disorder by a psychiatrist or psychologist

and *(in either case)*

- significant (lower than 99 per cent of Americans of the same age) deficits in adaptive function in two or more major life activities as measured on a standardized test of adaptive behavior.

Detailed information about how "developmental disability" is determined is contained in Section 2 of the Department's Regulations Implementing the Vermont Developmental Disabilities Act of 1996 (available on-line at: http://www.ddmhs.state.vt.us/legislation/legislation.html).

Every three years, DAIL adopts a plan—the **System of Care Plan**—describing the nature, extent, allocation, and timing of services that will be provided to people with DD and their families with state and federal funds. The plan is revised annually based upon fiscal resources and program priorities.

Criteria for receiving funding for developmental services are in the System of Care Plan. This plan defines the circumstances for which funding can be used to meet the needs of new and existing clients. As these priorities may change annually,

[3] Developmental Disabilities Act of 1996, 18 V.S.A. §§8721 et seq.

[4] Division of Disability and Aging Services, Vermont Department of Aging and Independent Living (2011, March). Regulations Implementing the Developmental Disabilities Act of 1996, Sections 1.01 – 1.20.

reference should be made to the most current System of Care Plan, which is always available at the DAIL Web site (http://dail.vermont.gov/).
Current priorities include funding to:

- prevent an adult from imminent risk to personal health and safety.
- provide training for parents with developmental disabilities.
- prevent or end institutionalization (defined as Vermont Psychiatric Care Hospital [VPCH], psychiatric hospitals, intermediate care facilities [ICFs/MR], and nursing homes).
- prevent or end institutionalization to a nursing facility.
- provide employment supports for adults 19 through 26 who are out of school.
- prevent an adult who poses a risk to public safety from endangering others (although this "does not substitute/replace Corrections supervision" for people who have committed and have been convicted of a crime.[5])

This last public safety category can include:

- individuals who have maxed out a corrections sentence and pose a public safety risk.
- individuals who were substantiated for abuse by DCF or APS or otherwise known to have committed a dangerous act but who were not prosecuted.
- young adults who were in DCF custody because of offending and are aging out of DCF custody.
- individuals under community supervision of Department of Corrections.

If an individual is under DOC supervision, DSP funding will pay for supports related to the person's disabilities; DOC is expected to take responsibility for supervision for community safety. A person who has been charged with a crime and whose case is still pending is not eligible for funding relating to public safety concerns.

NOTE: **IF AN INDIVIDUAL IS NOT ELIGIBLE FOR DEVELOPMENTAL SERVICES PROGRAMS, THERE ARE MANY OTHER RESOURCES. SEE CHAPTER 25: RESOURCES.**

[5] Vermont State System of Care Plan for Developmental Services, Three Year Plan FY 2015-FY 2017, p. 21 (2014).

The System of Care Plan states that DSP funding cannot be used for institutional placements, residential schools/treatment centers, or to develop new congregate residences with more than four beds.[6] There is a current exemption for out of state placements for adults who pose a public safety risk when no equivalent level of support can be provided in state.

PAYING FOR DEVELOPMENTAL SERVICES

Nearly all developmental services in Vermont are paid for by a combination of federal and state funds through Vermont's Home and Community-based Waiver (HCBW) program. This program allows Medicaid funds to be spent flexibly in community settings to keep people safe and out of nursing homes and state institutions for people with intellectual disability (such as the former Brandon Training School, closed in 1993).

Of every dollar spent on services, about 55-60 cents comes from the federal government, and 40-45 cents comes from the Vermont legislature. At present, the federal government matches all state expenditures. Thus, the limit on funding is based upon the annual allocation from the Legislature.

Most people with developmental disabilities have a long term, even lifetime need for services and supports. In recent years, there have been more people seeking new services than the number of persons leaving because of moving, becoming independent, or dying. Thus, the only way to fund new needs or new clients is by increasing funds from the Legislature or by cutting existing services. As mentioned previously, the System of Care Plan is designed to describe on an annual basis how much funding is available and what the priorities for funding will be.
A person who is eligible and in need of services which meet a System of Care Plan priority will receive from the DA an **authorized funding limit (AFL)** which describes the types of services that can be funded for the person and the amount of money available to pay for each service. The person and the person's Collaborative Team will then come together to determine what program will best meet the person's needs and how the services should be designed.

If the person doesn't use or need all the services funded, the DA will reduce the person's budget and transfer the money to someone else in need. If the person's

[6] Ibid., page 43.

needs increase, the DA can increase the budget if the new needs meet a System of Care Plan priority.

As a general rule, Medicaid funds cannot be used to pay for an individual's room and board. This does not usually pose a problem because the vast majority of people who receive developmental services receive Supplemental Security Income (SSI) or Social Security Disability Income (SSDI), which is used to cover room and board costs. People who live in apartments can qualify for Section 8 housing supports that subsidize housing costs in excess of 30 per cent of a person's income.

TYPES OF SERVICES OFFERED

Provider agencies offer a comprehensive range of services designed to support individuals and families at all levels of need. Service and support plans are developed around the specific needs of an individual as determined by a **needs assessment**. The needs assessment is performed by the DA in collaboration with the person and his guardian or family upon the person's entry into services and at least annually thereafter. All funded supports must then be delineated in the person's ISA and reviewed on at least an annual basis.

Supports may include:

- Residential supports
- Community and social supports
- Employment services
- Family support
- Support and service coordination
- Medical and nursing support
- Emotional and behavioral support
- Clinical, psychiatric, and crisis support
- Transportation
- Supervised/assisted living (minimal residential support for independent living)

Specialized supports include:

- Communication supports
- Continuing education and literacy enhancement

- Social and sexual education
- Adaptive equipment, accessibility and home modification
- Parenting skills for parents with disabilities
- Supports for sex offenders and others with criminal offense histories
- Aging and end-of-life care

The **Developmental Home** (DH) model (also referred to as a Shared Living Home [SLH]) is the most common setting for adults receiving residential supports in Vermont. Individualized home supports are provided for one or two people in the home or apartment of the residential providers. Home providers have a contractual agreement with the DA or SSA and have specific responsibilities to carry out the ISA.

THE ISA (INDIVIDUAL SUPPORT AGREEMENT)

Everyone who receives DSP funding must have an **Individual Support Agreement (ISA)**. The ISA is a written agreement that lists the supports that will be paid for with state and federal funds. The ISA details the goals of the person with DD, which, at a minimum, should include participation in treatment without further offenses. Supports and outcomes should be defined clearly and listed on the ISA.

The ISA will shape the work of the Collaborative Team, along with input from the therapist working with the person. Thus, it is imperative that the whole team, including the person with DD/PSB, work together to develop the ISA. This way members will be invested in the plan and the full support of all team members will be secured. Without full support, there is a good chance that the team will fail in its mission.

Behavior Support Plans are developed in the context of the ISA for individuals who present behavioral challenges that require medical or skilled clinical intervention. Positive supports should be the foundation of any plan. Support needs are not limited to formal interventions and services but include informal supports, which enhance a person's physical, emotional, and spiritual well being. The need for medical and psychological interventions should be explained by the appropriate professional (e.g., treating physician or mental health provider) before they are included in the support plan.

The plan should be reviewed on a schedule in accordance with the ISA process, or more frequently if needed. Requirements to keep community members and the person with DD/PSB safe will be detailed in the plan. Any restrictive practices that are detailed in the plan require initial review by the agency's **professional review committee (PRC)**, and the committee may recommend changes in the plan. Any plan that requires restraints must also be reviewed by the **DDSD Human Rights Committee (HRC)**. More information is found in the Behavior Support Guidelines of DDSD (for a copy, see the DAIL Web site).

Team members should receive copies of the ISA. They may be asked to acknowledge, in writing, that they have read the plan and that training has been completed to their satisfaction. Any **special training** needed by team members is detailed in the ISA along with a timeline for initial training and subsequent supervision. The DS case manager will arrange for and/or provide and oversee the training content.

ROLE OF THE DEVELOPMENTAL SERVICES SYSTEM

PERSONS UNDER CORRECTIONAL SUPERVISION

The Department of Corrections (DOC) has primary responsibility for assuring community safety from a person who has been convicted of a crime, even if he has a developmental disability. However, the person may still qualify for developmental services based upon developmental needs; for instance, he may be an adult who will be homeless if he doesn't receive residential supports.

In a situation like this, the Correctional Services Specialist (CSS) may assist the person to apply for developmental services. Once developmental services are established, the CSS will meet regularly with the person to assure that he is complying with his community supervision (probation, parole, supervised community sentence, or conditional re-entry) conditions, and the CSS will need to assure that the developmental services staff understands the community supervision conditions and when to report a violation. Ordinarily it will be the developmental services case manager who will serve as liaison with the Corrections staff. (See Chapter 11: The Collaborative Team and Chapter 13: Supervision by Department of Corrections).

Some areas of the state have therapy groups specifically designed for persons with DD/PSB. These groups are open to individuals who are under correctional supervision, even if the person does not need or qualify for other developmental services. Payment is arranged on an individual basis.

If a person with DD/PSB is in a correctional facility, he does not receive developmental services. Medicaid-funded services stop when a person enters a correctional facility. Sometimes individuals seek developmental services in order to leave prison sooner. In general, this will not be possible. The System of Care Plan states that it is not a funding priority to "…prevent an individual who has been charged with or convicted of a crime from going to or staying in jail or to prevent charges from being filed."

An individual may receive developmental services upon leaving the correctional facility. If Corrections staff think that a person may benefit from services and/or in fulfillment of statutory reentry planning, DOC staff can assist a person to apply for developmental services (see previous section Applying for Services). The application should be sent to the DA for the county where the person was residing before he was incarcerated unless DOC has determined that they will not be returning to that community. Then the application will go to the DA where they are going to be residing. The DA will conduct the evaluation and needs assessment while the person is still incarcerated. It is recommended that the application process start at least six months before the person's projected release date.

In rare instances, DOC may contract with DAIL to provide residential supports and supervision to a person who would otherwise be incarcerated. This occurs in cases where the person cannot fit into the correctional setting because of developmental disabilities or where Corrections staff think that an early release on conditional re-entry to a DS setting will promote the person's safe transition to the community.

Developmental services staff are available to consult with Corrections staff who have questions or need assistance in providing correctional supervision to an offender with DD. Assistance is available through the DA or through DDSD at (802) 241-0304.

INDIVIDUALS UNDER CIVIL COMMITMENT (ACT 248)

DAIL bears responsibility for community safety in the case of a person who has been committed to the Commissioner of DAIL under Act 248. These individuals

have priority for funding under the System of Care Plan. Supports, services, and budgets are individualized but typically include residential supports, community and work supports, individual and group therapy, psychiatric supports (if needed), respite, and case management (service coordination).

Not every DA has supports for serving persons with DD/PSB who have high needs. If a persons with DD/PSB lives in a county that does not have needed supports, DAIL may move the person to another county.

SCHOOL-AGED INDIVIDUALS

The relationship between developmental services and the school team for persons with DD/PSB will depend upon the nature of the sexually abusive behavior and whether the person is in DCF custody, is living with family, or is living in a Developmental Services Program residence. In every case, it is essential to obtain authorizations for release of information so that school officials and developmental services staff may fully exchange information.

School officials may need considerable information about best practices for supporting persons with DD/PSB. Persons with DD/PSB under DCF custody or the Office of Public Guardian will have a **surrogate parent**, who is the legally authorized decision-maker for school services. It is particularly important for this person to understand best practices for supporting persons with DD/PSB. Sharing this manual with key members of the school team could be helpful.

In working with school services, it is important to know what the staff who actually supervise the individual have observed, and to include them in the Collaborative Team. For instance, it is not helpful for the only team member to be a school case manager if the person with DD/PSB spends most of his day with a paraprofessional aide and the school bus driver. It is essential that these direct service school staff understand the individual's risks and treatment plan and have an opportunity to communicate directly with individuals responsible for other parts of the person's life.

PERSONS WITH DD/PSB IN DCF CUSTODY

Most youth with DD/PSB in DCF custody are supervised outside of the developmental services system. Many continue to be sent to residential treatment

facilities. In a few cases, however, DCF contracts with a DA for the supervision and support of a youth with DD/PSB. In these cases, it is essential to include the person's DCF worker as a member of the Collaborative Team; this is the legal guardian for the youth.

TRANSITION FROM DCF CUSTODY

Transition from DCF custody into adult DS services requires significant planning and preparation. When a DA becomes aware of an adolescent who will be seeking developmental services at age 18, it is essential for staff to be proactive in planning. DA staff should have active contact with the DCF worker and youth with DD/PSB and let them know what services are available. Well before the youth's 18th birthday, they should assure that:

- an application for developmental services is filed.
- an application for SSI is filed with Social Security.
- an application for guardianship is filed if the DCF worker thinks the person will need a guardian (see Chapter 8: Guardianship).
- an authorization for release of information is signed giving DSP staff access to all relevant records maintained by DCF and by the residential treatment facility, if any. Experience has shown that DSP staff should review these records and make copies of all relevant history and assessments promptly; it becomes more difficult to obtain this information after the youth turns 18.

NON-ADJUDICATED PERSONS WITH DD/PSB

Developmental Services Program supports many people who are known to have engaged in sexually abusive behavior but who are not under any order of adjudication. This may be because: they completed their sentence; the offense(s) occurred when they were a juvenile; they were not prosecuted; or the charges against them were dismissed.

Where staff know that a person has engaged in sexually abusive behavior, they cannot ignore the risk. The following guidelines are designed to provide guidance to programs that serve people with DD who are known or suspected to be at risk of committing a sexual offense, and who are **not** under any court ordered supervision, such as probation, parole, supervised community sentence, DCF custody, or Act 248.

These guidelines reflect the obligation of developmental services programs to balance concerns for community safety, rights of the individual, professional ethics, and agency liability. A person is suspected of being **at risk** to commit a sexual offense if a qualified mental health professional has found that the person's behaviors indicate the person is at significant risk of engaging in or continuing to engage in illegal sexual behaviors. For the purposes of this policy, a **qualified mental health professional** is a person skilled and experienced in the identification and assessment of sexual abusers.

GUIDELINES FOR DSP SUPPORT OF NON-ADJUDICATED PERSONS WITH DD/PSB

1. The agency has an obligation to assist the person with DD/PSB and his guardian to learn about services that can help decrease the person's risk of sexually offending. The agency shall assist a willing person to access such services on an ongoing basis.

2. The agency shall evaluate the person's risk for sexual offending. The evaluation may range from an internal case review to an external evaluation of the person. If the person will not cooperate with a recommended risk assessment, the agency may take the most conservative service delivery approach to manage the person's risk of sexually abusing.

3. Services and supports may be modified to reduce the person's risk of sexually abusing. These modifications may include limiting the person's access to potential victims or refusing services which would place the person in high-risk situations.

4. Services and supports which do not increase a person's risk shall not be used as a contingency or denied, except as described in #5 below.

5. The agency may make services and supports for a person who presents an assessed risk of sexually abusing contingent upon the person's granting the agency authorization to inform neighbors, co-workers, or others who may be at risk, or who may be in a position to minimize risk (e.g., an employer or landlord). This authorization may extend beyond the "duty to warn," as defined in Vermont law, to any individuals in the risk category (e.g., any children in the neighborhood.

CHAPTER 13:
SUPERVISION BY
THE DEPARTMENT OF CORRECTIONS

This section of the manual provides an overview of the responsibilities of the Department of Corrections in the supervision of individuals who are on probation, parole, or conditional re-entry (formerly called "furlough"). For those outside the Department of Corrections, this section will aid in understanding the responsibilities and the limitations of Corrections supervision.

ROLE OF THE CORRECTIONAL SERVICES SPECIALIST

The **Correctional Services Specialist (CSS)**, also referred to as a probation or parole officer, has the responsibility of monitoring the behavior of the person under supervision to ensure his compliance with conditions imposed by the court (for probation), the Parole Board (for parole), or the Department of Corrections (for conditional re-entry). Additionally, the CSS may be required to complete a Presentence Investigation (PSI) report on an individual prior to sentencing (see Chapter 4: Presentence Investigation). Typically, the judge orders this report, which is sometimes at the request of the prosecutor or the defense attorney.

The purpose of supervision for a person convicted of a sex offense is to monitor his behavior in the community and to intervene prior to a possible reoffense. This is accomplished by meeting with the person and maintaining contact with his treatment provider and others who have regular contact with him, such as his employer, family members, pastor, and landlord. The CSS has the authority to bring the offender before the court or the Parole Board if the person is not abiding by the conditions of his probation or parole.

ADAPTING CORRECTIONAL SUPERVISION FOR PERSONS WITH DD/PSB

There are many similarities between individuals who have DD and individuals without DD who have committed sex offenses. Both populations often express attitudes that support sexual offending, have poor problem solving skills, and exhibit poor impulse control. Cognitive-behavioral modalities are applicable to both groups. However, there are important differences of which the CSS should be aware (Association for the Treatment of Sexual Abusers, 2015; Blasingame, 2014; Haaven, Little & Petre-Miller, 1990).

Persons with DD often have greater difficulty completing daily living activities and solving life crises, and, as a result, they become more dependent on the program and staff. To compensate for these deficiencies, individuals with DD often exaggerate their accomplishments, are sensitive to criticism, overreact to feedback, and are more fearful of change.

Other differences include difficulty in understanding legal requirements, difficulty in remembering without repetition, tendency toward acquiescence (thus, the importance of avoiding yes/no questions), little or no reading skills, and poor understanding of dates and finances. The DS case manager may be helpful in aiding the CSS to understand the person's learning style and suggesting techniques or supports to assist in communication and to distinguish noncompliance from poor coping skills. For instance, a person with DD may not respond to a letter scheduling an appointment; this may be because the individual does not read or is not use to opening and responding to his mail. The CSS may need to arrange to send a copy of any written material to a family member or support staff.

Most importantly, the pace of change with an individual with DD will be slow. Individuals with DD will be slower to grasp treatment concepts and will need ample support to incorporate concepts learned in treatment into daily life. Individuals with DD often find it difficult to generalize skills learned in one setting (e.g., residential setting) to other settings (e.g., community or work setting). Therefore, individuals should practice the same skill in multiple settings under various circumstances.

The CSS needs to be clear, concrete, and use language geared to the learning level of the supervisee. When educating the supervisee about managing risk, identify a small number of key risk factors and coping strategies so as not to overwhelm the person with too many new tasks to learn. Although it is important to challenge

high-risk behaviors, the person with DD may take a disproportionate amount of time to make changes. How the CSS addresses risky behavior will go a long way in encouraging a person with DD/PSB to continue to share this information and learn other ways to behave.

CONDITIONS OF PROBATION AND PAROLE

With an individual who has committed a sex offense, a CSS ordinarily recommends special conditions of probation/parole that are tailored to the individual's risk factors to sexually reoffend. Each condition must be reasonably related to the individual's offense. State v. Cornell, 2016 VT 47 (2016). For example, most individuals convicted of sexually abusing a child will have a condition limiting their contact with children.

Specialized conditions enable the CSS to intervene prior to the commission of a new sexual offense. Failure to adhere to conditions could cause a supervisee to be charged with the crime of violating his conditions of probation or parole and result in sanctions being administered (see sample probation conditions in Chapter 5: Sentencing.). In the case of persons with DD/PSB, the conditions may require cooperation with treatment and supervision by a DS program.

COOPERATION BETWEEN CORRECTIONS AND DEVELOPMENTAL SERVICES PROGRAMS

The Department of Corrections and the DS program staff bring different skills and expertise. When Corrections and DS staff are both involved with a person with DD/PSB, Corrections will take the lead on making decisions to protect public safety (prevent reoffending) and the DS staff will take the lead in providing support in activities of daily living. If Corrections has selected the DS program to provide treatment to the person with DD/PSB, the two programs will have to work closely in a Collaborative Team.

During the pre-sentencing phase of the criminal justice proceedings, the CSS will probably need to prepare a Presentence Investigation (PSI) report. The PSI is a comprehensive background report on the defendant that includes recommendations for sentencing and treatment options (see Chapter 4: Presentence Investigation). When writing the PSI, the CSS should seek input from the DS case manager in order to identify the services that will be available to the individual. This will assist

the CSS in making realistic and relevant sentencing and treatment recommendations to the court. If the victim chooses to cooperate, the CSS or DOC victim services coordinator will interview her and include this information in the report. This information can be helpful for the Collaborative Team in using a victim-centered approach.

Later, when a person with DD/PSB is placed on probation or is released on parole, a Collaborative Team composed of the CSS, DS program staff, treatment provider, guardian (if applicable) and family will help to maintain community safety while allowing the person to live in the community (see Chapter 11: The Collaborative Team). Identifying the roles of the Collaborative Team members is important in order to avoid confusion and conflict.

In planning the process of information management, it is helpful to develop a case plan outlining how and when information will be shared among the team members. Individuals in sexual abuser treatment are routinely expected to sign waivers of confidentiality and information release forms so that all members of the team can share information. Each member of the Collaborative Team must obtain an authorization for release of information from the person with DD/PSB (and the individual's guardian, if applicable) so that all information can flow freely among Collaborative Team members.

Cooperation and clear communication between the case manager and corrections personnel are imperative to community safety and good case planning. Both should be willing to share information openly, as both are responsible for supervision and public safety.

Some probation, parole, or developmental services requirements may overlap. An effort should be made to clarify each person's roles. For example, supervision is a role that is required of both the case manager and the CSS, but it is the responsibility of the CSS to report violations of law to the Court. Both parties may have an interest in employment being maintained by the person with DD/PSB, but it is the case manager's responsibility (along with the client's) to assure that the he has the supports he needs to succeed at the job.

The developmental services **ISA** (see Chapter 12: on The Vermont Developmental Services System) should include all of the conditions of probation or parole, along with input from the CSS (and other Corrections personnel if the person with DD/PSB is being released from a correctional facility). Clarity is needed regarding the level and type of supervision required, the risk factors for reoffense, reporting

conditions, living situations, employment, and treatment options and requirements. Duplication of services can be avoided and a more effective support plan written—one that ensures both community safety and that the person's needs are also being met. It is also important for correctional staff and developmental services staff to agree on how much responsibility the person with DD/PSB should assume for compliance with treatment and supervision expectations and when it is necessary for staff to provide support and accommodations.

Setting and maintaining boundaries with the person with DD/PSB will be more effective if the CSS and case manager work in tandem rather than at odds with each other. Working together, the CSS and the case manager are in a position to assess risk factors and the level and type of supervision required at any point in time. Collaboration can be beneficial for the CSS and case manager in that they are able to communicate with and confide in a knowledgeable professional when an outlet is needed or when issues arise.

Communication between the CSS and the DS case manager should happen on all levels. For example, psychopharmacological interventions may be provided to persons with DD/PSB by developmental services programs. The CSS should be kept informed of all such interventions by the DS team. Likewise, if a person with DD/PSB is sanctioned because of a violation, the DS case manager should be informed immediately. Information from visits with the family where staff are not present should be shared with the team. Even seemingly unimportant decisions should be shared for everyone's best interest.

VIOLATIONS OF PROBATION/PAROLE/CONDITIONAL RE-ENTRY

The CSS has the authority to violate a supervisee's probation, parole or conditional re-entry status if the person violates one or more of his conditions. For a violation of probation or parole, the supervisee has to go back to court or to the Parole Board and may face incarceration. For a violation of conditional re-entry, the supervisee may be sent directly to prison by the CSS. The CSS, in deciding when a violation should be brought, typically consults with team members. Some situations may occur that are so high risk that the CSS may have to make an emergency arrest and consult with team members after the fact.

PART FIVE

SUPERVISION AND SUPPORT: ASSESSMENT, SAFETY, TREATMENT, REASSESSMENT

CHAPTER 14:
ASSESSMENT AND
PSYCHOSEXUAL EVALUATIONS

A thorough assessment is the first step in providing effective services to someone who has engaged in sexually inappropriate behavior. This section of the manual provides an overview of the assessment process and focuses on the use of psychosexual evaluations. For a person with DD/PSB, a **Psychosexual evaluation** can determine the nature of his sexually abusive behavior, treatment needs, amenability to treatment, risk for reoffense, and supervision needs. This manual does not address other types of evaluations that person with DD/PSB may undergo, such as evaluations to determine intellectual functioning, adaptive functioning, competency to stand trial, and mental state at the time of an offense.

EVALUATOR QUALIFICATIONS

Evaluators should have specialized training in the assessment of sexually abusive behavior, an advanced degree in a mental health profession, and a license, certification, or registration to practice independently.

Evaluators should also be familiar with the characteristics of individuals with developmental disabilities and feel comfortable communicating with people with DD.

APPROPRIATE REFERRAL QUESTIONS

Ideally, individuals who are referred for a psychosexual evaluation already have been found to have engaged in sexually abusive behavior. This is an important issue since evaluators should not be placed in the role of determining guilt or innocence. That is the role of the criminal justice system, not the evaluator or developmental services system (Association for the Treatment of Sexual Abusers, 2014; McGrath, 2014). Mental health professionals have no expertise in determining whether or not someone has committed a sexual offense. There is simply no known psychological or physiological test, profile, evaluation procedure,

or combination of such tools that can be used to prove or disprove whether someone has committed a specific sexual act.

Preferably, determining whether an individual has engaged in sexually abusive behavior is based on one of two criteria. First, the individual admits to having engaged in sexually abusive behavior, or, second, a court, or other official legal entity, such as state a child protective services or adult protective services agency, has render a finding that the individual has committed a sexually abusive act.

Evaluations conducted under Vermont's civil commitment law for people with intellectual disability, **Act 248**, pose some special challenges (for more information, see Chapter 7: Act 248). In these cases, the court has found that there is a factual basis to conclude that an individual has committed a sexual offense even though the person cannot be put on trial because he is incompetent to stand trial. Therefore, evaluators typically proceed with an evaluation under the assumption that the individual has perpetrated the offense for which he has been committed under Act 248.

Individuals may be referred for a **pre-plea** psychosexual evaluation when an individual has been charged with but has not been convicted of a crime. Typically, a defense attorney, sometimes with the agreement of a prosecutor, uses the evaluation to assist in negotiating a plea agreement. The evaluator usually addresses the referral questions from an "If…., then…." perspective. For example, in a pre-plea psychosexual evaluations, the evaluator might say, "If this person were found guilty of the offenses for which he has been charged, then….(e.g., this is what his risk would be or this is what his treatment and supervision needs would be.)."

Another type of challenging referral request arises when a developmental services program seeks a psychosexual evaluation for a person who has not committed a known sexually abusive act but who is believed to pose a high risk of sexually offending. In this case, the purpose of the evaluation is to prevent sexual offenses in the future. This is an atypical use of a psychosexual evaluation and considerable caution should be utilized. There is a great risk of labeling a person as a sexual abuser and placing restrictions on him in the absence of the due process protections that usually accompany such a decision. (For more discussion of this issue, see Chapter 12: Vermont Developmental Services System on serving nonadjudicated persons with DD/PSB).

For all evaluation requests, the referral source should identify the referral questions for the evaluator. If the referral source does not ask specific referral questions, the referral source risks not being satisfied with the evaluation. It is often helpful for the referral source, such as a DS agency, to send a letter to the evaluator summarizing the purpose and arrangements for the evaluation. This helps ensure that there are no misunderstandings. (See Appendix C for a sample Psychosexual Referral Letter.)

Typical referral questions concern the following:

- Diagnosis and/or problem formulation
- Treatment needs
- Amenability to treatment
- Level of danger presented
- Placement recommendations
- Supervision recommendations
- Treatment recommendations

INFORMED CONSENT

Prior to beginning an evaluation, the evaluator must obtain informed consent from the individual being evaluated, ideally in writing. If the examinee has a court-appointed guardian, his legal guardian must give informed consent, preferably in collaboration with the person being evaluated.

The explanation of the individual's rights regarding his "informed consent" should include the following (Association for the Treatment of Sexual Abusers, 2014):

- The purpose of the evaluation
- The nature and duration of the evaluation
- The fees for the evaluation
- The confidentiality of the evaluation
- How and to whom the evaluation results will be communicated
- The potential risks and benefits of the evaluation

The explanation should be concrete and clear. The evaluator may use role-plays or other techniques to be sure the person understands how the evaluation or disclosures can be used. It is especially important that the individual understand

what will happen if he discloses an unreported case of child abuse. Evaluators should not simply ask if the client understands his rights and accept a yes or no answer. The evaluator must ensure that the consent is voluntary and is based on knowledge of the risks and benefits. Periodically, the evaluator may need to remind the individual about the consequences of disclosure during the course of the evaluation.

If the individual refuses to give consent for the evaluation, the evaluator cannot proceed, and must notify the referral source. If the evaluator believes the person does not really understand and cannot give informed consent, the evaluator should not to perform the evaluation and should inform the referral source. The evaluator and referral source may wish to involve family members or service providers in explaining the evaluation process and risks. If this is not successful, the referral source may apply for a court-appointed guardian for the person.

DATA SOURCES

A thorough psychosexual evaluation requires information from many sources. The person who made the referral should provide or assist the evaluator in obtaining background information. Recommended background information includes:

- previous psychological testing and other assessments of cognitive and adaptive functioning.
- social and family histories.
- police affidavits, criminal record checks, victim and witness statements, and previous assessment and treatment reports.
- information about prior abuse behavior contained in developmental services, mental health, Department for Children and Families (DCF), and school records.

Data to be gathered and developed by the evaluator include:

- Updated psychological testing
- Client interviews
- Interviews with people who know the individual, such as current and previous service providers, family members, teachers, employers, partners, and probation/parole officers
- Risk assessments

TIME FRAME

The evaluator and the referral source should have clear expectations regarding an appropriate time frame for completion of the evaluation.

- The referral source should convey to the evaluator how long it will take to get background records.
- The initial interview should be scheduled soon after that date.
- The evaluator should notify the referral source as to how long the evaluation will take and when the evaluation will be complete.

In general, the evaluator should not commence an evaluation without having access to the necessary background information. Evaluators are cautioned against curtailing the information-gathering process for the purpose of satisfying an external time frame. However, if it is necessary to write a preliminary or provisional evaluation, the report should clearly express that a definitive evaluation must be based on information not yet available.

ASSESSMENT PRINCIPLES

Evaluators should be guided by three principles of effective correctional intervention. These are the **risk**, **needs**, and **responsivity principles** (Andrews & Bonta, 2010; Association for the Treatment of Sexual Abusers, 2014; Hanson, Bourgon, Helmus, & Hodgson, 2009). These principles provide a framework for assessing differences among individuals who commit crime, including persons with DD/PSB, in order to inform program admission, placement, supervision, and other service delivery decisions (Blasingame, Boer, Guidry, Haaven, & Wilson, 2014).

RISK PRINCIPLE: WHO TO TREAT

The risk principle states that services are typically more effective in reducing reoffending when they are delivered proportionally to the risk level of the individual. Therefore, each person with DD/PSB should be evaluated using structured assessment instruments in order to match the intensity of services to his risk level. Higher risk individuals generally are referred to more intensive services and lower risk individuals are referred to less intensive services. In essence, the risk principle helps decide "who" should receive the most intensive services. This principle allows staff to allocate available treatment and supervision resources to those individuals who are at greatest risk to reoffend and for whom services can make the greatest impact on reducing victimization rates. Conversely, it helps staff to identify lower risk individuals for whom intensive services may not be useful and even harmful (Hanson et al., 2009; Lovins, Lowenkamp, & Latessa, 2009).

EACH PERSON WITH DD/PSB SHOULD BE EVALUATED USING VALIDATED ASSESSMENT INSTRUMENTS IN ORDER TO MATCH THE INTENSITY OF SERVICES TO HIS RISK LEVEL.

NEEDS PRINCIPLE: WHAT TO TREAT

The second principle, the needs principle, highlights that intervention is most effective if it targets the "needs" of individuals that are most directly related to their sexual abusing behavior. These are variously called "**criminogenic needs**" or "**dynamic risk factors**." These include pro-offending attitudes and beliefs, emotion management problems, impulsivity, abuse supportive sexual interests, and poor social skills. In essence, the needs principle helps providers decide "what" types of problems to treat.

RESPONSIVITY PRINCIPLE: HOW TO TREAT

The third principle, the responsivity principle, states that programs should be offered in a format to which an individual can successfully respond. In essence, the responsivity principle concerns "how" to deliver services to individuals who have committed offenses. Services are most effective if they are delivered in a manner that matches an individual's motivation, ability, learning style, and personality

characteristics. Responsivity factors that should be considered in an evaluation include level of denial, intelligence, physical disability, reading and writing ability, mental illness, and degree of criminality.

ASSESSMENT OUTLINE

The following assessment outline details the types of information that should comprise a comprehensive psychosexual evaluation of a person with DD/PSB (Blasingame, 2015; McGrath, 2015; Wilson & Burnes, 2011). Organized in the format of a typical report (McGrath, 1993), the headings and subheadings divide the assessment into several sections that allow the reader to find information easily.

IDENTIFYING INFORMATION

The identifying information section and the next three sections of the report orient the reader to the person with DD/PSB, the reason for the referral, and the procedures used during the evaluation.

This section should include the individual's name, gender, race, marital status, living situation, and legal status (e.g., guardianship, Act 248, probation).

REASON FOR REFERRAL

The referral source is named in this section and the reason for the referral is detailed. As noted previously, typical referral questions concern diagnosis, risk, treatment needs, supervision needs, and disposition recommendations.

SOURCES OF INFORMATION

A clear account of the information and procedures used to conduct the assessment should be detailed. Listing the data sources tells the reader how thorough the assessment was, or it can alert the reader to the absence of potentially important information.

CURRENT PROBLEM SEXUAL BEHAVIOR

The problem sexual behavior for which the individual is currently being evaluated should be detailed in this section of the report. The evaluator should describe the behavior in detail, including the age and gender of the victim, relationship of the victim to the person with DD/PSB, and frequency and duration of the abuse. The report should also clearly identify any discrepancies or lack of discrepancies between the version of the abusive behavior reported by the person with DD/PSB and those of the victim and other people interviewed.

PRIOR SEXUAL OFFENSES

Prior sexually abusive behaviors should be described in chronological order in the same manner as the current sexually abusive behavior.

OTHER CRIMINAL HISTORY

The individual's non-sexual criminal history, including his prior behavior under supervision and incarcerated history should be detailed in this section. Offenses in the past, which did not result in arrest, should also be noted if they are documented in the person's records and the reliability of the reports is high.

SEXUAL HISTORY

This section details the individual's sexual victimization and trauma history, masturbatory fantasies, sexual outlet frequency, pornography use, heterosexual experiences, homosexual experiences, and history of paraphilic behaviors. Information about the individual's level of sex education should also be covered in this section.

MENTAL STATUS

The mental status examination documents the individual's general level of psychological and cognitive functioning at the time of the evaluation. This information is sometimes useful to verify that the person with DD/PSB was in fact competent to give informed consent to undergo the evaluation.

PERSONAL AND SOCIAL HISTORY

Several aspects of the individual's personal and social history should be documented, much of which can be used to assess his risk, treatment needs, and responsivity factors. Areas for inquiry include:

- Family history
- Developmental history
- Educational history
- Employment history
- Financial history
- Marital history
- Residence history
- Medical history
- Psychiatric history
- Substance abuse history
- Social relationship history
- Religious affiliation
- Recreational history

TEST AND INVENTORY RESULTS

This section of the report includes the results of instruments used to assess the individual's cognitive functioning, learning style, mental health, personality functioning, sexual arousal and interests, and risk for reoffense.

A thorough assessment of cognitive functioning and learning style is particularly important in evaluating individuals who have a developmental disability. Important areas include:

- General intellectual functioning using standardized IQ tests
- Receptive and expressive language skills
- Attention blocks
- Emotional blocks to learning
- Hearing impairment
- Reading and writing skills
- Memory
- Adaptive functioning using a standardized test

If the evaluator believes that the cognitive functioning or learning style of the individual are unusually complex, an assessment by an evaluator with specialized expertise in evaluating the cognitive functioning of people with DD should be recommended. Testing should also access or screen for mental health problems and the individual's sexual attitudes, knowledge, and behavior.

Assessment of sexual arousal and interest patterns is important but should be undertaken with caution. Of methods available, the penile plethysmograph is quite intrusive and questions remain about its reliability and validity with persons with DD/PSB (Blasingame et al, 2014; Wilson & Burns, 2011). The polygraph is used in some jurisdictions to assess sexual interests and for other purposes (McGrath et al., 2010), but minimal research on this tool has been conducted with persons with DD/PSB. Of note, Abrams (1989) found that the validity of polygraph test results appears to decrease with persons in the lower IQ ranges. Viewing time measures are less intrusive than the penile plethysmograph and polygraph and have shown some promise with persons with DD/PSB (Blasingame, Abel, Jordan, & Weigel, 2011).

Several risk assessment instruments appear to be useful with persons with DD/PSB, but more research is needed in this area (Blasingame et al., 2014; Keller, 2016). DAIL prepares Public Safety Risk Assessments to assist DS agencies in providing appropriate support and supervision services to persons with DD/PSB. To assess static risk factors, which are unchangeable aspects of an individual's history that raise the risk of sexual reoffending, the public safety assessments typically use the Vermont Assessment of Sex Offender Risk-2 (VASOR-2; McGrath, Hoke, & Lasher, 2013; McGrath, Lasher, Cumming, Langton, & Hoke, 2014). To assess dynamic risk factors, which are changeable aspects of an individual's current functioning that may raise or decrease the risk of sexual reoffending, the public safety assessments typically rely on data the DS agency provides from the Sex Offender Treatment Intervention and Progress (SOTIPS; McGrath, Cumming, & Lasher, 2013; McGrath, Lasher, & Cumming, 2012). DS agencies administer the SOTIPS as part of an initial assessment and as part of follow-up evaluations approximately every 12 months.

Although DAIL now uses the SOTIPS as its primary sexual abuse specific dynamic risk assessment measure, Blasingame (2014) notes that its precursor, the Treatment Intervention and Progress Scale for Sexual Abusers with Intellectual Disability (TIPS-ID; McGrath, Livingston, & Falk, 2007) surveys a larger number of interventions targets and is a useful tool for making case management decisions.

Other instruments that assess risk for future sexual reoffending may be useful for evaluating persons with DD/PSB (Blasingame et al., 2014; Keller, 2016). These include the Static-99R (Hanson & Thornton, 2000; Helmus, 2009), Stable-2007 (Hanson, Harris, Scott, & Helmus, 2007), Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997), and the Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually (ARMIDILO-S—Boer, Haaven et al., 2012). Additionally, The Risk of Sexual Abuse of Children (ROSAC; McGrath, Allin, & Cumming, 2015) is a structured professional guide that can help professionals assess the risk an adult male sexual abuser poses to a particular child and under what circumstances, if any, the person might safely be allowed contact with the child.

For predicting the likelihood that someone who has committed a sexual offense will reoffend by committing a future violent offense, which includes sexual and non-sexual violence, the Violence Risk Appraisal Guide (VRAG: Quinsey, Harris, Rice, & Cormier, 2005) and the HCR-20 (Douglas, Hart, Webster, & Belfrage, 2013) can be a useful assessment tools.

ASSESSMENT

The assessment section provides an opportunity for the evaluator to express opinions about the meaning of the data that has been collected and presented in the previous sections of the report. It can be divided into four subsections, as follows.

1. **Diagnosis or Problem Formulation**. Applicable diagnoses from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders can be detailed here. In this subsection, the evaluator can describe a framework for understanding the individual and his sexual abusing behavior.

2. **Risk**. This subsection should describe the risk of reoffense that the individual poses to the community. It should be grounded with structured assessment measures noted above when one or more is appropriate for the individual being assessed.

3. **Treatment Needs**. The treatment needs subsection should detail the individual's problem areas that are most directly related to his or her offending behavior and should be the focus of treatment (see Chapters 16 and 17, the Treatment and Training chapters of this manual).

4. **Responsivity Issues**. This subsection of the report should make recommendations for how to deliver supervision and treatment in a manner from which the person with DD/PSB can best benefit. Recommendations should be as concrete and practical as possible.

RECOMMENDATIONS

The recommendation section should provide the referral source with information about various disposition options and how to implement them. These include:

- Residence (e.g., prison, staffed residential setting, independent living)
- Level of supervision (e.g., arms-length, eyes-on, periodic staff checks)
- Supervision conditions (e.g., no child contact, no weapon possession)
- Treatment services (e.g., individual, sex offender group, medication)

COMMUNICATION OF EVALUATION RESULTS

The person with DD/PSB who was evaluated should have an opportunity to have a face-to-face meeting with the evaluator to have the results and recommendations explained. The evaluator should ask the individual whether he wants this to be a private session, or wants others, such as service providers or the referral source, to be present. The results of the report should also be discussed with the individual's Collaborative Team to facilitate case planning.

CHAPTER 15:
TYPES OF SEXUAL BEHAVIOR PROBLEMS

Not all persons with DD/PSB are alike, and there is no such thing as a profile of individuals who commit sexually abusive acts. Persons with DD/PSB vary significantly in age and represent all races, ethnicities, and socioeconomic classes. They vary considerably in personal and social characteristics, motivations, abilities, sexual knowledge and preferences, intensity of sex drive, attitudes toward abusing, and other aspects of personality and behavior.

PROGRAMS AND PROFESSIONALS SERVING PERSONS WITH DD/PSB NEED TO UNDERSTAND THE SPECIFIC AND UNIQUE CHARACTERISTICS OF EACH OF THE INDIVIDUALS THEY SERVE AND TAILOR SUPERVISION AND TREATMENT SERVICES ACCORDINGLY.

Persons with DD/PSB also vary in terms of the characteristics of individuals that they victimize (e.g., children or adults; males or females; family, acquaintances, or strangers) and the types of sexually abusive behaviors they commit (e.g., rape, molesting, or exhibitionism). Some individuals commit only one type of sexual abuse against one type of victim. Others commit more than one type of sexually abusive behavior against more than one type of victim. This is commonly called "crossover" offending.

Most persons with DD/PSB probably have a preferred abusing pattern, but some will "cross over" if their preferred victim type is unavailable (Cumming & McGrath, 2005). Some individuals simply have multiple problematic sexual interests. Identifying the true rates of crossover offending is challenging, but research suggests it may be substantial. For example, approximately half (53.4%) of 103 men with DD/PSB in a Vermont study had a history of committing more than one type of sex offense (McGrath et al., 2007). This rate is similar to that reported in the general sexual offender literature (e.g., Heil et al., 2003).

TYPOLOGIES

Considering the relatively high rate of crossover offending and considerable individual differences among persons with DD/PSB, it is clear that most persons with DD/PSB do not fit into neat categories. Men without DD who commit sexual offenses are difficult to categorize as well. Yet, a large amount of research has attempted to identify sex offender typologies to group together individuals that have common characteristics.

Sex offender typologies have shown considerable problems though. It is difficult to put people into boxes. Most typologies do not help predict recidivism or guide providers to deliver improved treatment or supervision services (e. g., Camilleri & Quincy, 2008). Nonetheless, sex offender typologies are sometimes applied to persons with DD/PSB, so it can be helpful for professionals who work with this population to be familiar with typology language and the broader research in this area.

MEN WHO MOLEST CHILDREN

Practically every typology for men who molest children is composed of two broad categories. In the DSM-5 (American Psychiatric Association, 2013), men who meet the criteria for being diagnosed as having pedophilia (sexual interest in children) are specified as either being the "exclusive type" (attracted only to children) or the "nonexclusive type" (attracted to children and adults). Similarly, Groth, Hobson, and Gary (1982) label men who molest children as either fixated, reflecting a primary sexual attraction to children, or regressed, reflecting a secondary interest in children. Knight (1992) uses the categories high fixation and low fixation to children to make the same distinctions. A model used by the FBI uses the terms situational and preferential child molesters (Lanning, 1986). It is important for professionals who work with persons with DD/PSB to be familiar with this language.

Several common characteristics distinguish between exclusive and non-exclusive type men who molest children. There are far fewer exclusive type child molesters than non-exclusive type child molesters, but they typically begin abusing at an earlier age, molest more victims, have mostly male victims, and have higher reoffending rates.

MEN WHO RAPE ADULTS

Typologies of men who commit rape focus mostly on degree of aggression and motivation for offending. Arguably the earliest and most well known typology classified men who rape adults as motivated by anger, power, or sadism (Groth, 1979). Knight's (1999) has classified rapists as opportunistic, pervasively angry, vindictive, or sexual motivated; and as having low or high social competence; and, for sexually motivated rapists, as being sadistic or nonsadistic. Lanning's (1986) typology is commonly used by law enforcement agencies. He also categorizes men who rape as being primarily motivated by power or anger, with a small subset of anger motivated individuals as being also motivated by sadism. He notes that some rape offenses are opportunistic, such as an individual who is robbing a home and takes the opportunity to rape a woman who is there alone.

MEN WHO COMMIT NON-CONTACT SEX OFFENSES

Three common non-contact sex offenses are exhibitionism, voyeurism, and viewing child pornography (see next section). In particular, it is common that men who commit non-contact sex offenses often do so multiple times before they get caught (Abel et al, 1989). Persons with DD/PSB however are typically under close supervision by family or professionals; so undetected offending may be less likely than among the DD population than persons without DD.

- **Exhibitionists**. These are individuals who derive sexual excitement from the act of exposing their genitals in public.

- **Voyeurs**. These are individuals who derive sexual pleasure from looking into private spaces of unsuspecting victims and are sometimes referred to as "Peeping Toms."

MEN WHO COMMIT CHILD PORNOGRAPHY OFFENSES

Child pornography has become much more accessible since the advent of the Internet. Some Persons with DD/PSB have good computer skills and a small subgroup of these individuals have used the Internet to access child pornography. Several researchers have tried to categorize individuals who use child pornography (e.g., Hernandez, 2000; Krone, 2004), although it appears no typology is specific to persons with DD/PSB.

Listed are four broad typologies of men who commit child pornography offenses.

- **Browsers.** These individuals responded out of curiosity to spam, accidently hit on an inappropriate site, were given inappropriate materials, or otherwise did not actively seek out and continue to use child pornography.

- **Collectors.** These individuals have marked sexual interest in children and make plans to seek opportunities find and collect child pornography.

- **Collector-molesters.** These individuals collect child pornography and have crossed the line and have actually molested one or more children.

- **Profiteer.** These individuals produce child pornography and typically have marked pedophilic and/or antisocial traits.

COUNTERFEIT DEVIANCE

A model that is specific to categorizing persons with DD/PSB is called "counterfeit deviance" and is based on assessing a person's motivation for engaging in PSB (Hingsburger, Griffiths, & Quinsey, 1991). In this model, an individual's PSB is categorized as either being driven by "deviant" sexual interests or by "non-deviant" sexual interests, termed counterfeit deviance. For example, a person with DD/PSB might expose himself to others for the purpose of sexual gratification, and this would indicate a deviant sexual interest. On the other hand, a person with DD/PSB might expose himself to others while masturbating in a semi-public location in a group home because he does not have privacy to masturbate elsewhere or has not learned appropriate social norms. In this case, the behavior is sexually deviant but the motivation is not. Some research challenges the counterfeit deviance model, but is certainly important to consider a person's understanding of sexual social norms and how environmental factors (e.g., no privacy in a group home) can impact risk to engage in PSB (Griffiths Hinsburger, Hoath, & Ioannou, 2013; Lindsay, 2009).

PATHWAYS TO ABUSING

Early research suggested that individuals who committed sexual offenses followed a single, or at least a similar, pathway towards offending. However, newer research has identified four pathways leading to offending (Ward & Hudson, 2000; Ward, Hudson, & Keenan, 1998). It is called the self-regulation model and describes the ways people who commit sexually abusive acts regulate and manage their emotions and behavior. These authors found that the four pathways leading to sexual abusing serve two divergent goals: avoidance, in which the person's goal is to avoid sexually abusing, and approach, in which sexual abusing is the goal. The four pathways are as follows:

1. **Avoidant-passive**. This pathway is comparable to the original relapse prevention single model pathway of offending. Here individuals want to avoid abusing but have inadequate coping skills and therefore fail to be proactive in avoiding risky and managing situations.

2. **Avoidant-active**. These individuals also want to avoid offending, but they choose ineffective coping strategies, such as drinking excessively or reinforcing their abuse-related sexual interests by masturbating to inappropriate fantasies.

3. **Approach-automatic**. Individuals following this pathway have a desire to abuse others sexually, but do not engage in active planning. Instead, they take advantage of an opportunity when it presents itself.

4. **Approach-explicit**. These individuals seek opportunities to abuse others and do not see anything wrong with their sexual conduct. They often spend considerable time and energy planning the offenses.

Most persons with DD/PSB appear to follow the approach versus avoidant pathway (Keeling et al., 2006; Lindsay, Steptoe, & Beech, 2008).

APPLICATION OF TYPOLOGIES

Debating whether or not a typology or abuse category exactly fits a person with DD/PSB is less important than engaging the basic ideas and concepts underlying a typology or diagnosis. In working with persons with DD/PSB, an effort should be made to understand their individual differences by considering a variety of dimensions. Some of the factors that should be taken into account are the individual's:

- sexual preferences and arousal patterns in terms of victim choice (e.g., age, gender, developmental status, and vulnerability).
- sexual preferences and arousal patterns in terms of behavior (e.g., non-contact versus contact offenses)
- motivation for offending (e.g., sexual gratification, anger, power, and sadism)
- methods and tactics of victim selection (e.g., planned predatory activities vs. opportunistic offenses).
- sexual maturation, knowledge, and skills.
- social and emotional development and skills.
- level of functioning.
- availability of appropriate sexual partners.
- use of force during offenses.
- mental health and substance abuse status.
- organicity (i.e., a psychological or behavioral abnormality associated with brain injury or dysfunction).
- drug and alcohol abuse.

Understanding these factors within a complete history and battery of assessments can provide a basis for assessing risk, designing intervention strategies, and ensuring appropriate supervision of the person with DD/PSB. See Chapter 14: Assessment and Psychosexual Evaluations for more information.

CHAPTER 16:
TREATMENT AND TRAINING:
GOALS OF TREATMENT

The **basic elements of treatment** and its effectiveness are described in this chapter with attention to particular considerations for persons with DD/PSB. Chapter 17 describes in more detail ways to adapt and deliver treatment to persons with DD/PSB.

Many written curriculum guides for treatment of persons with DD/PSB are available nationally. A list of curriculum materials can be found Appendix D.

TREATMENT APPROACH AND EFFECTIVENESS

Treatment interventions should be delivered according to the same three principles that guide assessments – risk, need, and responsivity (see Chapter 14: Assessment and Psychosexual Evaluations). The RNR principles (Andrews & Bonta, 2010) state that programs should provide the most treatment and supervision services to individuals who are at moderate or higher risk to reoffend (risk), help clients address issues that are closely linked to reoffending (criminogenic needs), and use treatment methods that engage clients and are matched to their learning styles and abilities (responsivity). Across multiple treatment outcome studies in the United States and elsewhere, programs that follow RNR principles show lower reoffense rates than programs that do not follow these principles (Hanson, Bourgon, Helmus, & Hodgson, 2009; Schmucker & Lösel, 2015).

Treatment studies in Vermont are also encouraging. After Vermont closed the Brandon Training School (BTS) in 1993, it moved to a totally community-based model of services. During the next decade, 103 adult males with DD/PSB were served and followed in the community. Of these individuals, 11 (10.7%) were identified as having committed a new sexually abusive act. This represents an approximately 90% success rate. The majority of new offenses were noncontact offenses against staff members, relatives, or housemates (McGrath, Livingston, & Falk, 2007) as opposed to individuals outside the person's close social network. This reoffense rate is similar to findings in the general sexual offender literature (e.g., Hansen et al., 2002; Losel & Schmucker, 2005), as well as rates reported for

adult male sex offenders released from Vermont prisons (McGrath, Cumming, Livingston, & Hoke, 2003) and those on community supervision (McGrath, Hoke, & Vojtisek, 1998).

MODELS OF TREATMENT

Cognitive-behavioral treatment is the most common and effective treatment model for helping persons with sexual behavior problems reduce risk to reoffend. Cognitive therapy focuses on helping people change how they think so that they can change the way they feel and act. Behavior therapy helps people learn and practice new ways of behaving.

Several variations of the cognitive-behavioral model have been used in treatment programs for people with sexual behavior problems. **Relapse prevention** (Laws, Hudson, & Ward, 2000) focuses on helping persons with DD/PSB learn self-management skills to prevent relapse and teaches others how to supervise the person. Use of relapse prevention however has diminished as an overarching treatment model in recent years. This is in part because it describes only one pathway to offending, unlike the **self-regulation** model (see Chapter 15), which describes four pathways to offending (Ward & Hudson, 2000**)**. Another criticism of relapse prevention is that it overemphasizes teaching people what not to do (avoidance goals) as opposed to what to do (approach goals). A focus on approach goals emphasizes how to live a good life that is inconsistent with offending, and this is the basis of the **good lives** model (Prescott, & Ward, 2010) and the **old me/new me** model (Haaven, 2006). Simply put, these two models posit that if individuals learn how to get basic needs in met socially acceptable ways, they will not use sexual abusing others as a way to get their needs meet

Of course, the developmental services systems have long focused on strength-based approaches for providing services to individuals under their care. Overall, a blending of models is likely to be the most effective approach to helping persons with DD/PSB not abuse again. The focus is to learn new prosocial ways of thinking and behaving, avoid risky behaviors and situations, and achieve positive life goals that are incompatible with hurting others.

PHASES OF TREATMENT

Treatment programs should sequence services in a logical manner. There are four common treatment phases (McGrath, Cumming, & Williams, 2014) in programs for individuals who have committed sexually abusive acts. The phases overlap somewhat and returning to an earlier phase is often indicated. The following are the four phases and the recommended sequence.

1. **Engagement and Motivation**. The most powerful influences on treatment change are the quality of the relationship that a helper has with a client and the client's attitude towards change. So, the first task of treatment is to engage and help motivate the person. Therapeutic style is important. The most effective providers are those who are respectful, warm, genuine, directive, and empathetic. Providers who are cold, hostile, shaming and deceptive will not be effective in helping people change (Marshall, Marshall, Serran, & O'Brien, 2011).

PHASES OF TREATMENT

1. Engagement and Motivation
2. Identification of strengths and treatment needs
3. Skill building to enhance strengths and overcome deficits
4. Transition planning

   Strategies for engaging and motivating clients include:

   - Listening
   - Meeting them where they are.
   - Learning about their worldview and goals.
   - Rolling with resistance
   - Supporting their self-efficacy.

   These strategies are all components of motivation interviewing (Miller & Rollnick, 2013), an evidence-based approach for helping people change.

   During this initial phase of treatment, focusing too much on the sexual abusing behavior can be threatening to clients and undermine the therapeutic relationship. And, as will see later, a focus offense denial and minimization is not likley to reduce reoffending risk (Mann, Hanson, & Thornton, 2010).

2. **Identification of strengths and treatment needs**. This phase of treatment involves first identifying client strengths, which should be supported to facilitate positive change. Second, treatment needs are identified, which will become central targets of treatment.

3. **Skill building to enhance strengths and overcome deficits**. The third treatment phase focuses on helping each client build on his strengths and address his treatment needs. This involves considerable skill practice, which includes learning prosocial ways of thinking and behaving, avoiding risky behaviors and situations, and achieving positive life goals that are incompatible with hurting others. The "Treatment Goals" section of this chapter details the treatment needs that persons with DD/PSB have that are closely linked to continuing to sexually abuse others.

4. **Transition planning**. This phase of treatment involves each helping person with DD/PSB prepare to move from a higher level of care to a lower level of care. If the person was in prison, transition planning would help prepare him for release to the community. If the person was in a highly supervised residential setting in the community, transition planning would help prepare him for more independent community living. If the person was attending weekly group treatment, transition planning might involve reducing treatment to twice a month and then once a month. The goal here is the help the person live safely in the community while retaining the greatest level of self-determined independence as possible.

MAJOR TREATMENT TARGETS

The second RNR principle, the need principle, focuses on what to target in treatment. To reduce future sexual abusing behavior, treatment should focus primarily on problems that persons with DD/PSB have that are closely linked to sexual abusing behavior (Hanson, Bourgon, et al., 2009). These are called criminogenic needs or dynamic risk factors.

Ruth Mann and her colleagues (Mann, Hanson, & Thornton, 2010) conducted a comprehensive analysis of research studies to identify the major dynamic risk factors of men who commit sex offenses. The dynamic risk factors they identified overlap considerably with those of persons with DD/PSB (Blasingame, 2014; Lindsey, 2009). The textbox here lists seven targets that should be a major focus of treatment for persons with DD/PS in order to reduce sexual reoffending. The following sections discuss each risk factor in more detail.

MAJOR TREATMENT TARGETS

1. ACCURATE INFORMATION ABOUT SEXUALITY
2. GENERAL SELF-REGULATION
3. SEXUAL SELF-REGULATION
4. ATTITUDES SUPPORTIVE OF SEXUAL ABUSE
5. INTIMATE AND OTHER SOCIAL RELATIONSHIPS
6. RISK MANAGEMENT SKILLS
7. COMMUNITY INTEGRATION AND SUPPORTS

ROLE OF OFFENSE ADMISSION AND RESPONSIBILITY

Before returning to the major treatment targets listed in the text box, it is important to address the issue of offense admission and responsibility, which is not listed in the text box as a major treatment target. Traditionally, one of the first steps in sexual abuser treatment programs was to ask clients to describe in depth and accept responsibility for their sexually abusive behavior. Many providers argued that it is difficult to treat a problem unless a person accepts that they have the problem (McGrath et al., 2010).

Since the first edition of this best practice manual in 2005, research evidence has continued to mount that sexual offense denial and minimization, overall, are not predictors of sexual reoffending (Mann et al., 2010; Ware & Mann, 2012). That is to say that among men who have committed sexual offenses, the reoffense rates of those who admit committing sexual offenses and those that deny committing sexual offenses are not different. Based on this evidence, researchers and

practitioners increasingly argue that offense denial or minimization should not be an impediment to entering and benefiting from treatment (Association for the Treatment of Sexual Abusers, 2015; Yates, 2009). The argument is that if an individual remains in denial but addresses treatment needs linked to his sexual offending, such as learning how to think before acting, manage sexual impulses, control emotions, and develop a prosocial support system, then he will arguably have reduced his risk to sexually offend.

Accurately identifying a client's treatment needs, which is the second phase of treatment described earlier, is required for developing an effective service plan. It certainly can be easier to identify a client's treatment needs if he is willing and able to recall and describe his PSB as opposed to if he denies his PSB.

Men who admit their sexual abusing behavior do appear to more easily engage in treatment, which is a responsivity issue in the RNR model (Jung & Nunes, 2012). So, it is certainly reasonable and good practice to ask an individual about his PSB. This includes asking what he was feeling, thinking and doing at the times before, during, and after his abusing behavior. However, there are other ways to get this information. Individuals will often be willing to "tell the story" about an abusing incident but just leave out the part about the actual abuse or how they were responsible for committing the abuse. In these cases, the "story" and the person's other personal history often provides enough information to reliably identify the individual's strength and treatment needs. As well, the details of his abusing behavior usually are described in court and police records. The idea is to get a "good enough" account of the abuse to help identify the person's treatment needs.

For individuals who are willing to talk about their PSB, be cautious about spending too much time on the topic. Treatment overly focused on a person's sexual abusing behavior, especially for a lower risk individual, runs the risk of having the person adopt a deviant self-label and see himself as more deviant than he really may be. This runs the risk of "shaming" the individual, which can undermine positive therapeutic progress. As well, providers should not become overly focused on having clients discuss problem sexual behavior in treatment groups. We do not want group members to begin developing more anti-social attitudes and beliefs from associating with others who have similar or more severe problems (see Chapter 17: Treatment and Training: Methods of Adapting and Delivering Treatment for more information regarding individual versus group treatment). Treatment should focus primarily on problems that if the person successfully addresses will reduce his risk to engage in future problem sexual behavior. We now return to the major treatment targets listed earlier in the text box.

1. ACCURATE INFORMATION ABOUT SEXUALITY

Lack of accurate information about sexuality and lack of awareness of social norms about sexual behavior have been identified as risk factors for sexual acting out among persons with DD (Blasingame et al., 2014).

ACCURATE SEXUAL KNOWLEDGE

Many people with DD lack accurate information about basic sexual matters. While they have all the feelings and desires of people without disabilities, they may not have received the appropriate information or education. Families and schools often exclude people with DD from sex education classes because they think they don't need it or because they are not comfortable addressing these topics with people with disabilities. Social isolation, especially during puberty and adolescence, often prevents people with DD from picking up information from same-age peers. Many offenders learn unrealistic ideas about relationships and sexuality via television shows and videos. Additionally, knowledge of sexuality may be complicated for an individual who has been a victim of sexual abuse.

THE FOCUS AND FRAMEWORK OF SEX EDUCATION

The focus of sex education within a treatment program should be to identify the person's knowledge gaps and misinformation and to correct these. A standardized curriculum is the best way to do this (see resources at the end of Chapter 17: Treatment and Training: Methods of Adapting and Delivering Treatment). If the therapist is not comfortable offering sexuality information, he or she should refer the person to someone who has been trained in sexual education and who can convey such information in a matter-of-fact, accessible manner. Some programs offer a sex education group in conjunction with other treatments.

People with DD who commit sexual offenses should have correct information about the following:

- Their bodies and bodily functions
- Hygiene
- Pregnancy
- Sexually Transmitted Infections (STIs)
- HIV and AIDS
- Birth control
- Practicing safe sex
- Sexual techniques
- Sexual orientation

Teaching sexual information should take into account the individual's current circumstances and level of activity. Pre- and post-assessments of the person's knowledge base of sexuality information provide a framework for education.

The information taught should concentrate on that which the individual can apply directly to his life now or in the near future. For instance, at a certain stage, detailed instruction in interpersonal sexual techniques may not be advisable because the offender will have no opportunities for sexual relationships in the foreseeable future.

In addition to anatomy and physical facts, sexuality training includes social and legal information, such as:

- the legal age of consent.
- laws against sex with family members.
- laws against sex with children.
- places where sex is not allowed (public space versus private space).
- laws against sex for hire/prostitution.
- what constitutes sexual contact.

Many people with DD need practice to comprehend and apply these essential boundaries. For instance, a person with DD/PSB may not be able to tell the difference between a 12-year-old and a 16-year-old. Similarly, private space needs to be defined in concrete terms (the bedroom is okay; the living room is not okay).

2. GENERAL SELF-REGULATION

General self-regulation concerns how well someone is able to control his thoughts, emotions, and behaviors. Persons with DD/PSB who have or develop good self-regulation skills will have a lower their risk to act out sexually than individuals who do not have these skills. Various aspects of self-regulation include emotion management, problem solving, good mental health, and appropriate substance use.

EMOTION MANAGEMENT

Non-sexual feelings and emotions can be connected to sexual feelings in confusing and problematic ways. Feelings of anxiety, depression, or humiliation can become associated with sexual arousal. **Any emotion the person with DD/PSB finds intolerable, such as anger, may stimulate sexual feelings and impulsive behavior.** Treatment programs for persons with DD/PSB need to teach skills of emotional self-regulation.

Learning to disconnect feelings of emotional distress from sexual feelings starts with learning to accurately identify the emotions and feelings a person has. This may be difficult for many people with DD. Offenders also need to learn that they do not have to act on their emotions. This population needs assistance in learning skills to deal with impulse control problems. Being able to stay with an emotion, to experience it, to label it and to not act on it is a skill. Learning to self-soothe and value oneself is another skill that a person needs to learn before he can regulate his emotions.

Helping a person with DD/PSB to identify and regulate his emotions may require consideration of family dynamics. In families in which the person's feelings were not validated, he may have learned either to suppress or to exaggerate certain emotions.

Developing emotional self-regulation skills calls for attending to the various everyday factors that can affect emotional experience. This includes getting enough sleep, eating properly, engaging in physical activity, and having positive experiences and relationships in life.

Anger management therapy can be very helpful to persons with DD/PSB for whom feeling angry was closely linked to abusing. Over the years, a number of anger management programs have been developed, any one of which may be suitable for

an individual or groups of persons with DD/PSB. These programs share a number of common elements, as summarized below.

- Recognizing and labeling anger. Individuals learn to identify the physical signs (for example, muscle tension and clenched fists) that indicate anger in themselves and others.
- Identifying situations and cues that lead to anger.
- Understanding the external circumstances as well the internal triggers that provoke anger.
- Learning skills to reduce anger.
- Learning to express anger in healthy, socially constructive ways.
- Learning to relax, through relaxation exercises and breathing deeply.

It is important to note that sexual acting out is not associated with negative feelings for all individuals. Some persons with DD/PSB are at risk of abusing when they are doing and feeling well emotionally (see Pathways to Abusing section in Chapter 15).

PROBLEM-SOLVING SKILLS

A person's ability to identify and solve life problems is related to the person's ability to self-regulate and avoid reoffending. Examples of life problems are:

- problems getting along with a housemate.
- problems at work.
- financial problems.
- family or health problems.

Persons with DD/PSB are not expected to become independent in solving all of life's problems (who of us is?). In fact, learning to ask others for help solving a problem is itself a problem solving skill. Treatment should assist persons with DD/PSB to learn general problem-solving skills, and to get to the point where a new problem does not feel overwhelming or lead to panic.

Community supports and home supports should give the persons with DD/PSB experience with the steps of problem solving so that he learns:

- to recognize and define problems.
- to brainstorm possible solutions.
- to weigh the pros and cons of possible solutions.
- to recognize sources of help and to ask for help.
- to carry out a plan of action.
- to evaluate the outcome.

MENTAL HEALTH TREATMENT

Persons with DD/PSB should have a careful diagnostic assessment by a licensed mental health professional. Depression, bi-polar disorders, obsessive-compulsive disorders, and organic brain damage may all be associated with sexual acting out, and may also prevent the person from progressing in treatment.

People with DD experience the same range of mental health problems as the general population and are more likely than non-disabled persons to develop such problems. These problems warrant attention in their own right but often contribute to PSB as well. For example, a depressed person with DD may sexually act out as a way of coping with acute feelings of hopelessness and helplessness.

Certain mental health problems are particularly important to consider and address. Many persons with DD/PSB have themselves been victims of physical, sexual, or emotional abuse and may be suffering from Post-Traumatic Stress Disorder (PTSD) or another trauma-related disorder such as borderline personality disorder.

Referral to a psychiatrist or clinical psychologist is necessary if the person is in need of psychotherapeutic treatment or drugs. It may be difficult to find experienced mental health professionals who are willing and able to provide services to persons with DD/PSB. It is worth the investment of time and effort to identify such persons and to establish a relationship with them. In some instances, it may be necessary to convince less experienced professionals that they have or can acquire the skills to work with people with DD.

For certain mental health problems experienced by persons with DD/PSB, very specific treatment methods are available and should be used in preference to non-

specific psychotherapy or supportive counseling. For example, borderline personality disorder is a serious mental health problem involving significant deficits in emotional self-regulation. It has proven to be difficult to treat and is not responsive to most traditional psychotherapies. A cognitive behavior therapy method called **dialectical behavior therapy** was developed by Marsha Linehan (2014) to deal with the problems in self-regulation and other key features of the disorder. The approach teaches the person concrete skills following a well-organized treatment manual. While it was not developed specifically for people with developmental disabilities, it can be extremely useful as a component of the overall treatment plan for offenders who present with borderline personality disorder or with symptoms of the disorder.

SUBSTANCE ABUSE

If a person with DD/PSB is abusing drugs or alcohol, he will not be able to progress in treatment. Alcohol consumption should be prohibited if the person has a history of abusing alcohol. Substance abuse treatment should be provided if needed.

Learning to drink responsibly in a social setting may be an important social skill for offenders who do not have a past history of alcohol abuse. The offender must check with his physician to assure that he is medically cleared to consume alcohol.

3. SEXUAL SELF-REGULATION

Sexual self-regulation centers around problems with **sexual interests** and **sex drive**. Some persons with DD/PSB are more aroused to abusive sexual behavior than to appropriate sexual behavior, while others are not at all aroused to appropriate sexual behavior. Some persons with DD/PSB have a very high sex drive and have difficulty not acting on their sexually intrusive thoughts. Some persons with DD/PSB think about sex or engage in sexual activity to cope with difficult emotions. Individuals with sexual self-regulation problems should receive treatment to address these difficulties.

Persons with DD/PSB who learn to control their sexual arousal reduce their risk of abusing again. Treatment for arousal control problems has two goals: (1) To help individuals **control, reduce, or eliminate abusive sexual arousal and interests**; and (2) to help individuals **develop, maintain, and strengthen healthy sexual**

arousal and expression. The following strategies must be matched to the person's ability to understand and implement them.

INCREASING HEALTHY SEXUAL INTERESTS AND AROUSAL

Techniques to **increase healthy sexual arousal** include:

- Orgasmic reconditioning. This refers to positive conditioning procedures in which the person pairs appropriate sexual fantasies with masturbation and orgasm. Many persons with DD/PSB have abusive sexual fantasies while masturbating. Reconditioning techniques work by pairing healthy sexual images and fantasies with the pleasurable feelings of orgasm. Tapes, photos, or other materials with appropriate sexual images and themes can be provided to a person who needs help developing positive images.

DECREASING ABUSIVE SEXUAL AROUSAL

Techniques to **decrease abusive sexual arousal** include the following:

- Avoidance of pornography and other abusive images.

- Avoidance of masturbating to abuse related thoughts.

- Covert sensitization. This is a counter-conditioning approach that pairs abusive sexual fantasies with aversive or escape images. With this technique, for example, the person with DD/PSB imagines a high risk scene that could lead to abusing. It might be the chain of behaviors that led to his sexual abusing in the past. When he gets to the point just before he commits a sexually abusive act, he interrupts the scene by yelling "STOP" and practices fantasies of **successfully** escaping before engaging in abusive behavior. This technique can be practiced using role play, audio-tapes, or cue cards (Burke, Dwyer, & Rieling, 2015; McGrath, 2001).

- Odor aversion. The individual uses a foul odor in this procedure, such as ammonia, to interrupt sexually abusive urges or thoughts (Burke et al., 2015). Administration of foul odors by others, such as the therapist, are considered aversive procedures and are not permitted. However, the person may be offered

this technique as one that he may use himself. It can be effective because it is concrete. If the offender has control of the offensive odor and the use of the technique is completely voluntary, it is not considered an aversive procedure.

- Environmental controls. This refers to controlling the person's environment by reducing access to stimulants (such as young children) that trigger abuse-related sexual urges.

- Medication. Medication can be considered for certain individuals to decrease abusive sexual arousal. The next section discusses this possibility in more depth.

MEDICATION

Medication is another treatment option (McGrath et al., 2010; Nair, 2016). It should be considered for individuals whose sex drive is so high that:

- preoccupation with sex interrupts focusing on other activities.
- the individual is constantly reinforcing deviant arousal through frequent masturbation.
- the individual's sex drive causes self-injurious behavior.

No drug will **change** a person's **focus of arousal**. For instance, there is no drug that will change a person from being sexually interested in children to being interested in adults.

The most commonly used drugs to reduce sexual arousal are:

- **SSRIs (Selective Serotonin Reuptake Inhibitors)**. Examples: Prozac, Paxil, Zoloft, Effexor, and Luvox. These drugs are used primarily to treat depression or obsessive-compulsive disorder but they have the effect in many people of decreasing libido. They are relatively safe. SSRIs are usually the first choice when the person wants to try a medication approach.

- **Anti-androgens**. These drugs reduce sexual arousal and libido (sex drive). Examples: Depo-Provera and Lupron. They can have unwanted side effects such as weight gain and loss of bone density. Most side effects can be eliminated by stopping the drug. Particular caution should be used with adolescent males who have not reached physical or sexual maturity.

Medications should NEVER be used to control arousal without the person's full agreement and consent. If the person has a guardian, the guardian must also consent.

RESPONSE TO MEDICATIONS IS HIGHLY INDIVIDUAL AND CLOSE MONITORING IS ESSENTIAL. A MEDICINE THAT IS EFFECTIVE FOR ONE PERSON MAY NOT HAVE THE SAME EFFECT FOR ANOTHER. SIDE EFFECTS ARE ALSO INDIVIDUAL.

SSRIS AND ANTI-ANDROGENS SHOULD BE PRESCRIBED ONLY BY A PHYSICIAN WHO IS FAMILIAR WITH THE USE AND SIDE EFFECTS OF THESE DRUGS.

ADDRESSING SELF-INJURIOUS AUTO-EROTIC BEHAVIOR

Staff should be aware that self-injurious behavior may occur, particularly when a person's sexual outlets have been blocked. Staff may first become aware of self-injury when the person talks about soreness or pain in the genital area in general, upon urinating, or during a physical examination. Self-injury may occur from excessive masturbation. It may also occur when a person inserts objects into the penis or rectum. If staff suspect a person may be engaging in self-injurious behavior, they should question the individual about objects (such as kitchen utensils) he may be bringing into the bedroom.

It is important to provide a supportive framework to talk about excessive masturbation. Staff should be careful to define it not as a shameful activity but as a normal activity that is being done to excess. Some people may not know how to masturbate. There are graphic printed materials and videos to teach safe masturbation technique (see sources at the end of this chapter). It is best to watch the video with the person and then to have him watch it alone.

5. ATTITUDES THAT SUPPORT SEXUAL ABUSE AND OTHER ABUSIVE BEHAVIOR

Having attitudes that support sexual abuse is common among individuals that commit sexual offenses. Modifying distorted attitudes may reduce the likelihood of recidivism, but are particularly difficult to change for persons with DD/PSB.

SEXUAL ABUSE SUPPORTIVE ATTITUDES

A focus of treatment is to change attitudes that support or condone sexual abusing. Examples of such thoughts and attitudes are:

- *Children enjoy sex with adults.*
- *Children can consent to sex with adults.*
- *If a child does not resist, he is consenting to sex.*
- *Women say "no" when they mean "yes."*
- *If a woman is wearing certain types of clothes, it means she is asking for sex.*
- *Men can't be expected to control themselves once they get turned on.*

Role playing and cognitive therapy can be used to challenge these attitudes. Watching TV and videos and discussing the attitudes of the characters helps to relate abstract ideas to actual situations. The curriculum materials in Appendix D contain several resources.

For persons with DD/PSB, one of the best ways of supporting change is for the person to spend time with men who serve as positive role models and who express healthy attitudes about sex and respectful attitudes about women.

GENERAL CRIMINAL AND RULE-BREAKING ATTITUDES

In addition to changing attitudes about sexual behavior, the person may need to learn new attitudes towards non-sexual criminal activity and rule-breaking behaviors.

Examples of thoughts and attitudes that support general criminal or rule-breaking activity include the following:

- *Rules are made to be broken.*
- *It's only wrong if you get caught.*
- *Everyone does it (i.e., breaks a rule or the law), so it's okay if I do it.*
- *I want what I want when I want it.*

Role models with pro-social attitudes are usually the best teachers. Watching TV or videos with the person and discussing the attitudes of the characters toward law-abiding behavior can be an effective teaching tool. Material that presents rule-

breakers as heroic should be avoided. "New Me" and "Old Me" charts may help the person to recognize and self-correct attitudes that support rule-breaking.

EMPATHY

Attitudes that support abusing described in the preceding sections do not consider the feelings of victims. Clearly, there is a link between having abuse supportive attitudes and lack of victim empathy. Activities that promote empathy are often included in sexual abuser treatment programs. Empathy is having and showing concern about others. It has four components.

- Recognizing emotional distress in others
- Seeing another person's perspective
- Experiencing vicarious emotional responses
- Communicating empathy to others

Cognitive limitations though may make it hard for many individuals with DD to recognize another person's distress and put them in the place of another. Again, treatment interventions must be matched to the person developmental level.

Since the first edition of this best practice manual, there has been a shift in how many programs are addressing empathy as a treatment target. Research evidence indicates that targeting victim-specific empathy (i.e., empathy for a past victim) does not appear to reduce the risk of sexual reoffending (Hanson & Morton-Bourgon, 2004, 2005; Mann et al., 2010). Some individuals have a profound lack of empathy towards others. Developing victim empathy might reduce their risk to reoffend, but that would be exceedingly difficult to do. Sometimes individuals are generally empathic in their interactions with others but do things that are not empathetic under certain conditions. They justify acting out because they were under stress, consumed with anger at the person, or did not feel they could control their sexual arousal. They are very self-centered and trying to get them to see the harm they cause others can be challenging. As we know from motivational interviewing, arguing a position, such as trying to convince someone of the harm that they have caused a victim, can often back fire; the person takes the opposite position of the argument (Miller & Rollnick, 2013).

Based on a review of the literature on victim empathy among sex offenders, Barnett and Mann (2013) concluded that less focus should be given on creating

empathy for past victims, and more emphasis should be placed on what caused the failure to empathize with the victim at the time of the offense. The focus then is on how to help a person become aware of and address issues that might block them from having empathy in future situations that could lead to sexual abuse. This involves teaching general empathy skills and general victim empathy about sexual abuse victims, and not focusing as much on victim-specific empathy for the person they abused.

6. INTIMATE AND OTHER SOCIAL RELATIONSHIPS

Nearly all persons with persons with DD/PSB enter treatment with significant deficits in their social skills. Few have had successful employment. Few have close and satisfying friendships. Few have volunteered or participated in churches or community organizations. Many have been teased and ridiculed throughout life and have a negative self-image. Many have problems with mental health or emotional regulation.

Deficits in social competence result in negative emotions and conflicts that, in turn, may be precursors to problem sexual behavior. Developing positive social skills and interpersonal success provides the foundation for a responsible and satisfying lifestyle.

Developing social competence includes forming and maintaining healthy consenting relationships with age appropriate peers. This includes development of job and community living skills, a pro-social sense of self worth, an identity associated with pro-social values (Haaven, 2006), and the ability to deal with the frustrations, temptations, and barriers of everyday living.

SOCIAL SKILLS TRAINING

Social skill and relationship training are critical aspects of treatment for persons with DD/PSB. In best practice, this training should be incorporated incrementally into the therapeutic process. Persons with DD/PSB are often socially isolated and have poor communication skills. Their social skills deficits can make it difficult or impossible to have healthy consenting relationships with age-appropriate partners. Persons with DD/PSB need to learn:

- how to identify appropriate and inappropriate dating partners.
- strategies for meeting people.
- how to develop and maintain friendships, including resolving disagreements and maintaining conversations.
- leisure skills; in groups, with friends, and alone
- dating customs.
- how to find out if a person is consenting to sex.

A social skills group can be a good forum to model, teach, and practice appropriate social interactions. Successful groups may be all-male, all-female, or co-ed. Persons with DD/PSB can be included successfully in social skills group with persons with DD who do not have PSB, as long as precautions are taken to create a safe group where no one will be a victim.

Learning to read facial expressions and body language is an important coping skill. Many persons with DD/PSB are not aware of their own facial expressions and body language and it is difficult for them to read others. Misreading another's expressions and body language can lead a person with DD/PSB to believe a victim wants to have sex with him. For example, some persons with DD/PSB report that if a woman smiles at him, it means she wants to have sex with him.

Another skill is learning to interpret an interaction accurately. If a person is rejected, he may feel sadness. To this he may add his interpretations, beliefs and assumptions. A person's sadness at being rejected by a woman may be tinged with anger because he has made an assumption that the woman who rejected him was being cruel and is not worthy of his kindness. He may believe all women are cruel and not worthy of kindness. This misinterpretation may lead a person to devalue the woman and, in doing so, he may find it easier to offend against her.

At some point, working with a social skills group needs to develop into actual practice for the individual. A person may need support in how to meet potential partners or friends, such as attending dances, going on small group outings, or participating in self-advocacy activities. Double dates with support staff are a good first step in the dating/"getting to know you" process. Support staff prompt and coach the individual prior to events. Disclosure of the individual's risk patterns needs to occur before the person is left alone with a date.

For more information about social skill training, see the resource material at the end of Chapter 17: Treatment and Training: Methods of Adapting and Delivering Treatment.

7. RISK MANAGEMENT SKILLS

Although an ultimate goal of treatment is to help the person with DD/PSB learn to live a good life (approach goals) that is incompatible with hurting others, this needs to be balanced with the person learning how to avoid or mange risks related to abusing again (avoidance goals). At least initially, learning risk management skills is an important part of treatment. For a person with DD/PSB who has committed multiple offenses, his sexual behavior may follow a predictable **pattern**. Although members of the collaborative team should identify evident abusing pattern to assist the person manage his risk, many individuals with DD will have limited ability to understand patterns of causal relationships.

When possible, he should learn to:

- **identify** his risk factors.
- **avoid** risky situations.
- **escape** or **cope** when he finds himself in a risky situation.

Here is a list of risk factors identified by a person with DD/PSB in central Vermont.

Physical signs	**Feeling/thinking signs**	**Behavioral signs**
• Not sleeping • Masturbating several times a day • Being tense all the time	• Feeling depressed • Feeling angry • Thinking that, if I did it right, I could have sex with that child	• Drinking alcohol • Isolating; being alone • Watching movies with children in them • Looking at or saving pictures of children

Over time, the person with DD/PSB, depending on his developmental level, should learn to answer the following questions:

- How did you plan/carry out/set up the sexually abusive acts?
- What feelings or moods increase your risk to commit sexually abusive acts?
- What thoughts increase your risk to sexually abusive acts?
- What sexual fantasies increase your risk to sexually abusive acts?
- What behaviors increase your risk to sexually abusive acts?
- In what situations would you be at risk to sexually abusive acts?
- Who are the types of people most at risk from you?

Eventually, a person with DD/PSB should be able to practice and show understanding of his risk factors and manage them in role playing during therapy sessions. He should be able to identify and report high risk fantasies, thoughts, and feelings. When faced with any new situation, he should be able to make a risk plan, also called a Safety Plan (described below). Use of a safety plan and a focus on risk management (avoidance strategy) should fade over time as an individual learns to lead a good life (approach strategy) that is incompatible with abusing other.

SUCCESS EXPECTANCE

James Haaven (2002) suggests presenting risk management to people with DD in terms of "success expectance," emphasizing what to do rather than the steps that lead to doom. His model is as follows:

1. Define NEW ME. Who do I want to be? How will I act then?
2. Identify skills I need to be NEW ME.
3. Learn and practice the skills one by one.
4. Define Set-Ups (risks) and Give-Ups (lapse) that are part of OLD ME (things that get me off the track to NEW ME).
5. Learn and perfect coping skills when faced with Set Ups and Give Ups.

PREPARING A SAFETY PLAN

One behavioral support is the use of a **Safety Plan**, which may be created and completed prior to an outing. The person with DD/PSB fills out the safety plan sheet and puts it in his pocket, which acts as his reminder and reference during the outing. The person should create the plan himself (or with assistance) since it is an exercise to (1) define risks he may face in the community and (2) describe how he will manage these risks. Staff must be vigilant about how the form is completed; many individuals begin to write the same things each time they go out without giving it much thought at all. The goal is for the person to **think** before he goes out into the community and to be **prepared**.

To create a plan, the person makes two columns on a sheet of paper. In one column, he lists things in the community that might be risky for him and in the other column lists what actions he can take (by himself or with his support person) to counteract those risks. Writing the plan, signing it, sharing it with the support person, and having it witnessed makes this a very concrete support.

SAMPLE SAFETY PLAN	
Risk	**Action**
Staring at children	Count to 1 and look somewhere else. Tell a support person. Walk away; leave situation
Standing too close to people	Move back two steps
Voice getting louder, getting excited, not listening	Use indoor voice; take deep slow breaths
Signed: _____ Witness: _____	

Ultimately, the person needs to demonstrate risk avoidance and the ability to escape in **unplanned** circumstances or when he is having high risk thoughts or fantasies. Escape strategies for coping with risk situations include:

- Self-talk (Stop, Think, Decide)
- Deep breathing or other cool-down techniques
- Telling someone about the risk
- Looking away
- Leaving

7. COMMUNITY INTEGRATION AND SUPPORTS

Progress that an individual with DD/PSB makes in secure residential settings should be is reinforced and strengthened by treatment, supervision, and supports when he steps down to less secure settings. As an individual lives more independently in the community, services should be reduced gradually as the person learns to lead a life that is incompatible with abusing others. Although some individuals will learn to live safely in the community on their own, a significant percentage of individuals with DD/PSB will always needs supervision and supports related to their DD and/or PSB. As well, some individuals that need supervision and supports may reject services. In all cases, however, services should help an individual achieve the greatest degree of safe community integration that he desires.

Successful community integration involves helping the person with DD/PSB develop skills and resources in several areas. These include:

- housing
- financial security
- money management
- employment
- education
- physical and mental health care
- risk management
- leisure activities
- healthy relationships
- social supports

Successful community integration involves helping the person with DD/PSB learn how to overcome barriers (e.g., communication, embarrassment) on how and when to get help. For instance, the person with DD/PSB should have a clear idea about whom to call when he:

- is sick.
- has a problem and doesn't know what to do.
- feels like hurting someone.
- feels lonely or sad.
- has sexual thoughts about children.

To be safe over the long haul, the person with DD/PSB needs to have and trust a strong social and support network. Haaven (2002) describes relationship building as the "**center post of treatment**." At the same time, the person needs to learn how to recognize people who aren't good for him and what to do if those people want to spend time with him. The person's ability to develop and maintain relationships with supportive individuals is strongly correlated with long-term success.

People in the person's support network may include family, friends, co-workers and employers, and church members. People in the support network should be individuals who lead a pro-social lifestyle and who actively support the individual's efforts to lead a fulfilling life that is incompatible with offending.

CHAPTER 17: TREATMENT AND TRAINING: METHODS OF ADAPTING AND DELIVERING TREATMENT

Treatment and training programs that are successful with persons with DD/PSB are constantly creating new ways to help their clients learn. This is a hallmark of the **responsivity principle**, which is that programs should be offered in a format to which an individual can successfully respond (see risk, needs, and responsivity principles in Chapter 14: Assessment and Psychosexual Evaluations). The responsivity principle concerns "how" to deliver services to individuals who have committed offenses. Services are most effective if they are delivered in a manner that matches an individual's motivation, ability, learning style, and personality characteristics. While each person's program is tailored to his individual learning style, some tried and true methods used in creating a program are explained in this chapter.

DEVELOP A GOOD WORKING RELATIONSHIP

Perhaps the most important factor in helping a person with DD/PSB lead an abuse free life is ensuring that he has a good working relationship with his service providers. Service providers should interact with the person in a respectful, warm, genuine, firm, fair, directive, and empathetic manner (Andrews & Bonta, 2010: Marshall et al., 2011). Having unconditional positive regard for the person can go a long way to develop a good working relationship. Judging a person's actions, such a being clear that sexual abuse is wrong, is appropriate, and it is very different than judging the person. Interactional styles that are hostile, shaming, and deceptive will have a negative effect on helping the person achieve positive life goals.

PROVIDE TRAUMA INFORMED SERVICES

As we have reviewed earlier, people with DD experience high rates of physical, emotional, and sexual abuse (see Chapter 1: What is "Developmental Disability"?). An individual's reactions to these and other types of trauma (e. g., witnessing violence, parental separation), must be considered in delivering services. The experience of trauma can deeply influence how an individual views the world (e.g., safe versus unsafe), manages his emotions, and behaves. People who experience trauma, especially at a young age, often develop coping skills that were originally adaptive for dealing with a trauma but are maladaptive now. Traumatic experiences have been associated with a range of problems such as lack of trust, self-doubt, hypervigilence, intrusive thoughts, and exaggerated startle response (American Psychiatric Association, 2013).

Trauma Informed care (TIC) employs strengths-based treatment approaches that take into consideration the impact of trauma on an individual (Levenson & Willis, 2014; Substance Abuse and Mental Health Services Administration, 2013). TIC stresses providing services in an environment in which the client feels safe. It seeks to ensure that services do not re-traumatize the client. As described above, this includes developing a trusting working relationship with the client. TIC strives to maximize client choice in developing service plans. Ideally, service plans are developed collaboratively among the client, his advocates, and services providers. TIC seeks to empower clients, in part by recognizing and acknowledging the resiliency of how a client originally coped with a trauma, even though the strategies used may currently be maladaptive.

Many of the principles of TIC are reflected in the sections of this chapter that following.

BE POSITIVE RATHER THAN PUNITIVE

Supportive and positive approaches are proven to be more effective than punitive approaches in changing people's behavior, including persons with DD/PSB (Andrews & Bonta, 2010; Marshall et al., 2011; Widahl, Garland, Culhane, & McCarty, 2011). Persons with DD/PSB often begin programs with very low self-images and a history of being unsuccessful. Haaven's (2006) "new me" approach emphasizes the critical importance of helping the individual with DD/PSB develop positive identity. Such change requires motivation and the belief that an individual

can change. Staff need to communicate confidence that the person can change. Tasks should be broken down into manageable steps that offer repeated positive reinforcements. Programs should provide frequent opportunities for success and generous recognition of success.

PROVIDE PLENTIFUL SUPPORTED PRACTICE

Classroom experience must always be translated into actual practice. Persons with DD often find it difficult to generalize skills learned in one setting (e.g., residential setting) to other settings (e.g., community or work setting). Therefore, individuals should practice the same skill in multiple settings under various circumstances. Persons with DD/PSB need several hours of supported community practice for every hour of group or individual therapy. Translating concepts from a classroom or therapy setting to real life practice is particularly difficult for most people with DD. The program should put its most skilled staff into community support activities, where the individual tries out new skills and gets immediate feedback from support staff to reinforce or improve his skills.

Homework assignments, such social skills practice or developing safety plans, should be supported by all paid support staff—residential, respite, and community staff—as the person with DD/PSB needs to learn that his skills apply in all settings.

TEACH LABELS, NOT ABSTRACTIONS

Concepts are best communicated by simple, straightforward choices or symbols:

- Old Me/New Me
- Stop/Go
- Red light/Green light

LINK EMOTION AND LEARNING

People learn and remember best when learning is paired with emotion. Fun, excitement, humor, drama, movement, and action all provide an emotional charge that improves a person's capacity to learn and retain information.

USE TIME AND PATIENCE, REPETITION, AND REINFORCEMENT

Anyone who undertakes treatment of persons with DD/PSB must expect that learning and change will take time. Concepts need to be repeated and reinforced, using visuals, role playing, and community practice.

Slow progress is not the same as no progress. If a person with DD/PSB is not making any progress, blame should not be placed on his disabilities but upon the teaching and treatment modalities, and these should be changed.

GROUP VERSUS INDIVIDUAL

Group treatment is the most common mode of service delivery with men who have committed sex offenses, but it is typically augmented with some individual treatment and other ancillary services (McGrath et al., 2010).

Groups can be closed, open, or a mix of both. In closed groups, clients typically begin the treatment group together and progress through various treatment phases as a group. In open groups, clients begin and complete the group at different times and work on assignments at their own pace. In closed groups that are facilitated using a treatment manual, the sequencing of interventions is set in the manual. Open groups provide more flexibility, and sequencing can be more individualized. With increased flexibility though, a risk is that providers may drift away from delivering the program as designed.

Advantages of group include that it is more economical than individual treatment. A power of the group is its ability to both support and challenge the person with DD/PSB. An individual therapist may not have the same impact as a group of a person's peers to support successes and challenge problem behavior, or to break down an individual's sense of being alone. It is in the group that the individual may learn that he is one of a number of people with similar problems and that he has the opportunity to see people like him who are making positive changes in their lives. In addition, many recommended treatment activities, such as role playing and practicing social skills are difficult in the confines of individual therapy.

Group treatment does carry some risks. Just as group members can be a pro-social influence, they can also influence one another in anti-social ways. Individuals can

develop anti-social attitudes and beliefs from associating with others who have serious problems in these areas. The greatest potential harm is perhaps to low risk individuals who are placed in treatment groups with high risk individuals. In groups that focus too much on deviant sexual thoughts and behaviors, group members may adopt deviant self-labels and see themselves as more criminal or sexually deviant than they really are. In groups, it may be difficult to individualize a persons' treatment.

In support of individual treatment, Schmucker and Losel's (2015) exhaustive review of good quality treatment studies found that programs providing more individual treatment sessions were more effective than those that provided few or no individual sessions. They theorize that more individualization yields better results for several reasons. Some men hide in group sessions but cannot hide in individual sessions. Groups with heterogeneous group members may not meet each member's individual treatment needs. Individual treatment can be tailored to the individual. Therapeutic relationship is important to successful outcomes, and individual treatment may allow for the development of a better therapeutic bond. Sometimes individual therapy is necessary because the individual does not have the self-confidence or verbal skills to work in a group setting.

Considering the pros and cons of group and individual treatment, some suggestions are offered. Individual treatment is a good setting in which to discuss and teach how to manage an individual's problematic sexual behavior. This models appropriate boundaries. Especially for individuals with DD, it is important to learn that the common social norm is that sexual matters should be discussed in a private and not in a public setting. Additionally, by having discussions about problematic sexual behavior in individual as opposed to group sessions, clients are not exposed to the potential harmful effects of listening to each other's descriptions of other problematic sexual behavior. Group treatment, if it is recommended, can then focus on learning and practicing skills in areas such as self-regulation, social relationships, and problem solving.

FREQUENCY, COMPOSITION, AND SIZE OF GROUPS

The desirable treatment group size ranges from five to eight individuals. If the group is larger than eight, it should be split into two groups. One therapy group per week is common, with one hour as a standard length for a group session.

Additional therapy groups or psycho-educational groups can be added if resources allow.

Group composition needs to be carefully considered and continually assessed. While a wide range of typologies can be accommodated in the same group, the level of intellectual functioning has to be considered. Clinicians must always be alert for the formation of non-consensual sexual contact between the members of a group where one member becomes the aggressor and another member the victim. Again, use caution about providing too many services, especially group services, to low risk individuals.

Numerous correctional rehabilitation studies show that **intensive services delivered to low risk offenders may result in *increased* recidivism** (Andrews & Bonta, 2010; Gendreau et al., 2001). To protect against this effect, groups specifically for low risk offenders may be formed which focus on specific areas of need, such as sexual education and social skills training. Finally, for individuals who have mastered the concepts of risk management, a maintenance group or graduation from group should be considered.

OBSERVERS IN GROUP

Non-clinical staff can be included as observers in group sessions (on a rotating basis and with permission of group members) to gain a clearer understanding of the topics and progress of each of the participants. This is a positive training strategy for new staff and can also function as a concrete demonstration to persons in the group and all staff that the treatment team functions as a unit. This can reduce the incidence of "splitting" within the team.

CONCRETE AND SIMPLIFIED FORMS

Complex forms for the person with DD/PSB to complete for safety planning, community disclosure, or other purposes aren't helpful. It is necessary to decide what are the **essentials** for each skill and to work towards that skill. The result may not contain all that the therapist or other staff wanted to include, but it is sufficient to meet the basic safety needs. Consideration of more complex processes may well come as the client becomes more comfortable with the application. Resource

curricula listed in Appendix D provide sample forms, including the Washington County Mental Health (WCMH) S.T.A.R.T. manual.

CHECK FOR UNDERSTANDING

Staff or therapists can assess the person's understanding of words, ideas, and concepts by asking him to paraphrase. At any time, staff can ask a program participant to demonstrate his understanding of whatever is being discussed or worked on at that moment.

This checking for understanding must be done in a respectful and supportive manner. Many people with DD have learned to cope with uncomfortable situations by pretending to understand. They are often skilled at sensing verbal or behavioral cues from authority figures and appearing to understand when, in reality, they don't understand. They have learned that authority figures like to hear "yes," and that people will like them better if they agree or just go along. With experience in the program and the development of trust, participants should learn to identify and signal when they don't understand.

AVOID OVERLY LONG SEQUENCING

Persons with DD/PSB typically cannot absorb the multiple steps of behavior chains or cycles as it is taught in many therapy programs for nondisabled offenders. The strategy of teaching from the concrete to the abstract is more effective with people with DD. Skills (such as risk awareness) are presented as a **single subject** that is practiced and mastered on its own before there is an expectation that it be integrated into a sequence. Avoiding elaborate abstracted sequences and concentrating on more finite concepts seems to produce better results. Focusing on a simpler three-stage sequence to describe the cycle, such as "Fantasy-Plan-Action," may be more productive.

ROLE PLAY AND SKILL PRACTICE

Role playing is used frequently in treatment and training groups. It offers the chance for the person to identify with the thoughts and feelings of others by acting

out their roles. It provides opportunities to practice skills in a safe setting and enhances learning through participation and drama.

Recommended steps for teaching new skills are similar across a variety of correctional programs (McGrath, Cumming, & Williams, 2014). These commonly include the following steps:

1. identify the skill to teach
2. help the client identify the usefulness of the skill
3. model the skill, as in a demonstration role play
4. have the client practice the skill in the treatment session
5. provide corrective feedback
6. assign skill practice outside of treatment sessions
7. provide opportunities and encouragement to enhance the skill

The goal is to ensure enough skill practice that the client achieves lasting changes in their thinking and behaviour.

USE OF CAMERAS AND PHOTOS

Video cameras can be used in a variety of ways:

- To record and later discuss role plays.
- To practice community disclosure.
- To record and provide feedback to the person on facial expressions and other visual cues.
- To create a short (2-4 minute) script of the individual acting out self-management skills (for instance, acting appropriately when a child comes upon the scene unexpectedly). This technique is called video self-modeling.

Photographs have multiple uses. Taken discreetly and with the help of staff, simple snapshots of community settings can be a tool for a person who doesn't read to document and record risk settings. Pictures of people in social scenarios can be used to teach social competencies. Cut from magazines, photos can be used to help identify facial cues and to correctly identify social boundaries. Another activity is to use magazine pictures to create collages that express "Old Me" and "New Me."

ADAPTATIONS FOR PEOPLE WHO DON'T READ AND WRITE

Programs must provide techniques or adaptations that are meaningful for people who do not read and write. For instance, a safety plan, even if dictated, is not going to be a resource for a person who does not read. In this case, a photo collage, drawings, a video, or an audiotape might be a better way to record plans for persons who do not read. Similarly, a written script for disclosure won't help someone who can't read, but a video or audiotape might be a good resource. Support staff should ordinarily be willing to take dictation from a client who can read but cannot write fluently. Posters, collages, graphics, videos, and role playing are all good resources for activities in a group that includes individuals who do not read.

DEALING WITH LAPSES AND REOFFENSES

LAPSES

Lapse behaviors are behaviors that have been identified as precursors of reoffending for the individual or violation of a rule of the program. Lapse behaviors are expected to occur, and are accepted as part of the treatment cycle. It is important for persons with DD/PSB to learn from little mistakes to avoid making big mistakes. In fact, the reporting by the person with DD/PSB of lapse behavior is viewed as an indicator of commitment and progress in treatment. The client is rewarded for this commitment. While reporting a lapse after it has been reported by other sources is less than a full positive, it is still a step along the positive treatment continuum. Such a lapse can be used as a "**teaching moment**" if the differences between self reporting and after the fact reporting are made clear. Persons with DD/PSB may take considerably longer to voluntarily self report lapses, both because of the complexity of the task and the need for the members to understand that it is safe to make these disclosures.

RELAPSES OR REOCCURRENCES

Relapse behavior is the commission of a new sexually abusive act. The reporting of relapse behavior does not shield a person from legal consequences and is not kept secret. It is reported to the appropriate authorities and the client is held accountable. While a case is pending, the client and his attorney should determine

whether the client should discuss or remain silent about any problem sexual behavior. Individual circumstances will dictate what type of treatment services, if any, he should receive while the case is pending.

LOCATING AND WORKING WITH THERAPISTS

An appropriate therapist will have specialized skills in sexual abuser therapy and a willingness to work with individuals with DD and their teams. An advanced degree in a mental health discipline and a state license or certificate to practice independently are basic requirements. The therapist should also have training in the assessment and treatment of sexually deviant behavior and be familiar with abuser and victim issues. A therapist who is new to the field of sexual abuser therapy should make a formal arrangement for supervision by a therapist who is experienced in the field. The field of sexual abuser therapy is well established. A person seeking a mentor should seek a therapist who is familiar with best practices in the field and who continues to update her skills by attending seminars and reading professional journals.

It is possible for a therapist who lacks experience in working with people with DD to learn this skill on the job. A good candidate is a therapist who is eager to learn how to adapt his skills to the needs of people with cognitive impairments and who is willing to pursue more formal training in that area.

The therapist must be willing to work as part of the Collaborative Team. The contract with the therapist should include ample compensated time outside of the therapy sessions for the therapist to meet with the team. The therapist should require the person with DD/PSB to sign a limited waiver of confidentiality so as to allow for the therapist to communicate openly with team members.

EVALUATION OF PROGRESS

Providers should evaluate the treatment progress of individuals under their care on a regular basis. Evaluations should focus on assessing how well individuals have reduced their "criminogenic needs"—namely, problems that are closely linked to their sexual abusing behavior.

Providers can assess treatment progress in a variety of ways. Ideally, clients and providers will have mutually accepted treatment goals and form a collaborative working relationship. It is important to discuss treatment goals with persons with DD/PSB and to involve them in assessing their own progress.

Formal pre- and post-testing should be used to assess treatment progress. At a minimum, providers in Vermont should administer the Sexual Offender Treatment Needs Progress Scale (McGrath, Cumming, & Lasher, 2013) at the beginning of treatment and at least every twelve months thereafter. This scale is designed to provide a structured way for clinicians, support workers, case managers, home providers, and program administrators to identify, monitor, and manage the treatment, supervision, and placement needs of adult males (ages 18 and older) with DD who have committed sexually abusive acts. It focuses on progress in the same areas of treatment described in Chapter 16: Treatment and Training: Goals of Treatment.

The individual's Collaborative Team should meet periodically to discuss his treatment progress and should invite all staff and home support providers who support this individual. This is important because each person involved typically observes the individual in different settings. Collectively discussing the individual's progress can provide a clearer picture of how well the client is functioning and successfully managing his risk to reoffend.

CHAPTER 18:
SUPERVISION FOR SAFETY AND COMPLIANCE

Restrictions and supervision requirements often set boundaries on the person with DD/PSB that he may not have experienced in the past. The person with DD/PSB may have understood abstractly that he is "in trouble," but now the specific limitations he must fulfill are delineated. Requirements or restrictions may be difficult but may also provide an incentive for him to change his behavior. The reduction of restrictions may follow his progress in developing prosocial skills and managing his risk.

We need to acknowledge though that no matter what risk management approach is taken, risk of sexual reoffense cannot totally be eliminated. Despite good evidence that treatment and supervision can reduce sexual reoffending rates (see Chapter 16: Treatment and Training: Goals of Treatment), no level of services can guarantee that an individual with DD/PSB will never sexually abuse again. Even individuals in the general population with no recorded history of committing sexual offenses present some risk to act out sexually. Estimates are that 1% to 2% of the adult male population will eventually be convicted of a sexual crime (California Office of the Attorney General, 2004 and P. Marshall, 1997; as cited in Hanson & Morton-Bourgon, 2005). As well, Hanson et al. (2016) have summarized several studies that indicate that the sexual offending rate of offenders with no recorded history of a sexual offense is 1% to 2% within the first 5 years after release into the community.

The legal system and agencies developing public policies often struggle with how to balance protecting the public from unwanted risk and taking away people's rights to lead self-determined lives (Doren, 2002). Developmental agencies and individuals who provide services to persons with DD/PSB also struggle with what are the appropriate amounts of risk management and risk reduction services for an individual (Burns-Lynch, Salzer, & Baron, 2010).

We must remember that more services are not always better. In fact, some types of services have no impact on or can actually increase an individual's risk to reoffend. For example, providing intensive services to low risk individuals or mixing low

risk individuals with high risk individuals is contraindicated (Hanson et al., 2009; Lovins, Lowenkamp, & Latessa, 2009; Schumucker & Losel, 2015).

The risk, need, and responsivity principles (see Chapter 14: Assessment and Psychological Evaluations) provide a broad guide for determining:

- **Who** should get the most supervision?
- **What** dynamic risk factors should be the target of supervision?
- **How** should supervision services be delivered based on the learning style and other personal characteristics of the individual?

ROLE OF THE COLLABORATIVE TEAM

A primary role of the Collaborative Team is to determine what levels of supervision and restriction are necessary to protect community safety (see Chapter 11: The Collaborative Team) while helping the individual with DD/PSB learn to live a satisfying offense free self-determined life. There is no "one-size-fits-all" approach for determining the level of supervision, restriction, and monitoring for person with DD/PSB. Ideally, supervision levels should be tailored to the risk, needs, and responsivity (RNR) factors of the person with DD/PSB. At times, however, there are fixed parameters such as probation or parole conditions or an Act 248 order that may supersede fully implementing the RNR approach.

The legal system and the person's team need to be familiar with the variety of supervision and monitoring techniques available and select those which are related to the specifics of the case. These should be designed toward:

- helping the person with DD/PSB lead a satisfying, offense-free life.
- protecting the victim.
- preventing sexual reoffense.
- preventing other criminal activity.
- keeping the person with DD/PSB himself safe.
- preventing elopement.
- providing reminders and reinforcement of risk reduction techniques.
- enhancing the progress toward treatment goals.

Levels of supervision and restriction should reflect the:

- person's risk to reoffend as measured on structured risk assessment measures.
- severity of past offenses.
- recent threats and fantasies.
- offending patterns (few or many obvious precursors).
- the risks inherent in the setting.
- the vulnerability of potential victims in the setting.
- progress in treatment, including preparing and following safety plans.
- disclosure to individuals who need to know.

Imposing restrictions on privacy and personal liberties raises concerns about civil liberties. Although safety is a priority, the capacity to institute restrictions poses many opportunities for abuse. Programs that strive to teach offenders to respect the law, must themselves respect the rights upon which our legal system is founded. Restrictions must always be considered time-limited. On-going assessment and modification of restrictions by the Collaborative Team is an essential component of supervision for safety.

COURT-ORDERED REQUIREMENTS

Court-ordered restrictions and supervision requirements are mandatory for the individual and his team to fulfill. If a team or individual disagrees with a court-ordered restriction, the team or individual should request a court hearing, rather than just ignoring or changing the court ordered requirements.

An Act 248 order may give the Commissioner or the team authority to impose supervision requirements and restrictions on the person with DD/PSB. With such an order, it is important for the team to be clear about who actually has the authority to impose the restrictions. Probation and parole conditions often give the CSS authority to approve the person's residence.

DEVELOPMENTAL SERVICE AGENCY REQUIREMENTS

When developmental services agencies impose restrictions or supervision requirements on persons with DD/PSB, the Collaborative Team must be clear about its authority to do so:

- Has it been given authority by the court order?
- Has the individual agreed to the requirements as a condition of participating in sexual abuser treatment?
- Has the person's guardian authorized the restrictions?
- Is the agency imposing the restrictions as a condition of offering specific supports (such as residential services) to the person?

STAFF AND NETWORK SUPERVISION

Teams should be familiar with the varied supervision techniques so as to select those that are most effective and least restrictive.

Supervision plans need to have flexibility. A program director or therapist should be empowered to make emergency adjustments to increase supervision when the individual's level of risk increases and the Collaborative Team can't be convened quickly. Decisions to decrease supervision are rarely emergencies and ordinarily should involve input from the whole team.

Although a supervisor is usually a paid staff person, the agency may approve guardians, family members, co-workers or other members of the individual's support network to provide supervision. The key issue is not that the supervisor is paid but whether or not the supervisor understands and is able to implement the person's supervision plan (see Chapter 24: Selection and Support of Supervisors).

LEVELS OF SUPERVISION

The level of supervision must be specified in the individual's written plan and all supervisors must know what level of supervision is expected. The level of supervision required **must always consider** risk factors and may vary depending upon the setting. For instance, an individual might have unsupervised time in his residence but he may need eyes-on supervision in a risky community setting. The team needs to review at regular intervals how the client is doing.

Arms-length supervision. Arms-length supervision is designed to assure that the supervisor can exercise physical control of the person with DD/PSB at all times. Arms-length supervision may require 2:1 staffing (or very rarely even 3:1), depending on the relative strength and speed of the person with DD/PSB and supervisor. Arms-length supervision is typically provided in community settings for an individual who is at high risk to elope or whose offense pattern involves speed of offense.

Eyes-on supervision. Eyes-on supervision is designed to assure that the supervisor can intervene quickly if the person with DD/PSB approaches a potential victim, starts to engage in a risk behavior, gets into a dangerous situation, or shows signs of attempting to elope. People providing eyes-on supervision must keep the person with DD/PSB within a clear line of sight, adjusting physical proximity to the risks posed by the individual and the setting. Eyes-on supervision is the most usual level of community supervision for individuals who require staff supervision. Eyes-on supervision may also be required in a residential setting.

Single stall bathrooms are the safest option for individuals under eyes-on or arms-length supervision.

Residential supervision. The team needs to be clear about what level of supervision is required when the person with DD/PSB is in the home. For instance, **24-hour supervision** does not necessarily mean eyes-on or arms-length supervision 24 hours a day. An individual may need arms-length supervision in the community but may be safe to be alone in his own room or be safe for eyes-on supervision on the grounds of his house.

The situations where eyes-on or arms-length supervision are needed must be individualized to the person with DD/PSB and the setting. Eyes-on supervision may be required in a home situation when:

- the person with DD/PSB watches television, videos, or is on the computer.
- there is a vulnerable person or animal in the house.
- the person with DD/PSB poses a high risk to elope.
- the person with DD/PSB has used weapons or hidden weapons in his room.
- there are concerns for the individual's own safety.

Awake overnight supervision. Awake overnight supervision may be required when the person with DD/PSB poses a high risk of elopement, there is a vulnerable person in the home overnight, or the individual is going through a medical or psychiatric crisis (e.g., suicide watch). Awake overnight supervision should be a temporary measure while the setting is adjusted by removing the vulnerable person, addressing the crisis, or installing alarms.

Low intensity community supervision. Low intensity community supervision is used for persons with DD/PSB whose abuse pattern does not involve speed or when the individual is in a low-risk setting. The supervisor checks in periodically with eyes-on supervision and has the ability to intensify supervision when risk factors are present (such as when a child enters a store or the person with DD/PSB is emotionally unstable).

Covert Supervision. A person with DD/PSB under covert supervision is watched by someone he does not know. The purpose of covert supervision is to assess the Individual's behavior when he does not realize he is being watched while maintaining the capacity to intervene promptly if a risk situation develops. A covert situation does not require surprise; the person with DD/PSB is told in advance that a person he does not know may watch him in certain settings.

Intermittent Supervision. There is a range of methods of intermittent supervision. Scheduled visits and phone calls are usually accompanied by random unannounced calls or visits. This type of supervision is used when there is a high degree of confidence in the person's ability to follow a safety plan, yet the team still wants to check on the person's behavior.

RESIDENTIAL RESTRICTIONS

Restrictions in a residential setting can diminish costs, promote an individual's autonomy, and increase community safety.

HOME LOCATION

Although there is no established relationship between proximity to schools or child care facilities and sex offense recidivism (e.g., Minnesota Department of Corrections, 2007; Nobles, Levenson, & Youstin, 2012; Zandbergen, Levenson, & Hart, 2010), a person's individual risk factors and treatment needs should be

considered when selecting a home location. Considering home location can be a vital, practical way to increase safety and independence. Key members of the Collaborative Team should visit the proposed home to assess the setting for the individual's risk factors (e.g., children, playgrounds, schools, bars, etc.). Seasonal changes must be kept in mind (e.g., a baseball field may present no risk in the winter but a high risk in the spring and summer). Factors not immediately apparent must be explored and identified, such as a bus stop or children bicycling in the neighborhood. Neighbors and staff who can be supportive or on-call may be a positive factor at a particular location. For some individuals, distance from public transportation, neighbors, highways, and stores is a safety factor; for others, proximity to agency staff, neighbors, stores and public transportation may contribute to the individual's ability to be independent.

CURFEW

The person with DD/PSB under curfew is required to be at home during set hours—typically nights and weekends. Curfews are monitored by phone check-ins, family or roommates, neighbors, unannounced visits, or electronic monitoring devices. Breaking curfew is a lapse behavior that is not necessarily dangerous per se, but it can signal to the team that an individual is cycling into relapse behavior.

ALARMS, MOTION DETECTORS AND ROOM MONITORS

Electronic alarm systems are widely available and can be installed in bedroom doorways, stairwells, windows, and exit doors. Electronic alarms are preferred to locks on windows and doors since locked exits pose a fire safety danger. Alarms are set to sound if the individual leaves his room or leaves the building. Alarms involve an initial cost but are often less costly than eyes-on or awake staff in a residential setting. Bedroom and stairwell alarms or motion detectors are used where there is a concern that the person with DD/PSB poses a risk to another resident of the home. Alarms for household safety are used when the person with DD/PSB may pose a risk to another person in the household. This is usually a concern only at night when the residential supervisor is sleeping. Alarms on exterior exits are needed only when there is a danger that the person with DD/PSB will leave the home unsupervised without permission. For a more detailed discussion, see Chapter 21: Residential Supports.

A team needs to be realistic about whether to rely on window and door alarms. Certain technologically sophisticated individuals may be able to dismantle or deactivate an alarm. Additionally, an alarm does not stop a person from leaving; it simply notifies the supervisor that the person has left. Thus, an alarm is only as effective as the speed with which staff can respond. An alarm allows staff to notify the police that the person with DD/PSB is at large, and to notify neighbors or other potential victims who may be at risk. Knowing that an electronic alarm will sound can have a deterrent effect on a person with DD/PSB who might otherwise be tempted to elope.

If alarms are used as part of a safety plan, all residential staff must be trained in their use and maintenance. Reliable staff must be designated to regularly check that the alarms are in working order.

ROOM SEARCHES

A room search may be authorized if there is reason to believe the person with DD/PSB is hiding something in his room that could interfere with safety or treatment, such as:

- weapons or things that could be used as weapons.
- matches or other things to start fires (for individuals who are at risk of fire-starting).
- pornographic materials.

If the team thinks a room search is necessary, the person with DD/PSB and the guardian should be notified in advance (except in situations of imminent danger) that the search will occur. The actual room search, however, should be at a random, unannounced time.

The decision whether to search the room while the person with DD/PSB is present or absent will depend upon the individual's personality. Some people will be upset by witnessing a room search and others will be upset to think that someone might go into their room when they aren't there. The best practice is to include the individual in the decision about whether to search when he is present or absent.

PERSONAL SEARCHES

A "personal search" means going through a person's pockets and clothing to be sure he is not bringing contraband into the home. A personal search involves a type of physical confrontation that most people find upsetting. For this reason, it should not be used except in high-risk situations, such as risk of fire or risk of weapons, and should ideally be done in the presence of another person.

LOCKS

A person with DD/PSB may never be locked into his room or into a part of the house. However, a lock may be used to keep the personal space of another occupant of the house off limits. For instance, a master bedroom or a child's bedroom or bathroom may be kept locked during the day to keep the person with DD/PSB from having access to this space. Similarly, an occupant of the house may choose to lock his or her room from the inside for privacy.

TRAVEL RESTRICTIONS

Travel out of state is typically restricted for persons with DD/PSB under court-order because it is difficult or impossible to enforce a Vermont court order in another state (and even harder in another country). A person under supervision of Corrections will need permission to travel from his CSS. Travel out of state will be denied for a person under Act 248 until the team is confident that the individual poses no risk of elopement and the supervision plan is clear and reliable.

The person with DD/PSB should be restricted from traveling to a location where he may have an unplanned encounter with the victim. For certain individuals, traveling to a particular town or area may cause relapse behavior. Other individuals may experience relapse in unfamiliar settings. For instance, an unfamiliar setting may trigger the thought that "no one knows me here and I can get away with behavior I can't get away with at home."

Restrictions upon other high-risk locations for the individual should be tailored by the Collaborative Team. For instance, a person with DD/PSB who targets young children typically is restricted from playgrounds, schoolyards, bus stops, and public swimming pools.

In any case, the treatment goal is for the person with DD/PSB to internalize avoidance of high risk situations and not to depend upon external restrictions.

MEDIA RESTRICTIONS

Media restriction is a difficult area since most of us are uncomfortable with censorship. Additionally, in our society, it is difficult to draw a line between "acceptable" and "unacceptable" content.

As a general principle, the team should work with the person with DD/PSB to focus on media images that promote respectful interpersonal relationships. The person should learn to identify and refrain from using materials that encourage or promote abuse related sexual arousal or thinking and behavior patterns. When the person with DD/PSB is not yet able or ready to self-select appropriate media, the team may need to impose restrictions if it has the authority to do so and if the restrictions are clearly linked to decreasing the person's risk to reoffend sexually or in another violent manner.

Pornography. Restriction of pornography is a common element of sexual abuser supervision, although determining what is pornography or problematic for a specific individual can lead teams to endless debates. Common restrictions, which are relatively easy to monitor, include movies, videos, magazines, and books with explicit sexual content. Access to 900 telephone numbers can be blocked for persons with DD/PSB who have used this type of pornography. Among adolescents, extensive pornography use has been linked to having permissive sexual attitudes, stronger gender-stereotypical sexual beliefs, and increased rates of sexual aggression (e.g., Peter & Valkenburg, 2016). Pornography use among high risk adult male sex offenders has been linked to increased rates of sexual reoffending, but not among moderate and low risk sex offenders (Kingston, Fedoroff, Firestone, Curry, & Bradford, 2008).

Music. Some music available on CD, satellite, television, and the Internet has a high level of sexual or violent content. Exposure to songs with violent lyrics has been linked, at least in the short term, to aggressive thoughts and feelings (e.g., Anderson, Carnagey, & Eubanks, 2003). One way to limit music with this content is to restrict the person to listen to music, which can be heard on the radio.

Video Games. Video games often contain high levels of violence and sexual content. They should be screened in advance.

Internet. The Internet is a rich source of pornographic material. It may be difficult to restrict access for an Internet-savvy person even with a screening device such as "Net Nanny." For some persons with DD/PSB, it may be appropriate to prohibit access to a computer with an Internet hookup, or to permit this access only when the person has eyes-on supervision.

Television. Television can be more difficult to monitor or to judge what should be restricted because of the wide range of subject matter to consider—including commercials. Modifying television watching for men who have a strong sexual attraction to children presents a particularly great challenge since children may be present in advertisements even in shows with adult content.

The following are generally useful approaches when there are concerns about television viewing by a person with DD/PSB:

- Do not permit the person to watch television alone.
- Limit the cable access in the home to basic or "safe" channels, or purchase a commercially available channel-blocker.
- Assess the person's reactions to particular programs.

OTHER RESTRICTIONS

Contact with the Victim. Contact between the person with DD/PSB and the victim should not be permitted unless there is someone present to support the victim. Contact includes letters, cards, presents, email, texts, and telephone calls. It can even include the person with DD/PSB being in a physical space such as a home when the victim is not there.

Use of Alcohol. Alcohol use may be restricted and should be prohibited for anyone with a history of alcohol abuse or who has had a connection between drinking and problem sexual behavior. With proper authority (e.g., Act 248 or probation condition), Alcosensor or urinalysis may be used if there is a concern that the person with DD/PSB is abusing drugs or alcohol. To be effective, testing must be administered at random or unannounced. Alcohol and drug testing is available through substance abuse treatment programs in your area.

Possession of Firearms, Knives and Other Weapons. Possession of firearms, knives, and other weapons should routinely be prohibited for people under

correctional supervision and under Act 248. Federal law prohibits individuals with a guardian, under Act 248 commitment, or with a history of a felony from purchasing a gun.

Driving. Driving will be prohibited for anyone who poses a risk of elopement. For others, driving may be limited to when the person with DD/PSB is accompanied by an approved supervisor. If driving is necessary for daily living activity or to go to treatment, a system of checks may be implemented. For example, a specific route to a destination can be timed; the individual's plan would require a telephone call upon departure and another upon arrival.

Contact with Animals. While animals can be a positive aspect in someone's life, they are problematic if they pose a sexual temptation to a person with DD/PSB. Pets or contact with animals should be restricted for a person with a history of abusing animals.

Use of Binoculars/Telescopes. Long distance viewing with binoculars or a telescope is a form of voyeurism and can also be part of a planning and precursive process. A person with a history of voyeurism may shift to long-distance viewing if his free movement is restricted. Possession of binoculars or a telescope may be restricted if this is a concern.

Use of Cameras. Cameras (including video and cell phone cameras) should be prohibited for a person with DD/PSB who has photographed victims in the past. Cameras should be inspected if there is any concern about a person's use of a camera.

Use of Telephone, Mail, Text, and Email Services. Generally, private access to a telephone, mail, text, and email for contact with family and friends, and for personal business, such as a lawyer, is considered a protected right of privacy. It should not be restricted without a strong safety rationale. Use of these services may be monitored or limited when a person with DD/PSB:

- uses services in lapse, dangerous, or harassing behavior.
- uses services to have unauthorized contact with the victim or potential victims.
- engages services to contact friends or family that significantly interfere with treatment.
- abuses service privileges by running up unreasonable bills he cannot pay for.

If family contact using these types of services is upsetting for the person with DD/PSB, the best approach is to be sure that calls occur in a supportive environment when staff who are supportive can be present.

MONITORING FOR SAFETY AND COMPLIANCE

At any stage of an individual's treatment, the task of monitoring should be shared by a **network** of support persons. These include volunteers such as family and friends, employers, housemates, support staff, case managers, and therapists. People appropriate for a supervision network:

- believe the person committed the sexual abuse.
- are knowledgeable about sexual abuse dynamics.
- know and recognize the person's risk factors.
- agree not to keep secret any risky activities or lapse behavior.
- are willing to be contacted by the case manager or therapist

(For more information, see Chapter 24: Selection and Support of Supervisors).

TECHNOLOGIES

Electronic Bracelet. An electronic ankle or arm bracelet can provide a system of electronic monitoring to enforce a curfew or house arrest. The use of such a device may have a deterrent effect for some individuals.

Some devices are set to signal a central computer or an in-house device if the individual leaves the premises. Some can be used in conjunction with a global positioning system (GPS). If the person with DD/PSB is wearing an electronic bracelet, a central computer can track the specific location of the device. The devices may be useful if:

- the person with DD/PSB is unlikely to tamper with the device; and
- staff or police are in position to respond immediately if the individual leaves the premises.

Polygraph. The use of polygraphs for monitoring compliance is not recommended for individuals with developmental disabilities, because of concerns with reliability, validity, and effectiveness (e.g., Cumming & McGrath, 2005; McGrath, Cumming, Hoke, & Bonn-Miller, 2007).

Chapter 19:
CONFIDENTIALITY AND RELEASE OF INFORMATION

Many questions arise when program staff try to decide what case information they can reveal and to whom. On the one hand, some programs for persons with DD/PSB strive to have open communication among Collaborative Team members. On the other hand, workers operate under state and federal laws that protect client confidentiality. Rules in this area are complex.

CONFIDENTIALITY RULES FOR DEVELOPMENTAL AND MENTAL HEALTH SERVICES

Developmental and mental health programs operate under strict confidentiality rules[7]. In general, caregivers and treatment providers may not release ANY information about a person without the person's consent or the consent of the guardian. This includes the person's diagnosis and the fact that the person gets services from the agency.

Exceptions to the general rule of no release of information without consent include:

- situations where there may be danger to self or others (see Chapter 20: Disclosure for Safety and Treatment).
- reports of abuse, neglect or exploitation.
- medical emergencies (to ensure immediate needed treatment).
- court ordered releases (such as Act 248 orders).
- disclosure to state and federal reviewers for individuals who receive Medicaid.[8]

[7] The basic laws are the state confidentiality law at 18 V.S.A. §7103 and the federal law referred to as HIPAA (Health Insurance Portability and Accountability Act of 1996).

[8] Note that the performance contract between the Agency of Human Services (AHS) and each community developmental services provider requires the provider to obtain an authorization to release information to AHS from each voluntary client paid with public funds and to ask each involuntary client to authorize release of information to AHS.

Both federal and state law permit disclosure of confidential information for treatment purposes, but there can be disagreement about which information and how much treatment information can be disclosed without the person's consent.

Each developmental and mental health program has its own procedures and forms regarding release of confidential information. **This chapter is in no way intended to change or take the place of local program rules or agency policies.**

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

Since meaningful treatment likely cannot occur without sharing information, the person with DD/PSB and/or guardian should be asked (or required) at the beginning of treatment to sign an authorization to disclose or release information. Note: Authorizing release of information is different from consenting to treatment. **Authorization to release information** and **consent to treatment** forms should be separate documents and presented independently.

If the person with DD/PSB has a guardian in the area of "general supervision," the guardian must be asked to sign the authorization to release information. It is best practice to ask the person with DD/PSB to sign, too. A program's open communication approach among the "Collaborative Team" and who will have access to what information should be explained to the guardian and the individual.

An authorization to release information should be as specific as possible. For instance, rather than simply saying "all members of the Collaborative Team," the form should identify team members to the extent this is known. As applicable, authorizations should specifically name:

- the Correctional Services Specialist, if there is one.
- the Commissioner's designee if the person is on Act 248.
- the school representatives, if the person is school-aged.
- the DCF worker, if DCF is involved.
- medical treatment personnel.
- the victim advocate, if there is one.
- family members or other natural supports, such as an employer.

The authorization form should include an explanation of the program's obligation to report suspected abuse, neglect, or exploitation to DCF or APS and the duty to

warn (see Chapter 20: Disclosure for Safety and Treatment). If the program has a policy of reporting violations of conditions of release to Corrections, this should be included in the authorization form.

The authorization to release information form should include a specific expiration date or expiration event that relates to the purpose of the release of information. On or before that date, the form should be reviewed and updated with the person with DD/PSB and guardian, including a new expiration date for the next term of support.

Collaborative Team members should understand equally the policies of:

- open communication among team members.
- strict confidentiality with people outside the team.

Sharing of information among team members is a common principle of treatment with this population (Association for the Treatment of Sexual Abusers, 2014; Blasingame et al., 2014). If a person with DD/PSB refuses to authorize the release of information, most programs will refuse to offer treatment and will continue to counsel the individual about the importance of sharing information with team members. If the persons with DD/PSB agrees to the sharing of information but does not want particular information shared, or does not want information shared with a certain person (for instance, a particular family member), the team should accommodate the request if it is possible to do so without compromising safety.

RELEASE OF INFORMATION TO STAFF, CONTRACTORS, AND RELATED PERSONNEL

This section addresses the release of information to personnel who work with the individual on an occasional or limited basis and who are not members of the Collaborative Team.

Workers who provide supervision, even on a temporary basis, need information about the person's risky behavior, target groups, precursors, red flag behaviors, and how to respond if a risky situation arises. These workers may include day support staff, job coaches, respite workers, and companions. No separate authorization to release this type of information is required for a developmental services organization to release information to workers who provide "treatment," as that term is defined in state and federal law. Important information should be on the

Emergency Fact Sheet and should also be communicated verbally. Some workers may need full detailed information about the person's abusing history. A detailed history should be shared only on a need-to-know basis.

"**Peggy's law**"[9] is a Vermont state law that requires full written disclosure of any "relevant" information to any potential shared living provider or respite provider *who will be caring for a person in his or her home*. The law does not apply specifically to persons with DD/PSB but it includes any known past sex offending behavior. "Relevant information" means any information needed to protect the individual or others from harm, and includes any relevant history of violent behavior or conduct causing danger of harm to others, any precursors or dangerous behavior, and any medications being prescribed to the individual.

Written consent of the individual or his guardian (if any) is required for release of this information to a potential provider. If a known offender does not consent to release of information about his offending behavior to the potential respite worker or shared living provider, the person should not be placed in the home. Vermont law allows an agency to place a person in a home even though he refuses to consent to release of relevant information if the agency tells the home provider that the offender refused to release the information; however, information about past offending behavior and precursors of lapse behavior are so basic to safety that a person with DD/PSB should not be placed into a home setting without a "Peggy's law" disclosure.

More information about the requirements of Peggy's law including a Disclosure Form, Guidelines for Completing the Mandatory Disclosure Form, and Home Provider Mandatory Disclosure Law Implementation Questions and Answers are available upon request from DAIL.

RELEASE OF INFORMATION TO THE ATTORNEY OF THE PERSON WITH DD/PSB

An attorney who represents a person with DD/PSB for a case relating to sexually abusive behavior (such as an Act 248 review or a probation revocation case) should have access to all information the individual himself could access. In general, this means the whole case file. It is best practice for the attorney to present an authorization to release information signed by the individual or his guardian.

[9] 18 V.S.A. §7103(e).

It is important to determine what kind of case the lawyer is handling. In cases other than Act 248 reviews, the lawyer should always present an authorization to release information signed by the person with DD/PSB or his guardian before accessing any information or records.

CONFIDENTIALITY OF CERTAIN TYPES OF INFORMATION

COURT ORDERS

A court order, such as a guardianship order or an Act 248 order, is a legal document signed by a judge and is considered **public information**. A court order can be shared with anyone, including law enforcement, without a signed release.

Evaluations used in guardianship or Act 248 cases are often confidential. If such an evaluation is in a case file, it should be treated as a confidential document like other client records.

SCHOOL RECORDS

Although schools operate under a different federal records privacy law than developmental and mental health providers, in practice, the law is very similar. The confidentiality of all school records is strictly protected. School staff will need a signed release to share information among Collaborative Team members. Release of educational information or records requires a signed release by the parent or guardian. If the person with DD/PSB is over 18 and has no guardian, the individual signs the release.

DCF (FORMERLY SRS) RECORDS

DCF records are protected under state confidentiality and Health Insurance Portability and Accountability Act (HIPAA) laws. If a child is in DCF custody, the child's DCF caseworker is ordinarily responsible to authorize the release of any records.

CORRECTIONS RECORDS

Individuals who are under Corrections supervision in the community are usually asked to sign a release that authorizes treatment programs to notify the CSS of any condition violations, and also to provide reports to the CSS on the person's progress in treatment. Likewise, individuals under Corrections supervision are typically asked to authorize a full release of Corrections records to the treatment program. Corrections is authorized to release information to protect a victim. (For more information on release of information by Corrections, see Chapter 6: Sex Offender Registration Law.)

THERAPIST RECORDS

If the therapist who provides treatment to the person with DD/PSB is not an employee of the program, the person with DD/PSB (or guardian) must be asked to sign a specific authorization for the therapist to release information to the Collaborative Team. It is best practice to include any therapist who is addressing sex abuse and related issues (such as victimization or anger management) under the Collaborative Team's open communication umbrella.

If the person with DD/PSB is receiving therapy in another area (such as an eating disorder), it is recommended that the person be asked to authorize the therapist to release relevant information to the team. The person with DD/PSB may decline to authorize such a release and that choice should be respected. Note that records of treatment for alcohol and drug abuse have special strict confidentiality restrictions, and information about alcohol and drug treatment may not be subject to full release.

CONFIDENTIALITY DURING POLICE OR OTHER LAW ENFORCEMENT INVESTIGATIONS

Agency and DAIL staff are authorized to report any suspected criminal conduct by a person under Act 248 to law enforcement. Some persons with DD/PSB have authorized Collaborative Team members to disclose information about the offense to Corrections or law enforcement officers. (See section on General Authorization.) **The guidelines in this section apply only to those individuals who are not under Act 248 or have not authorized treatment team members to release information to law enforcement.**

When a person with DD/PSB is being investigated by the police, confidentiality becomes a matter of basic rights and may determine whether or not the person will be accused of or punished for a crime.

Collaborative Team members may feel pulled in different, often conflicting directions, including the desire:

- to be good citizens and do what the police request.
- to protect a person with DD/PSB from the consequences of a crime.
- to ensure the person with DD/PSB experiences consequences for a crime.
- to protect the client's confidentiality.

In Vermont, there is no legal mandate for citizens to report a crime or to cooperate in a criminal investigation, except for the obligation of mandated reporters to report to APS or DCF. If the law enforcement system believes it needs to have the testimony of a knowledgeable person or to search a location, it can call the witness to a grand jury, or get a search warrant or a court order for the witness to be questioned.

Reporting a crime to the police without the individual's consent violates confidentiality. However, if anybody is in danger, the police may be called to protect public safety.

A person with DD/PSB who is under suspicion for a new crime should not be questioned by a police officer, an APS investigator, or a DCF investigator without his guardian or case manager making sure that the person understands that he **does not have to answer any questions from the police** and that **answers to questions may be used to charge him with a crime**. The right against self-incrimination is a fundamental right of American citizens contained in the Fifth Amendment to the United States Constitution. If an individual is under investigation for a crime, the team should assist him to protect his constitutional rights by contacting the Disability Law Project or his public defender (if he has one). A person should be advised not to speak to law enforcement about a crime without first consulting with a lawyer.

Without specific authorization through court order or a signed release (see section on General Authorization for Release of Information earlier in this chapter), Collaborative Team members are not authorized to release information about the person to the police. If a team member asks permission to release specific information to the police, the team member should be certain that the individual

and/or his guardian understands that the information may be used to charge him with a crime.[10]

Team members may provide information to the police if (1) they have witnessed criminal conduct (for instance, a staff person sees a client throwing rocks at a car) or (2) they have been the victim of a crime (for instance, a staff person's car was stolen and he thinks a client stole it). ***Note:*** **The information provided should be limited to what the team member saw and heard as a witness or as a victim.** The team member should not share information irrelevant to the crime such as the person's IQ, what type of services he receives, or his past history.

If the **victim** of a crime *receives* developmental services (including the person with DD/PSB), the victim or her guardian may provide any information she chooses to investigating officers. Caution should be exercised in releasing information about the person's psychological functioning or history, as any information possessed by the prosecutor (the state's attorney or attorney general) must be shared with the defense attorney, and may be used against the victim if the victim is later called as a witness.

REPORTING TO APS AND DCF

Therapists, school personnel, medical and hospital staff, and any workers paid with DAIL funds are **mandated reporters** and **must** report any suspected abuse, neglect, or exploitation of a child or vulnerable adult. Reports about children are made to DCF; reports about vulnerable adults are made to APS.

Child Abuse and Neglect. Reports of Child Abuse or Neglect are filed with the Social Services District Office of the Department for Children and Families. A list of the Social Service District Office for every town can be found on their Web site (http://dcf.vermont.gov). The after-hours number for reporting child abuse or neglect is **1-800-649-5285** (24 hours a day, 7 days a week). Emergencies should be reported directly to the police.

Abuse of Vulnerable (Elderly or Disabled) Adults. Reports of abuse, neglect or exploitation of vulnerable adults are made to the Adult Protective Services office of DAIL. The phone number is 1-800-564-1612. There is on-line report form at

[10] Again, the accused or his guardian should be reminded of the advisability of consulting with a lawyer before agreeing to release confidential information.

the DAIL Web site. Emergencies should be reported directly to the police, and followed up with a report to APS.

While mandated reporters have a legal duty to report specific offenses and must provide all relevant information, confidentiality rules still apply to the provision of other information. For example, a formal authorization is still required for the release of a person's other confidential information such as his history or psychiatric diagnosis.

In treatment, persons with DD/PSB should be permitted to maintain a right of confidentiality in cases where they are a victim or where the alleged abuse is unrelated to their sex offending behavior. In these situations, if APS or DCF requests certain records, the persons with DD/PSB (or guardian) can expect to receive an explanation of why the investigator wants the records and how the information may be used.

Any information obtained by APS or DCF is likely to be turned over to the Attorney General's office and its confidentiality cannot be guaranteed. Thus, the same rules that apply to releasing records to police investigators apply to releasing records to APS or DCF investigators.

SEX OFFENDER REGISTRATION REQUIREMENTS

In Vermont, the law requires anyone who has been **convicted** (found guilty or pled guilty) of a sexual offense to register at the local police department by reporting his current address. This information is now available to the public. The registration law applies to people who were convicted in another state and now live in Vermont. The registration requirement **does not apply** to juvenile sexual offenders (unless they were convicted of a new offense after becoming an adult) nor to people committed under Act 248. For more information, see Chapter 6: Sex Offender Registration Law.

ACT 248 ORDERS

DAIL sends a copy of the Act 248 order to local law enforcement officials (sheriff, local police/constable, state police) with a cover letter stating the person's address. The letter asks the law enforcement officials to keep the information confidential unless they need to use it for public protection purposes.

RELEASE OF INFORMATION TO PAST AND POTENTIAL VICTIMS

Duty to Warn: A mental health or developmental services professional may release information to protect a person from harm if there is a strong reason to believe that the offender poses a risk of danger to an identifiable individual. (See additional information in Chapter 20: Disclosure for Safety and Treatment.)

Past victims: If a person with DD/PSB is under supervision of the Department of Corrections, corrections will notify the victim, upon request, if the person with DD/PSB escapes from confinement or a community program and when he is recaptured. Corrections will also notify the victim, upon request, before the person with DD/PSB is to be released from prison. 18 V.S.A. §5305. If the person with DD/PSB is released on "conditions of release," the victim is entitled to know what the conditions are. 18 V.S.A. §5305 (b). If the victim is a minor, a member of the victim's family may ask to be kept apprised of the offedner's status. 18 V.S.A. §5318.

In general, developmental and mental health programs *may not release* confidential information about a person with DD/PSB to the victim without the consent of the person with DD/PSB (or guardian). This is because the state confidentiality law governing developmental and mental health services does not permit the release without the consent of the person with DD/PSB except if the Collaborative Team believes the victim's safety is at risk. The victim may request information for peace of mind, in which case a therapy goal should be for the person with DD/PSB to agree to release information the victim is requesting.

CHAPTER 20:
DISCLOSURE FOR SAFETY AND TREATMENT

Teams that work with persons with DD/PSB often face dilemmas about when, how, and to whom to disclose a person's potential for dangerousness.

Disclosure may increase community safety in several ways:

- It gives potential victims and their caregivers information they can use to protect themselves and others.
- It gives people in the network of the person with DD/PSB information about precursors and risks so they can play an active role in relapse prevention.
- It gives the person with DD/PSB knowledge that he has support from friends, family, co-workers, etc., to help him stay on track.

In a perfectly rational world, disclosure would always be a good idea because the greater the network of people who can identify precursor behavior and take steps to protect vulnerable people the better. In reality, our society fears and stigmatizes people who have sexually offended. A disclosure, particularly one not skillfully made, can cause a person with DD/PSB to be fired, evicted, or ostracized. Thus, collaborative teams need to give careful attention to the timing, the manner, and the advisability of disclosure.

Disclosure occurs in two contexts:

- When **required** because of safety concerns
- As a **step in treatment** when the person with DD/PSB is ready to expand the network of people who can offer him support in living an offense free life

In practice, there is overlap between the two categories. For instance, disclosure to selected family members can open the door to honest communication *and* is a prerequisite for the person with DD/PSB to visit his family without staff supervision.

AUTHORITY TO MAKE OR REQUIRE DISCLOSURE

Any decision about whether or not to request or require that a person with DD/PSB make a disclosure should be made by the key individuals of the person's Collaborative Team. Any such decision should be documented in the case record, including the rationale for the decision and the names of those who participated. Ideally, a person with DD/PSB will accept responsibility and acknowledge the need to ask for help. Efforts should always be made to obtain the person's agreement to and cooperation with disclosure, although, under certain circumstances a developmental services agency may require disclosure without regard to consent of the person with DD/PSB or guardian.

1. **For individuals under Act 248**, the Commissioner's designee may authorize disclosure even if the individual or guardian disagrees. One purpose of disclosure is to reduce the risk of a new offense of the type that the individual has previously committed or which is closely related to the offense(s) for which the individual was placed under Act 248.

2. **For any individuals who receive developmental services**, the agency may require disclosure as a condition of providing supports that may contribute to creating a risk. For instance, when a developmental services agency supports a person on a job, the agency may make disclosures to the employer a condition of the supports; when the agency helps a person to move into an apartment, the agency may require disclosure to neighbors.

3. The "**duty to warn**"[11] places an obligation on therapists and developmental services programs to warn identified victims with or without the person's consent or participation. An **identified victim** is an individual who is at specific risk as opposed to all people in a category. For instance, if a person who has molested children shares fantasies about and intent to molest a particular child he has seen, it may be imperative to warn that child's parents, even though it may not be necessary to disclose to all parents in the neighborhood.

[11] The *duty to warn* is a concept from court cases where courts have held that a mental health professional has a duty to warn potential victims, even if the client does not give consent. The most famous case is the *Tarasoff decision.*

DECIDING WHETHER DISCLOSURE FOR SAFETY IS NECESSARY

There is no clear test for deciding when and to whom disclosure for safety needs to occur. The team must weigh several factors:

- Severity of harm of a new offense
- Ability of potential victims to protect themselves from harm (e.g., small children or people with DD may need extra protection; persons with DD/PSB who have used force pose a different threat from individuals who will accept a firm refusal)
- Degree and effectiveness of supervision (e.g., consider the person's amount of unaccompanied time or the likelihood of evading supervision)
- Risk of reoffense taking into account static and dynamic risk factors
- Conditions under which past offenses occurred
- Accessibility of victims in the environment

Decisions about disclosure for safety to employers, neighbors, and dating partners are often most problematic.

DISCLOSURE TO EMPLOYERS

A team may decide not to disclose in an employment setting where, for example, the person with DD/PSB has an approved supervisor at all times. One reason for choosing not to make disclosures is to avoid the potential situation where the employer unjustly fires the person out of fear.

Experience in Vermont has shown that, typically, if the person with DD/PSB is a good worker, the environment is low risk, and the person does a good job of disclosing, many employers will be supportive. A low risk job setting can be one of the best places to start fading supervision; thus, it is best to select jobs where disclosure can occur up front or in a planned fashion.

DISCLOSURE TO NEIGHBORS

Disclosing to neighbors, who may be strangers, can be difficult and the person with DD/PSB may experience hostility. If disclosure for a person under Corrections supervision contributes to a lack of housing or neighborhood hostility, there is a

special risk since the person may have to return to prison as a result. Selecting housing in a low risk setting is the best way to minimize the need for disclosure.

The most common reason for disclosing to neighbors is to minimize risk for unsupervised children. If the purpose of disclosing is to notify neighborhood parents of the need to supervise their children, the disclosure should focus on this goal rather than upon details of the offender's past behavior. The disclosure can be general and still effective—letting the parents know the person with DD/PSB may pose a risk to children of a certain age/gender if the child and person with DD/PSB are unsupervised.

DISCLOSURE TO DATING PARTNERS

When two people become interested in one another, the support team wants to encourage a positive social relationship. The Collaborative Team must support the individual to disclose his risk factors to the potential dating partner as early as possible. Until that occurs, dating should be carefully supervised. The decision about how early in a relationship to disclose will depend upon the person's abusing pattern and the partner's vulnerability. From the beginning, the person with DD/PSB should be told that disclosure will occur and, wherever possible, should participate in the disclosure.

HOW TO DISCLOSE

Disclosure is often better received when the person whose behavior is at issue does the disclosing. Thus, an effort should be made to have the person with DD/PSB do the disclosing, although he should generally be accompanied by trusted staff for this important step.

Preparation for disclosure usually occurs in the therapy. There are times when a person with DD/PSB may have consented to but is not prepared to carry out the disclosure. In this situation, the client prepares his individual disclosure in treatment and accompanies the support person who actually delivers it. The intention of this exercise is to build the confidence of the client to the point where he will feel comfortable enough to do it himself in the future.

Agency staff and/or a guardian will have to disclose in certain circumstances, including the following:

- The individual lacks the verbal skills to make a disclosure.
- The need for disclosure is urgent, and the individual is not willing or ready to disclose.

STEPS OF DISCLOSURE

1. **PERSON WITH DD/PSB ACCEPTS RESPONSIBILITY AND ACKNOWLEDGES NEED TO ASK FOR HELP**
2. **PERSON AND TEAM IDENTIFY PEOPLE TO WHOM DISCLOSURE NEEDS TO OCCUR**
3. **PERSON PREPARES (E.G., WRITES) DISCLOSURE SCRIPT**
4. **PERSON ROLE PLAYS**
5. **PERSON OR SUPPORT STAFF MAKE APPOINTMENT**
6. **DISCLOSURE OCCURS**
7. **FOLLOW-UP AND FEEDBACK:**
   - **SUPPORT STAFF**
   - **THERAPIST**
   - **PERSON WHO RECEIVED DISCLOSURE**

ELEMENTS OF A DISCLOSURE SCRIPT

Once the person with DD/PSB agrees to disclose, he will need help in preparing his disclosure script. He should also have opportunities to practice by role playing. The script is individualized but should usually contain the following elements:

Elements of Disclosure	Sample Text
Ask permission to talk about a difficult topic.	There is something difficult I would like to discuss with you. Is that all right?
Make disclosure.	I made a bad mistake a few years ago and I sexually touched a child.
Make statement of accountability.	I am getting treatment for my problem and I am staying away for children.
Request support.	I want to work here and I will work hard. I just want to be sure I will not be asked to have any contact with children.
Address questions or concerns.	Do you have any questions?
Give contact information for supports.	Here is my case manager's/therapist's/probation officer's card and phone number.
Request confidentiality.	I am giving you this information because I trust you but I am asking you to keep it private.
Thank person.	Thank you.

CONFIDENTIALITY OF A DISCLOSURE

Some people to whom disclosure is made will receive the information under a duty of confidentiality. Others will have no legal duty to keep the information confidential. In deciding to whom disclosure will be made and what will be disclosed, consideration should be given to whether the recipient of the information can be trusted to keep the information confidential.

Even individuals under a legal obligation of confidentiality, such as doctors, hospital employees, school staff, and mental health workers, may feel a need to discuss the information with colleagues or supervisors. When disclosure is made, it is important to discuss whether the information will go any farther, and to whom and in what form.

Individuals under no legal obligation to keep information confidential include family members, neighbors, co-workers, victims, and store owners. Employers may or may not keep information confidential. When disclosure is made to such people, it is important to discuss expectations about confidentiality, understanding that there is no legal requirement for such people to keep the disclosure confidential.

CHAPTER 21:
RESIDENTIAL SUPPORTS

The Developmental Services system can offer a range of residential options to a person with DD/PSB. The choice of a **residential model** takes account of the person's support needs in the following areas:

- Daily living skills (e.g., ability to cook, clean, be safe alone)
- Supervision needs for community safety
- Need for assistance to learn daily living skills
- Need for assistance to progress in therapy

Typically, residential supervisors spend more time with the person with DD/PSB than anyone else, and their skills and suitability are critical to the success of the program. Regardless of the residential model chosen, supervision personnel must be carefully screened, selected, trained, supervised, supported, and included in the Collaborative Team. Any model can fail if the residential support workers lack the knowledge and emotional resources to supervise the person with DD/PSB or do not receive adequate support and training.

RESIDENTIAL MODELS AVAILABLE IN VERMONT

Several residential models are available in Vermont for persons with DD/PSB. The choice of a residential model should take into consideration the person's personal and lifestyle preferences and work to accommodate those that are consistent with a living a fulfilling and abuse-free life.

Residential Models

Type of residential model	Level of supervision for safety	Need for help with daily living
Independent apartment or home	Low	Low
Contracted roommate	Low or moderate	Low or moderate
In-home supports	Low, moderate, or high	Low, moderate or high
Developmental home (DH), shared living home (SLH)	Low, moderate, or high	Low, moderate, or high
Split DH	High	Low, moderate, or high
Staffed home	High	Low, moderate, or high

Independent Apartment or Home

With this arrangement, the person with DD/PSB lives in his own apartment, trailer or house with monitoring and support from a case manager and/or Correctional Services Specialist. There may be support, monitoring, and on-call assistance from neighbors, family, or from staff living nearby. This model is appropriate for a person with DD/PSB who is capable of a significant level of independence and who is at a relatively low risk of reoffending.

Contracted Roommate

An approved individual—called a "contracted roommate"—receives a monthly stipend from the developmental services agency to be at the apartment for set hours, typically overnight. The roommate may have responsibilities related to supervision (such as assuring that the person with DD/PSB is at home when he is supposed to be), the person's disability (such as helping with cooking or maintaining the apartment), or a combination of the two.

This residential model is a good teaching tool for a person who can have some time alone at home and who is in the process of moving to independence. The contracted roommate model can serve as a goal for a person living in a more restrictive model who will always need some in-home support because of his disabilities.

IN-HOME SUPPORTS

In the in-home family support residential model, the person with DD/PSB lives with and receives support and supervision from one or more family members. This model can succeed **only** if all family members participate in and are capable of supporting the person with DD/PSB consistently in treatment. Family members often need to address their own feelings and issues when a person with DD/PSB is going through services. This model is advised only when the family demonstrates commitment to change and the ability to support the person in his recovery. (See Chapter 23: Families.)

DEVELOPMENTAL HOME /SHARED LIVING HOME

With a developmental home (DH), also referred to as a shared living home (SLH), an individual or couple accepts a contract with the developmental services program to provide support and supervision to a person with DD/PSB in the contractor's own home. This model combines developmental supports and training with supervision in what can be an emotionally supportive, personalized setting. This potentially flexible model can incorporate increasing time alone and independence for the person with DD/PSB. This option avoids the difficulty of finding rental housing for a person with DD/PSB who is often considered an undesirable tenant. Another advantage is that this model is cost effective; the stipend to the home providers is tax-free and the person's SSI check covers room and board. The level of contractor compensation varies widely, depending on what is expected of the home.

The model will fail if the screening fails to identify problematic attitudes and beliefs, or if the developmental services agency does not maintain close supervision and support of the home provider, who must wholeheartedly accept the treatment model and agree to supervision.

Providing a home to person with DD/PSB in treatment almost always requires lifestyle changes for the home provider, such as:

- installing alarms.
- limiting visits from grandchildren or nieces and nephews if they fall in the person's risk group.

- removing pictures of children from the walls, if viewing such pictures is a risk factor for the person with DD/PSB.
- not watching favorite television programs, if watching such programs is a risk factor for the person with DD/PSB.

The home provider must be included as a key member of the Collaborative Team and meetings ought to be scheduled at a time that the home provider can attend.

DH providers usually need to use respite staff on an hourly or daily basis to cover times when they are unavailable or need a break. The agency's contract with the DH provider should specify that respite staff will be subject to approval and training as supervisors. (See Chapter 24: Selection and Support of Supervisors.)

SPLIT DEVELOPMENTAL HOME

In a Split Developmental Home (DH), two contracted workers share residential responsibility for the person with DD/PSB. Thus, in addition to the vital screening, supervision, support, and inclusion on the Collaborative Team of each residential provider, the agency must determine that the two are able to work well collaboratively. The person with DD/PSB will spend part of the week at the home of one contractor and part of the week at the second contractor's home. Alternatively, the person may live fulltime in an apartment or home with the two providers splitting weekly responsibility for overnights at the home. Some persons with DD/PSB find moving from one home to another every week upsetting while others find the regular change refreshing.

This model is usually used where the person with DD/PSB requires more intense supervision than any available developmental home can provide. It can prevent burnout by supplying the residential providers with a regular break when a person with DD/PSB offers intense behavioral, emotional, or safety challenges, or requires nighttime supervision.

STAFFED HOME

In this residential model, the agency employs staff to provide round-the-clock (24/7) supervision to one to three persons with DD/PSB. In Vermont, this model is restricted to persons with DD/PSB who present an extremely high risk since staffed models are more costly than contracted models of residential support. A

disadvantage in addition to cost is that neighborhood opposition can arise when an agency rents or purchases a residence for the purpose of housing one or more persons with DD/PSB.

Agencies that use this model feel they have greater control over staff in an employee relationship as opposed to a contractor relationship. This model attracts skilled workers who are available for shift work but not for extended residential support, and who need benefits, such as health insurance.

One benefit of this model is the flexibility of being able to replace a staff member who isn't suitable without having to move the person with DD/PSB. The **home supervisor**—who is usually the case manager—must retain a high level of supervision and ongoing training with the employees. His or her skill and perseverance is necessary to monitor staff, to fill shifts, to cover vacancies, and, in general, to assure consistency within the home.

RESPITE HOME

Respite homes supplement the residential models listed above by providing short-term supervision, chiefly to give the residential provider a break for a night or two or for a vacation. They also provide a back-up when the residential provider experiences an illness or short-term emergency, or when the contract is terminated unexpectedly. Respite homes are usually contracted residences, but they may be staffed as well. They should be provided with information on how to contact on-call back-up staff.

Screening and training of respite homes is essential as many persons with DD/PSB are likely to test limits or lapse in their risk management in an unfamiliar setting. Also for this reason, programs should be cautious about placing two persons with DD/PSB together in a respite home. Respite homes work best when the person with DD/PSB uses the same home or homes for respite on a regular basis. In this way, the person with DD/PSB becomes familiar with the home and the home provider becomes familiar with the person with DD/PSB.

CRISIS HOME

These staffed homes, accessible on a regional or statewide basis, provide supervision in a crisis. The crisis may be a mental health crisis for the person with

DD/PSB or a residential crisis. Duration of stay in these homes is usually limited; there may be no vacancy if several people in the state are in crisis at the same time. These homes are accessed through the person's Developmental Services agency.

DOOR LOCKS, ALARMS, AND WINDOW SECURITY

Locks and alarms **to prevent egress** are needed only when there is a danger that the person with DD/PSB will leave the home unsupervised without permission. This decision is made by the Collaborative Team (unless it is covered in the court order). For persons with DD/PSB who pose a risk of elopement, the following are some guidelines.

- Exit doors and windows that are **not** part of a fire escape plan should be kept secure with a key lock when they are not in the line of sight of the home provider.
- Exit doors and windows that are part of a fire escape plan should have electronic alarms installed.

Locks and alarms **for household safety** are used when the person with DD/PSB may pose a risk to another person in the household. This is usually a concern only at night when the residential supervisor is sleeping. Some guidelines regarding use of locks and alarms used for household safety purposes are outlined below.

- It is never permitted to lock a person with DD/PSB into his room. This is a serious fire safety violation and violates the Developmental Services Behavior Support Guidelines.
- It is permitted, and perhaps advisable, for a household member who is vulnerable to lock his own bedroom door from the inside at night.
- It is permitted to put up a barrier or locked door to keep the person with DD/PSB out of a section of the house for safety during the night as long as the barrier will not interfere with fire escape plans.
- Motion detectors on the person's bedroom door, on a staircase, and/or on the bedroom door of a potential victim can provide overnight security as long as they are maintained in working order.

See also Chapter 18: Supervision for Safety and Compliance.

Note: Any arrangements to protect a vulnerable member of the household from a person with DD/PSB require the Collaborative Team to question whether the

residential arrangement is safe. Mechanical protections cannot be fully relied upon when there is a potential victim in the house.

TWO OR MORE PERSONS WITH DD/PSB IN A HOME

Vermont's developmental services system has a preference for individualizing services. Most residential models are limited to a single consumer in the home.

The single individual approach:

- allows for individualization of program and supports.
- promotes community integration with nondisabled citizens.
- prevents a consumer from being victimized in the home by another consumer.
- avoids competing or conflicting needs of two consumers.

Vermont's insistence upon individualized settings has been criticized by some as limiting offenders' access to developing peer relationship and to more intensely therapeutic residential supports.

There is no rule against housing two or more persons with DD/PSB together in a single home or against placing a person with DD/PSB in a home with a consumer who does not have similar problems, but the Collaborative Team needs to consider carefully whether there are any risks in the situation. The program is equally responsible for preventing abuse of another consumer as it is to prevent abuse of a member of the public. If two or more consumers are housed together, each person's risk should always be disclosed to the other consumer and his or her guardian. Safety and treatment considerations for the team in determining whether to house a person with DD/PSB with another consumer include the following:

- The person's pattern of abusing and victimization, including:
  - sexual preferences
  - secrecy
  - ability of each consumer to call for help and to say "no"
  - power relationships between the individuals
- Personal dynamics between the individuals
- Consumers' wishes and roommate preferences
- Level of supervision

- Physical layout of the home
- Potential benefits from creating a more intense therapeutic environment
- Benefits from promoting friendship among individuals

These considerations apply to short-term placements and respite situations as well as to long-term residential placements.

Note: A home with three or more individuals who require residential support must be inspected for fire safety by an inspector for the Department of Labor and Industry and be licensed by the DAIL Division of Licensing and Protection.

NEIGHBORS AND COMMUNITY SAFETY

Any decision to place a person with DD/PSB in a home includes an assessment of neighborhood risks. Almost every residential setting has some neighborhood risks, which include:

- potential victims.
- potential for elopement.
- potential for stimulating lapse behavior (such as children going by).

Neighborhood strengths should be assessed as well, such as:

- ability for the person with DD/PSB to be outside without close supervision.
- access to supports and services and employment.
- supportive neighbors.
- proximity of staff on call.
- cell phone service area.
- passable roads year-round.
- proximity to law enforcement.

The responsibility of the team is to:

- assess the risks and strengths.
- assess the magnitude of each risk and the potential harm presented by the risk.

- assess ways to address the risks (e.g., disclosure, window blinds, additional staffing, door alarms).
- carefully weigh and consider the alternatives.
- be willing to keep looking for the most appropriate setting.

Once a residence has been identified, the team will need to determine what disclosure, if any, is required (see Chapter 19: Confidentiality and Release of Information and Chapter 20: Disclosure for Safety and Treatment).

CHAPTER 22:
EMPLOYMENT

Getting a job and maintaining employment is an important part of treatment progress for a person with DD/PSB. Successful employment is associated with successful progress in sexual abuser treatment since:

- working successfully is evidence that the individual is willing to make a contribution to his own income and to society.
- successful work contributes to a person's sense of self-worth.
- the ability to maintain steady work is evidence that the person is able to work in a situation where there are expectations and demands.
- the workplace often provides a place for the individual to form new personal connections and interpersonal skills and to demonstrate competence.

JOB SUPPORTS

Some people with DD have the skills to find a job and to work independently, others need assistance in locating work or extra assistance in learning the skills and expectations of a job, and still others can maintain employment only with the support of a permanent job coach.

A JOB COACH MIGHT SUPPORT THE INDIVIDUAL TO MAINTAIN ATTENTION, REMIND HIM OF THE STEPS THAT NEED TO BE COMPLETED, OR PERFORM CERTAIN ACTIVITIES WHERE THE INDIVIDUAL NEEDS PHYSICAL SUPPORT.

A **job coach** is a person who supports the individual at the workplace to assist him with learning the job and meeting the expectations of the employer. The job coach may be needed only during the initial days or weeks on the job and he or she may fade as the individual develops job skills and natural supports in the workplace. Transition employment services of this type can be provided through a developmental services agency or the Division of Vocational Rehabilitation.

Work with the support of a permanent job coach is called **supported employment**. The role of the job coach is to support the individual to do the job, not to do the job for him. A job coach might support the individual to maintain attention, remind him of the steps that need to be completed, or perform certain activities where the individual needs physical support.

Purpose of Supervision at a Job Site

The purpose of supervision of a person with DD/PSB by staff at a job site must be clear and explicit. It is important for the job coach, the person with DD/PSB, and the employer to understand the responsibilities of the job coach in supporting the individual to do the job and providing supervision for safety. Often, the support staff begins by performing both roles. If a job coach provides supervision for safety, he or she must have the same safety training that the program provides to other community supervision staff (See Chapter 24: Selection and Support of Supervisors.).

Understanding the role of the job coach is most important as the person with DD/PSB becomes more independent on the job. If the person with DD/PSB is able to perform the job independently, then the job coach and team need only focus on assuring that there are supports in place to prevent danger to potential victims (see sections to follow on Safety of a Job Setting and Disclosure).

Safety of a Job Setting

Safety in an employment setting is created by a combination of the following factors:

- Minimal opportunity for exposure to potential victims
- Paid supports or natural supports (such as the employer or co-workers) who are aware of the person's risk and are willing to take action if an unsafe situation arises
- The person's own ability to develop and use risk management strategies

A job setting should be selected that minimizes risk; the Collaborative Team should not rely solely on staff supervision to deal with risk. A good match will be a job setting where the person with DD/PSB has **no unsupervised contact** with potential victims and **minimal or no supervised contact** with potential victims.

Most persons with DD/PSB will not need a full time job coach permanently. A job placement should consider the safety of the setting that will allow for the job coach to fade over time.

DISCLOSURE TO EMPLOYER

Over time, supervision by developmental services staff should fade and be replaced by natural supports on the job. Natural supports can be effective only if the person with DD/PSB discloses. Thus, it is important to select a job site where the person with DD/PSB will be willing to disclose, even if he does not do so at the beginning.

Persons with DD/PSB and their support staff are often worried that the individual will be harassed or fired if anyone at the workplace knows he has a history of sexual abusing. There are different approaches to this concern:

- Disclose before the person with DD/PSB is hired
- Disclose soon after the person with DD/PSB has started working
- Wait to disclose until the person with DD/PSB has proved himself to be a good worker

In general, it is preferable to disclose to the employer or supervisor earlier than later. This way the person with DD/PSB won't have to worry about his "secret" becoming known. Keeping secrets is not a suitable long-term strategy in relationships, including those at a job site.

CHAPTER 23:
FAMILIES

A person with DD/PSB does not exist in a vacuum. Often, he maintains a relationship with family members or may even live with them. It's important to look at the family dynamics to determine whether or not family contact should be (1) encouraged and fostered; (2) supported on a limited basis or (3) completely avoided. If there is contact, how much supervision is needed? The Collaborative Team will make recommendations regarding family contact with some deference to the opinion of the therapist. Of course, the client's wishes need to be considered, as well as those of the victim. Court restrictions, if any, must be followed.

WHO IS THE FAMILY?

Like other Americans, many persons with DD/PSB have a complex family structure. They may have families of origin and foster or adoptive families or blended families. Assessing key members of the family is an essential task. Grandparents, uncles and aunts, nieces and nephews, step-parents, and others may be a source of support and strength or they may be a part of an abusing cycle.

FAMILY EDUCATION AND TREATMENT

THE NEED

Family education and treatment are often critical elements of therapy for persons with DD/PSB both when the abuse occurs within the family and when the identified victim is outside the family. Particularly for persons with DD/PSB, families commonly remain one of their only social support networks outside the service system. Persons who commit sexual abuse who have positive social relationships are less likely to reoffend than those with negative and anti-social family and peer group relationships (Mann, Hanson, & Thornton, 2010). Negative relationships with parents and long separation from parents are associated with recidivism. Bringing supportive family members into the network and training them in the principles of sex offender treatment so that they can be a positive support is an essential aspect of treatment and supervision.

Families are key sources of information about the person with DD/PSB. They know about his childhood, past relationships, and the environments in which he grew up. Understanding only the perspective of the persons with DD/PSB on these issues gives the team a partial picture. The perspectives of other family members may be incomplete or distorted, but taken together with that of the person with DD/PSB, the various perspectives will give a fuller picture.

WHENEVER SUPPORTIVE FAMILY MEMBERS ARE IDENTIFIED, THEIR EDUCATION AND INVOLVEMENT IS A PRIORITY.

Immediate family of the persons with DD/PSB are usually devastated by the disclosure of sexually abusive behavior. They may experience shame, rejection, stigmatization, and economic discrimination as a result of their relative's actions. They need support to deal with their own extreme reactions to the disclosure.

Sometimes family members have become responsible by helping the persons with DD/PSB to keep his abusing secret or by minimizing the significance of the abusing behavior. Just as the persons with DD/PSB needs supportive therapy to address past offending and present risks, family members will also need support to acknowledge the seriousness of the situation and the ongoing risk.

Family members who have taken on the responsibilities for supervising the person with DD/PSB to prevent re-offenses may experience the same types of secondary trauma and burnout that paid workers experience and need the same types of supports. (See Chapter 24: Selection and Support of Supervisors).

Family members may be at sexual risk or already may have experienced victimization even if the initially-identified abuse was outside the family. The dynamics of sexual abuse within a family involve non-offending family members as well as the victim and person with DD/PSB. Clarification, remediation, and development of new, safe ways of interacting must involve the entire family when abuse has occurred within the family and the plan is for everyone to live together or have regular contact.

GOALS

The goals for family education and therapy can include:

- identification, protection, and treatment of all those harmed or at risk from the person with DD/PSB.
- healthy family support of the person with DD/PSB in treatment and relapse prevention.
- creation of a context where the person with DD/PSB can take responsibility for his actions (rather than blaming absent family members) and, where desired, can engage in clarification with the victim).
- an understanding of the conditions that influenced, supported, or allowed the abusing behavior, and changes in family dynamics that can contribute to changing those conditions.

UNDERSTANDING FAMILY FEELINGS

It is rare for families to start out by engaging positively and supportively in the treatment of a family member with DD/PSB. Family members have many strong emotions that have to be recognized and understood. They include:

- Shock and shame about the disclosure and fear that they will be judged and humiliated.
- Fear of what will happen to their family as the result of involvement by courts and government-sponsored social agencies. In fact, many families of persons with DD/PSB already have a history of unhappy contacts with schools and other government agencies.
- Reaction to the treatment professional as an authority figure interfering in their family dynamics.
- Belief that program staff do not understand or respect their family's cultural and ethnic heritage and child-rearing traditions.
- Fear of the consequences of further disclosure.
- Denial, minimization, or projection of blame.
- Divided loyalty when the victim and person with DD/PSB are both family members.
- Normal resistance to change of intimate relationships.

Working with families requires great skill to engage them in treatment and education through a respectful, nonjudgmental approach which acknowledges their pain, offers the potential for change and healing, and builds upon the strengths and resources of the family.

A family may be most open to help and change during the "crisis" period when the person with DD/PSB first enters treatment. The crisis challenges the family's image of itself. They may be more open to change than at a later time when negative opinions about the person with DD/PSB or about the treatment program staff have solidified. **Thus, it is recommended that family treatment and/or education be addressed sooner rather than later.**

Family members may enter the treatment relationship with denial, resistance, falsification, distortion, and incomplete information. These are normal reactions for family members just as they are for persons with DD/PSB. It is important to accept these **defensive reactions as normal protective reactions, which may change over time**, just as the reactions of the person with DD/PSB may change. In other words, be careful not to judge a family by an initial encounter or to dismiss their value to the healing process because of their own initial distortions.

Family members of persons with DD/PSB may have their own learning problems, although they may have developed coping mechanisms to hide them. A therapist or case manager who is working with a family needs to make a sensitive assessment of family members' learning styles. In particular, don't make an assumption that all family members can read.

It may be difficult for members of the Collaborative Team to offer a sufficiently objective and neutral stance with the family given their involvement with the person with DD/PSB and their role as enforcers of boundaries and restrictions. In this case, engaging a separate family therapist may be best.

METHODS OF FAMILY SUPPORT, EDUCATION AND TRAINING

Programs in rural areas have to be pragmatic about methods of assisting families to change and to learn. While family therapy may be desirable, it might be unavailable. As alternatives, multifamily education groups, which introduce families to the principles of therapy for persons with DD/PSB, may be helpful. Parent-peer support groups is another option.

If the victim was a family member, therapeutic support may be available through a victim advocacy organization. Often an alliance is built with that resource.

Lacking all these, the case manager and/or therapist need to try to establish an alliance with the family that is free from blame and recrimination. Where therapy resources are not available to a family, blame should not be placed upon the family for its failure to change.

FAMILY VISITATIONS

The term "visitation" is any form of contact, including telephone calls and letters. Visitation requires special planning and preparation where the person with DD/PSB has been a victim in the family or when the person with DD/PSB has victimized a family member. Even when the person with DD/PSB has not been a victim or an abuser in the family, a separation from family can make visiting their family members stressful events. If the person with DD/PSB regresses or acts inappropriately before, during, or after a family visit, this is a signal to look carefully at the dynamics of family contact, but it is not necessarily a reason to stop contact. Sometimes the person with DD/PSB needs a chance to work through difficult and uncomfortable feelings about his family and to move to a new level of acceptance and integration of these feelings. Family contact is difficult for many people. The fact that it is difficult doesn't mean that it should stop.

It is helpful to prepare by having some general discussion topics ready for the client to talk about during his family visits. The visits can be tense and there can be a lack of social skills, which can make for an awkward situation. Help the client to think of things he can tell his family, such as about his employment, where he's living, and what he does for social activities. Establish some type of nonverbal cue for the client to use if he is feeling anxious and wants to leave the situation. Sometimes, parents will want to know how treatment is going or how the client is behaving. It's best to defer those questions to the client if he is comfortable discussing it.

WHERE THE PERSON WITH DD/PSB HAS BEEN A VICTIM IN THE FAMILY

Sometimes, a person with DD/PSB has been a victim within his family of origin. In this event, his views about visiting with family should be respected. If he does not want to have contact, he should not be forced. There may be certain family members who were not involved in the abuse and who are supportive and safe. Arrangements can be made to visit safe family members in a location that does not bring back painful memories to the victim.

WHERE THE PERSON WITH DD/PSB HAS VICTIMIZED A FAMILY MEMBER

If the Department for Children and Families is involved with the client, the Collaborative Team must review and abide by any decisions that they have made. For instance, they may have decided that the client cannot visit at the parents' home. In the same vein, the case manager should be aware of and adhere to any conditions of probation, parole, or Act 248 that may limit or deny visitation. The Risk of Sexual Abuse of Children (ROSAC) risk assessment manual may provide assistance in determining if and under what conditions the person with DD/PSB might be safely allow contact with children in the family (McGrath, Allin, & Cumming, 2015).

Even if there is no legal bar, visits to the family where the person with DD/PSB has victimized a family member must be planned and scheduled in conjunction with an advocate or therapist for the victim. If the victim does not have an advocate or therapist, the sexual abuser treatment program should take the initiative to involve such a person in planning for visits to the family. Many of the recommendations below for visitation when the person with DD/PSB has been a victim also apply when another member of the family is a victim.

Some persons with DD/PSB have sexually abused pets that are still living with the family. The supervisor should be aware of any contact between the client and the animal. For instance, the supervisor may see the client use a demanding and controlling tone with the animal and be physically rough. The parents may not be aware of the abuse of the animal—or may not believe the abuse took place and may not protect the animal during visits. Vigilance in this area is imperative. Intervention should take place during the visit in a tactful way.

GENERAL RULES FOR SUPERVISED VISITS

Family visits that require supervision must be supervised by the case manager or another mature team member. The case manager should prepare the client for what to expect with the visit. A similar discussion should be held with the family members so that they know the ground rules. Often, the case manager—or whoever is supervising the visits—will be a model for the family members and they will look to the case manager for guidelines about the visits. Preparation discussions for the visit should consist of a plan with the following components:

1. Who will supervise the visits?
2. Who will be present during the visits? Who should not be present?
3. How long will the visits be?
4. Where will the visits take place? Sometimes it's advantageous to schedule the family visit outside of the family home in a neutral environment. If the visit is in the home, in which room(s) of the house will the visit take place? What are off-limit areas of the house for the client?
5. Discuss acceptable vs. unacceptable behaviors.
6. Discuss where the supervisor will be during the visit and coordinate a 15-minute check-in (see information to follow).
7. Define what behaviors will result in the visit being terminated.
8. What is the plan if company shows up during the visit?
9. What is the regular day and time for visits?
10. How frequent will the visits be?

While the case manager may remove herself from the immediate area of the visit, she should always have eyes and ears on supervision during initial visits. When visits are first initiated, it's wise to have a 15-minute check-in period with the client to determine how things are going and whether or not the visit should continue. The supervisor should attend to the parents' or family members' actions and topics of discussion. Frequently, parents and family members are in denial about their child having a sexual behavior problem, and they may say and do things that are not in the client's best interests. They may verbally make minimizing statements about the sexually abusive behavior and they may be physically inappropriate with boundaries. Some of these behaviors may be very subtle, so the supervisor must be alert to the dynamics. Intervention with the parents or family members should **not** be attempted during the visit. A sensitive discussion with the client after the visit is terminated and a separate meeting between the case manager and the family is a better way to proceed.

Termination of the visit should be on time. If the visit is scheduled to last one hour, it should end at one hour. If it is necessary to terminate a visit before the allotted time, the supervisor should make a brief and non-emotional, non-judgmental statement about why the visit has to be terminated early. The supervisor and client should then leave. There should be no discussion at that time. A meeting can be held with the parents later to discuss the visit and termination in depth. The supervisor should always follow up with the client immediately after the visit.

THE CASE MANAGER SHOULD ALWAYS HAVE EYES AND EARS ON SUPERVISION DURING INITIAL VISITS WITH FAMILY, AND, DESPITE NOT BEING IN THE IMMEDIATE AREA OF THE VISIT, MUST BE ALERT TO ANY PROBLEMS.

Visits may be extended for special occasions such as holidays and birthdays. These should be scheduled with prior notice to all parties.

Visits with the client's family must never be taken away as a punishment or consequence for inappropriate behaviors. The site of the visit may have to be moved to a conference room at the agency, but the client should always have access to family visits if he and they wish to have them. Some reasons for moving the visits to a neutral area may be that the client continually reverts to inappropriate behaviors when he is in his parents' home, there may be children at the home, or the parents may have abused the client. This is a fluid situation; when possible, visits should begin in the home and, if necessary, be moved to a neutral place. When the situation improves, the visits can be moved back to the parents' home.

FAMILY REUNIFICATION

Family reunification is a process, a continuum. It is not an "all-or-nothing" choice. It may start with very small steps and may end at any time. The process may even go backwards at times. Reunification is not always desirable. Several practitioners have detailed step-by-step processes and considerations for family reunification in more detail than discussed in this document (Center for Sex offender Management, 2005; Cumming & McGrath, 2005; Tabachnick & Pollard, 2016).

Reconciliation and clarification can be important therapy goals both for victims and persons with DD/PSB even if the reunification process does not advance.

Efforts to promote family reunification recognize (1) the importance of family in everyone's life and (2) the harmful impact of isolation from family. Separation often is the easiest way to promote safety, yet this approach negates the importance of family resources to the healing process and insulates the person with DD/PSB from having to deal with family issues.

FAMILY REUNIFICATION IS A PROCESS, A CONTINUUM.

Reunification is time-consuming, work-intensive, and emotionally and physically draining for all involved. Renewed contact must be gradual and phased, and each step must be completed before the next is attempted. The pace is determined by all the family members, the therapist, and other members of the Collaborative Team.

CHAPTER 24:
SELECTION AND SUPPORT OF SUPERVISORS

SELECTION OF SUPERVISORS

To be a supervisor, a person must be willing to assume the responsibility of protecting community safety. While a supervisor's connection to the person with DD/PSB may be personal or professional (and paid or unpaid), ultimately the right candidates will meet certain standards.

Whether paid or unpaid, a supervisor must:

- believe that the person with DD/PSB was sexually abusive towards another and could reoffend without supervision.
- be able to recognize the person's risk factors.
- agree not to keep secrets about the person's risky behavior.
- be willing to share information about the person's activities with the Collaborative Team.

In selecting supervisors *beware* of people who:

- cannot say "no" to the person with DD/PSB.
- are too overwhelmed by their personal or family issues to focus on their responsibilities as supervisor.
- are not respected by the person with DD/PSB.
- have issues with authority and reserve the right to make their own decisions about what's okay and what they need to report.
- hang onto myths about person with DD/PSB, even after education.
- doubt the guilt of the person with DD/PSB.
- cannot learn to recognize precursors of lapse behavior.
- have an approach that is punitive, rather than supportive.

Training should include a variety of modes, depending on the situation and whether the supervisor is paid or unpaid. Following training, to be approved as a

supervisor (paid or unpaid), the person should demonstrate that he or she knows the following:

- The sexual abusing history of the person with DD/PSB
- How to recognize warning signs of lapse behavior
- What the safety plan requires
- What to do if the person with DD/PSB violates the safety plan or engages in lapse behavior
- The level of supervision required
- How to help the person with DD/PSB stay on track
- Medical and psychiatric conditions that may be of concern, warning signs for problems, and the medicines prescribed
- The daily living skills of the person with DD/PSB
- The likes and dislikes of the person with DD/PSB
- What situations may lead to lapse behavior
- When and how to call for help

Selection of **contracted residential supervisors** (shared living and respite) is perhaps the most problematic. It is usually difficult to gauge from initial interviews with prospective home providers whether or not they are going to be good supervisors; they are approaching the interview as a job interview and want to make a good impression. Expectations should be made clear without revealing any specific client information. Certain attitudes to be wary of are relatively easy to spot:

- A goal of "curing" the person with DD/PSB
- Punitive attitudes toward persons who commit sex offenses
- Unwillingness to discuss values and attitudes about persons who commit sex offenses

Exploring the candidate's values and attitudes will be worth the time. Having to work with an unsuccessful home after the client has been there for a time and has made some connections may threaten the fabric of the team. It may also, ultimately, result in having to move the individual, causing him distress and losing valuable treatment time.

A visit to the home early in the approval process is necessary to indentify environmental risk factors and to look for indications of lifestyle that are inconsistent with supporting the offender. For instance, in an interview a couple

may say their children are grown and have left home, but if their home is full of photos of grandchildren who visit frequently, this may signal a lifestyle that won't work for a person with DD/PSB who has a strong sexual attraction to children. (For more information on residential supervisors, see Chapter 21: Residential Supports.)

REVOKING APPROVAL TO BE A SUPERVISOR

Sometimes people who have trained to be good supervisors don't follow through. When this happens, it's important to discover whether they are simply having trouble putting abstract concepts into concrete terms, or if they have decided, for whatever reason, that the standards are unnecessary.

If the problem is understanding, further training, including role playing and shadowing a skilled supervisor, may address the problem. When more training does not result in greater understanding or skill fairly quickly, the person should be temporarily suspended as a supervisor and not reinstated until she is able to demonstrate the necessary skills.

Anyone who purposefully and persistently violates program expectations needs to be terminated as a supervisor. As part of the termination process, it is advisable to document the specifics of the training offered.

Termination can be an unpleasant and anxiety-provoking duty; it's easy to postpone or avoid the task. Remember that failure to respond quickly means that the safety of the victim, the community, and/or the person with DD/PSB may be jeopardized by an untrustworthy supervisor.

At any stage of treatment, the task of monitoring the person with DD/PSB SHOULD BE SHARED BY A "NETWORK" OF SUPPORT PERSONS. THESE INCLUDE VOLUNTEERS SUCH AS FAMILY AND FRIENDS, EMPLOYERS, HOUSEMATES, SUPPORT STAFF, CASE MANAGERS, AND THERAPISTS.

PEOPLE APPROPRIATE FOR A SUPERVISION NETWORK:

- BELIEVE THE person with DD/PSB COMMITTED THE SEXUAL ABUSE.
- ARE KNOWLEDGEABLE ABOUT SEXUAL ABUSE DYNAMICS.
- KNOW AND RECOGNIZE RISK FACTORS FOR REOFFENSE.
- AGREE NOT TO KEEP SECRET ANY RISKY ACTIVITIES OR LAPSE BEHAVIOR.
- ARE WILLING TO BE CONTACTED BY THE CASE MANAGER OR THERAPIST.

SUPPORT TO ADDRESS SECONDARY TRAUMA

People who work or live with persons with DD/PSB should be aware of the phenomenon called **secondary trauma (**Hatcher & Noakes, 2010: Severson & Pettus-Davis, 2011). This term refers to the emotional and psychological impact of being exposed to the traumatic experiences of others. People who work with persons with DD/PSB, as well as family and friends, are subjected to secondary trauma in several ways:

- They may hear and imagine the sexual abuse disclosed by persons with DD/PSB and victims.
- They are overexposed to distorted perceptions of normal behavior.
- They are under pressure to be on the alert for risk and to be responsible for community safety.

SIGNS OF SECONDARY TRAUMA

- FEELING DISTRUSTFUL OF OTHERS
- FEELING OVERLY RESPONSIBLE FOR THE SAFETY OF THE COMMUNITY
- FEELING ISOLATED, UNAPPRECIATED, AND/OR MISUNDERSTOOD
- OVERUSING COPING SKILLS
- DENYING ONE'S OWN NEEDS BECAUSE OF "ALL THE WORK THAT MUST BE DONE TO PROTECT OTHERS"
- EXPERIENCING PROBLEMS IN PERSONAL AND WORK RELATIONSHIPS

Workers who experience too much secondary trauma can lose their effectiveness. This may have a harmful influence on the program and on the person with DD/PSB they are supposed to be supporting. Co-workers and supervisors should help colleagues be aware when they are showing signs of secondary trauma. Work settings should be designed to prevent and address secondary trauma among staff.

Workers at developmental services agencies may face particular challenges in addressing secondary trauma. Instead of getting support and appreciation from co-workers, they may be seen as reactionary or restrictive by staff in other parts of the agency who are trained in the values of self-determination.

A program that works with persons with DD/PSB should expect and prepare for secondary trauma among workers. Agencies should expect that some staff will have their own victim issues, and should provide support to staff to deal with those issues so they aren't projected onto clients.

No staff should be forced to take on an assignment of supervising person with DD/PSB; this type of work is **not** for everyone.

A program may provide opportunities for staff to meet with therapeutic professionals in a confidential setting to address personal trauma issues. Agencies should establish and maintain clear boundaries and expectations regarding issues of power, and provide a safe forum for discussing concerns and stressful situations that arise. Management staff should be trained to understand the dynamics of sex offending behavior and secondary trauma. Agencies should send a clear message that the failure of a person with DD/PSB is not the same as a worker's failure. Team-based decision-making and an environment where staff can laugh are essential.

- WORKERS WHO EXPERIENCE TOO MUCH SECONDARY TRAUMA CAN LOSE THEIR EFFECTIVENESS.
- INDIVIDUAL WORKERS SHOULD BE ALERT FOR SIGNS THAT THEY ARE SUFFERING THE EFFECTS OF SECONDARY TRAUMA.
- EVERY WORKER SHOULD SHARE CONCERNS WITH CO-WORKERS OR SUPERVISORS AND TAKE TIME TO TAKE CARE OF THEMSELVES.

Individual workers should be alert for signs that they are suffering the effects of secondary trauma. Workers should listen to feedback from colleagues, friends, and family members; share concerns with co-workers or supervisors; and take time to take care of themselves by being creative, getting away, appreciating the weather, getting exercise, socializing, and seeking peer support or counseling if needed.

PART SIX

RESOURCES

CHAPTER 25:
VERMONT RESOURCES

All the resources listed in this chapter provide assistance to individuals with developmental disabilities, *whether or not they are eligible for Developmental Services Program (DSP) funding*. DSP funding applies to a limited population. There are a significant number of people with developmental disabilities who are not eligible for DSP funding in Vermont. This chapter explores the resources available to the wider population of individuals with disabilities.

ADVOCACY/SUPPORT

Another Way - Drop-in center and daytime homeless shelter, provides support, peer counseling, a weekly Friday evening community meal, arts and crafts, and crisis intervention for people who have or have had psychiatric labels and/or emotional problems. 125 Barre St., Montpelier, VT 05602, (802) 229-0920.

ARC of Northwestern Vermont - (802) 524-5197

ARC-Rutland Area (RARC) - (802) 775-1370

Central Vermont ARC - (802) 223-6149

Champlain ARC (CARC) - (802) 658-2221

Developmentally Disabled Offenders Program - National clearinghouse for information about offenders with developmental disabilities. ARC of New Jersey, 985 Livingston Avenue, North Brunswick, NJ 08902, (732) 246-2525, www.arcnj.org.

Federation of Families for Children's Mental Health - Family-run organization supporting families whose children are experiencing or are at risk for experiencing emotional, behavioral, or mental health challenges. 600 Blair Park Rd., Williston, VT 05495, (802) 876-7021, 1-800-639-6071, or www.vffcmh.org.

Green Mountain Self-Advocates (GMSA) - Statewide self-advocacy network run and operated by people with developmental disabilities. 1-800-564-9990, (802) 229-2600, or gmsavt.org.

National Alliance for the Mentally Ill (NAMI) - Composed of individuals and families dealing with severe mental illness. 600 Blair Park Rd., Suite 301, Williston, VT 05495,1-800-639-6480, (802) 876-7949, or www.namivt.org.

University of Vermont's Center on Disability and Community Inclusion - Provides services, supports, and education to families, schools, and communities, and advocacy for the legal and civil rights of individuals with disabilities. 208 Colchester Avenue, Mann Hall, 3rd Floor, Burlington, VT 05405, (802) 656-4031, www.uvm.edu/~cdci.

Vermont Association for Mental Health and Addiction Recovery - Statewide citizens' organization working to promote mental health and mental health services. 100 State St., Suite 352, Montpelier, VT 05602, 1-800-639-4052, (802) 223-6263, or www.pear-vt.org.

Vermont Center for Independent Living (VCIL) - Private non-profit organization operated by and serving Vermonters with disabilities, promoting consumer choice, autonomy, and control. 11 East State Street, Montpelier, VT 05602, 1-800-639-1522, (802) 229-0501.

Vermont Children's Aid Society - Comprehensive program intended to improve children's well-being. Provides birth parent support services. 13 Kilborn St., Burlington, VT 05401, 1-800-479-0015.

Vermont Psychiatric Survivors - Consumer/survivor organization trying to fight tokenism, stigma, ignorance, and disunity among advocates. Offers peer support. 128 Merchants Row, Suite 606, Rutland, VT 05701, (802) 775-6834 or vermontpsychiatricsurvivors.org.

DISABILITY-SPECIFIC GROUPS

Alzheimer's Association - Provides support for people with Alzheimer's disease and related disorders, their families and their caregivers. 300 Cornerstone Drive, Suite 130, Williston, VT 05495, (802) 316-3839. www.alz.org

Autism Society of Vermont and Autism Information Center - Provides information, support, and training. P.O. Box 978, White River Junction, VT 05001, 1-800-559-7398, www.asvermont.org.

Brain Injury Association of Vermont - Brain injury prevention, research, education, and advocacy. 92 South Main St / P.O. Box 482, Waterbury, VT 05676, 802-244-6850 or 1-877-856-1772. www.biavt.org.

Vermont Association for the Blind and Visually Impaired - Provides comprehensive support services for visually impaired Vermonters. 60 Kimball Ave, South Burlington, VT 05403, (802) 863-1358 or vabvi.org.

EMPLOYMENT/EDUCATION

Vermont Department of Labor - Provides job training and referrals, unemployment compensation, Internet access, resumes, job interest and aptitude tests. 5 Green Mountain Drive / P.O. Box 488, Montpelier, VT 05601-0488, (802) 828-4000 or labor.vermont.org.

Vermont Adult Learning - Provides adult education and life skills programs statewide. 60 South Main St., Waterbury, VT 05676, 1-800-322-4004 or vtadultlearning.org.

Vermont Association of Business, Industry and Rehabilitation (VABIR) - Provides free employment and consultation services to workers with disabilities. 75 Talcott Road, Suite 70, Williston, VT 05495, (802) 878-1107.

Vocational Rehabilitation - Helps Vermonters with disabilities prepare for and find employment. 280 State Drive, HC 2 South, Waterbury, VT 05671, 1-866-879-6757 or vocrehab.vermont.gov.

HOUSING

Lamoille Housing Partnership - Provides affordable housing assistance. 49 Brigham St / P.O. Box 637, Morrisville, VT 05661, (802) 888-5714 or lamoillehousing.org.

Rutland County Housing Coalition - Assists homeless persons and those at risk for homelessness to find housing. 46 Evelyn St, Suite 201, Rutland, VT 05701, (802) 775-9286.

Vermont Community Action Programs - Provide assistance with advocacy, emergency food, utility and home fuel, landlord/tenant problems, housing.

> **Bennington-Rutland Opportunity Council (BROC)** - 60 Center Street, Rutland, VT 05701, 1-800-717-2762, (802) 775-0878.
>
> **CAPSTONE Community Action** – 20 Gable Place, Barre, VT 05641, 1-800-639-1053.
>
> **Champlain Valley Office of Economic Opportunity (CVOEO)** – 255 South Champlain St, Burlington, VT 05401, (802) 862-2771.
>
> **Northeast Kingdom Community Action (NEKCA)** – 70 Main St, Newport, VT 05858-5110, (802) 334-7316.
>
> **Southeastern Vermont Community Action (SEVCA)** - 91 Buck Drive, Westminster, VT 05158-9618, 1-800-464-9951, (802) 722-4575.

Vermont State Housing Authority - Provides assistance with Section 8 rent subsidy and other housing matters. 1 Prospect Street, Montpelier, VT 05602, (802) 828-3295, 1-800-820-5119.

LEGAL/COURT SYSTEM

Disability Law Project of Vermont Legal Aid (DLP) - Provides information, referral, investigation, and resolution of legal problems and complaints for persons with disabilities. 264 North Winooski Ave, Burlington, VT 05402, (802) 863-5620 or vtlegalaid.org.

Vermont Communication Support Project (VCSP) - provides communication assistance to people with developmental disabilities whose communication deficits interfere with their access to the justice system. Provides assistance to litigants and witnesses in family, probate, and superior court proceedings. Provides assistance to witnesses only in district court proceedings. 141 Main St, Suite 7, Montpelier, VT 05602, 1-888-686-8277 or www.disabilityrightsvt.org.

Disability Rights Vermont - a federally-authorized non-profit watchdog and advocacy organization working with individuals with disabilities, including physical, mental or developmental disabilities, to protect and promote their rights. 141 Main Street, Suite 7, Montpelier, VT 05602, 1-800-834-7890, (802) 229-1355 or www.disbilityrightsvt.org.

PSYCHIATRY/SUBSTANCE ABUSE SERVICES

Brattleboro Retreat - Provides a full range of diagnostic, therapeutic and rehabilitation services, including a well-regarded addiction treatment program. P.O. Box 803, Brattleboro, VT 05302-0803, 1-800-738-7328, (802) 257-7785.

Central Vermont Substance Abuse Services – 100 Hospitality Drive, Berlin, VT 05601, (802) 223-4156.

University of Vermont Medical Center – Seneca Center - Out-Patient psychiatry. 1 South Prospect Street, St. Josephs, Level 6, Burlington, VT 05401, (802) 891-4415.

Maple Leaf Treatment Center - Provides substance abuse treatment. 10 Maple Leaf Road, Underhill, VT 05489, 802-899-2911 or www.mapleleaf.org.

Spring Lake Ranch Residential Treatment Program - Therapeutic work community for people with emotional, psychiatric, and substance abuse problems. 1169 Spring Lake Road, Cuttingsville, VT 05738, (802) 492-3322 or springlakeranch.org.

Spruce Mountain Inn - Psychiatric Treatment Program, Residential & Day Treatment Services. 155 Towne Ave / P.O. Box 153, Plainfield, VT 05667, (802) 454-8353.

PREVENTION AND TREATMENT OF SEXUAL ABUSE

Adult Protective Services (APS) - An office within DAIL. APS staff investigate complaints of abuse, neglect or exploitation of vulnerable adults. As part of their investigation, they often intervene to protect the victim and prevent future abuse. 1-800-564-1612 or 802 241-0512. There is on-line report form at the DAIL Web site. Emergencies should be reported directly to the police, and followed up with a report to APS.

Prevent Child Abuse - Vermont - Umbrella organization of educational services to families, including Understanding and Responding to Sexual Behavior in Children and Adolescents, and Sexual Abuse Free Environment for Teens (SAFE-T). Hotline at 1-800-244-5373. P.O. Box 829, Montpelier, VT 05601-0829, (802) 229-5724, www.pcavt.org or email pcavt@together.net.

STOP IT NOW! Vermont - Confidential help-line to help prevent child sexual abuse. Open to abusers, family and friends of abusers. 1-888-773-8368 or stopitnow.org.

Vermont Center for the Prevention and Treatment of Sexual Abuse (VCPTSA) - Statewide program designed to address the treatment needs of both sexual abuse victims and offenders. Provides resource center and referral service to prevent and treat sexual abuse. 280 State Drive, Waterbury, VT 05671, (802) 241-0014 or (802) 241-0909 or http://humanservices.vermont.gov/center-for-prevention-and-treatment-of-sexual-abuse/about-us/

VICTIMS

Deaf Vermonters Advocacy Services - serves victims of domestic and sexual violence who are Deaf and hard of hearing, provides direct support through medical and legal advocacy and referral to therapeutic counseling; also provides prevention education. (802) 661-4091 or www.dvas.org.

Vermont Center for Crime Victim Services (CCVS) - Statewide organization that provides advocacy and information to victims of crime. Their Web site provides contact information for the Victim Assistants and local rape crisis centers in each area of the state. 58 South Main Street, Suite 1, Waterbury, VT 05676-1599, 1-800-750-1213, www.ccvs.state.vt.us.

GLOSSARY

This glossary includes terms specific to Vermont and general terms. General terms adapted from the "Glossary of Terms Used in the Management and Treatment of Sexual Offenders" document created by the Center for Sex Offender Management. A full version of the CSOM glossary can be found at the CSOM Web site, http://www.csom.org.

Several terms included in this glossary are not used in this manual; they are included here as a reference for those working in the field.

Abstinence: The decision to refrain from taking part in a self-prohibited behavior. For persons who commit sexual abuse, abstinence is marked by refraining from engaging in behaviors that are associated with their abusing patterns and not dwelling on deviant fantasies and thoughts.

Abstinence Violation Effect (AVE): A term used to describe high risk factors and a variety of changes in beliefs and behaviors that can result from engaging in lapses. Among the components of the AVE are: a sense that treatment was a failure; a belief that the lapse is a result of being weak-willed and unable to create personal change; a failure to anticipate that lapses will occur; and recalling only the positive aspects of the abusive behavior (also referred to as the Problem of Immediate Gratification). When persons who commit sexual abuse are not prepared to cope with the AVE, the likelihood of relapse increases. The AVE is experienced most strongly when clients believe that lapses should never occur.

Access to Potential Victims: Any time a person who commits sexual abuse is alone with a potential victim the person is considered to have access to a potential victim, and the potential victim is considered at risk.

Act 248: Vermont's commitment law for offenders with developmental disabilities who have been found incompetent to stand trial.

Adaptive Coping Response (ACR): A change in thoughts, feelings, and/or behaviors that helps persons who commit sexual abuse deal with risk factors and reduces the risk of lapse. Adaptive coping responses help persons who commit sexual abuse avoid reoffending (relapse), and may be general in nature (e.g., talking with a friend when upset, hurt, or angry) or specific to certain situations (e.g., avoiding children or refraining from masturbation to deviant fantasies).

General coping responses improve the quality of life. These responses include: effectively managing stress and anger; improving skill and ability to relate with others; changing life in ways which do not support sexually abusive behavior; learning to relax; and increasing knowledge, skills and ability to solve problems.

Specific coping responses deal with lapses and identified risk factors. These include: avoiding triggers to behavior (stimulus control); avoiding high risk factors; escaping from risk factors; developing specific coping methods for a particular problem and using them when the problem occurs; changing the way one thinks; learning ways to reduce the impact of the AVE; developing lapse contracts; setting positive approach goals; and using other methods of dealing with problems when they arise.

Adjudication: The process of rendering a judicial decision as to whether the facts alleged in a petition or other pleading are true; an adjudicatory hearing is that court proceeding in which it is determined whether the allegations of the petition are supported by legally-admissible evidence.

Aggravating Circumstances: Conditions that intensify the seriousness of the sexual abuse. Conditions may include age and gender of the victim, reduced physical and/or mental capacity of the victim, the level of cruelty used to perpetrate the abuse, the presence of a weapon during the commission of the offense, denial of responsibility, multiple victims, degree of planning before the offense, history of related conduct on the part of the person who committed sexual abuse, and/or the use of a position of status or trust to perpetrate the abuse.

Androgen: A steroid hormone producing masculine sex characteristics and having an influence on body and bone growth and on the sex drive.

Anti-androgen: A substance that blocks the production of male hormones.

Assault Cycle: The pattern of sexual abusing that includes triggers, feelings, behaviors, cognitive distortions, planning, etc. Methods of addressing the assault cycle may include charting, the use of a psycho educational curriculum, individual teaching/therapy, etc.

Authorization for Release of Information: Permission form that must be signed by the client to allow confidential information to be shared with others.

Authorized Funding Limit: The amount of money allocated to an individual to pay for Developmental Services.

Autoerotic: Self-stimulation; frequently equated with masturbation.

Aversive Conditioning: A behavioral technique designed to reduce deviant sexual arousal by exposing the client to a stimulus that arouses him and then introducing an unpleasant smell or physical sensation.

Behavior Support Plan: A plan developed in the context of the ISA for clients who present behavioral challenges that require skilled clinical intervention.

Child Pornography: Any audio, visual, or written material that depicts children engaging in sexual activities or behaviors, or images that emphasize genitalia and suggest sexual interest or availability.

Clarification: This procedure requires the person who committed sexual abuse to write a letter to the victim, in an effort to relieve the victim of any responsibility for the sexual abuse and clarify what occurred in language the victim can understand. Clarification is permitted only after the person who committed sexual abuse and victim have adequately demonstrated progress in their respective therapy programs. This is a supervised process by the abuser and victim's treatment provider and sometimes the supervision officer. This procedure is a pre-requisite for re-unification to occur. In cases where the victim is not in therapy, the abuser may still write a letter and the letter is kept in the abuser's treatment file.

This clarification process varies and should be designed to address the individual needs of the victim, which may require the abuser to accomplish some or all of the following tasks:

- Verbalize responsibility for his sexual abusing behavior and for making the victim endure the abuse;
- State why he chose the victim and how he misused those qualities to abuse him/her;
- Acknowledge "grooming" behavior which;
- Affected family relationships;
- Isolated the victim;
- Created confusion or guilt for the victim;
- Manipulated the victim into compliance; and

- Convinced the victim to keep the abuse secret.
- Support the victim's decision to report abuse and take responsibility for making the victim endure the legal process; and
- Make no request for forgiveness and ask no questions of the victim.

Cognitive Distortion: An irrational thought that persons who commit sexual abuse use to justify their behavior or to allow themselves to experience abusive emotions without attempting to change them. Cognitive distortions are ways persons who commit sexual abuse go about making excuses for justifying and minimizing their sexually abusive behavior.

Collaborative Team: A team of key individuals who interact with the person with DD/PSB, working to protect the community and to meet the needs of the offender. The team is critical for both supervision (to protect the public) and treatment.

Communication Specialist: Provided by the Vermont Communication Support Project, a person trained and experienced in communication with persons with DD who assists victims to understand and communicate during the court process.

Conditional Re-entry: Formerly called furlough, the opportunity for early release for offenders who engage honestly in treatment.

Conditions of Community Supervision: Requirements prescribed by the court as part of the sentence to assist the offender to lead a law-abiding life. Failure to observe these rules may lead to a revocation of community supervision, or graduated sanctions by the court. Examples of special conditions of community supervision for persons convicted of sex offenses are noted below:

- Enter, actively participate, and successfully complete a court recognized sex offender treatment program as directed by your supervising officer, within 30 days of the date of this order;
- No contact with the victim (or victim's family) without written permission from your supervising officer;
- Pay for victim counseling costs as directed by the supervising officer;

Contact: As a special condition of supervision or as a treatment rule, a person convicted of a sex offense is typically prohibited from contact with his victim or potential victims. Contact has several meanings noted below:

- Actual physical touching;

- Association or relationship: taking any action which furthers a relationship with a minor, such as writing letters, sending messages, buying presents, etc.; or
- Communication in any form is contact (including contact through a third party). This includes verbal communication, such as talking, and/or written communication such as letters, text messages or email. This also includes non-verbal communication, such as body language (waving, gesturing) and facial expressions, such as winking.

Conviction: The judgment of a jury or judge that a person is guilty of a crime as charged.

Correctional Services Specialist (CSS): Also referred to as a probation or parole officer, this person is responsible to monitor the behavior of the person with DD/PSB to ensure his compliance with conditions imposed by the court (for probation), the Parole Board (for parole), or the Department of Corrections (for conditional re-entry). The CSS may also complete a Presentence Investigation (PSI) report on a person prior to sentencing.

Covert Sensitization: A behavioral technique in which a deviant fantasy is paired with an unpleasant one.

Criminogenic Needs: The "treatment needs" of individuals that are most directly related to their sexual offending behavior, including pro-offending attitudes and beliefs, emotion management problems, impulsivity, offense related sexual interests, and poor social skills.

Crossover: A sexual behavior pattern which reveals that a person who has committed a sexual offense is aroused or acting out to sexual interests in addition to the offenses of record or conviction.

Cruising: The active seeking out of a victim for purposes of engaging in sexually abusive activity.

Denial: A psychological defense mechanism in which the person who has committed sexual abuse avoids taking responsibility for the abuse. Several types of denial have been identified:

1. Denial of facts: The person who abused may claim that the victim is lying or remembering incorrectly;
2. Denial of awareness: The person may claim that s/he experienced a blackout caused by alcohol or drugs and cannot remember;

3. Denial of impact: Refers to the minimization of harm to the victim;
4. Denial of responsibility: The person may blame the victim or a medical condition in order to reduce or avoid accepting responsibility;
5. Denial of grooming: The person may claim that he did not plan for the offense to occur;
6. Denial of sexual intent: The person may claim that s/he was attempting to educate the victim about his/her body, or that the victim bumped into the offender. In this type of denial, the offender tries to make the offense appear non-sexual; and
7. Denial of denial: The person appears to be disgusted by what has occurred in hopes others would believe he was not capable of committing such a crime.

Developmental Disability: See definitions in Chapter 1: What is "Developmental Disability"?

Developmental Disability Act of 1996 (DDA): The Vermont Act under which most state-funded services and supports for people with DD are developed. Services are delivered in accordance with the standards set by the Act, including intake and assessment, support coordination, residential supports, community supports, work supports, clinical services, crisis supports, respite and family supports.

Dialectical Behavior Therapy: A cognitive behavior therapy method developed by Marsha Linehan for treating people with borderline personality disorder.

Disinhibitors: Internal or external motivators (stimuli) that decrease reservations or prohibitions against engaging in sexual activities. An example of an internal disinhibitor is a cognitive distortion (e.g., "that 8-year-old is coming on to me," or "she said no, but she really wants to have sex with me"). Alcohol and drug use are examples of external disinhibitors.

Disposition: A final settlement of criminal charges.

DSM-5: The DSM-5 is an abbreviation for the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, which is a compendia of diagnoses and their definitions that are utilized universally in psychiatry and related professions.

Electronic Monitoring: An automated method of determining compliance with community supervision restrictions through the use of electronic devices. There are three main types of electronic monitoring utilizing different technologies:

1. Continuous Signaling Technology: The person wears a transmitting device that emits a continuous coded radio signal. A receiver-dialer is located in the person's home and is attached to the telephone. The receiver detects the transmitter's signals and conveys a message via telephone report to the central computer when it either stops receiving the message or the signal resumes again.
2. Programmed Contact Technology: This form of monitoring uses a computer to generate either random or scheduled telephone calls to the person during the hours the person should be at his/her residence. The person must answer the phone, and verify his/her presence at home by either transmitting a special beeping code from a special watch attached to the person's wrist, or through the use of voice or visual verification technology.
3. Global Positioning Technology (GPS): The technology can monitor a person's whereabouts at any time and place. A computer is programmed with the places the person should be at specific times and any areas that are off limits to the person (e.g., playgrounds and parks). The person wears a transmitting device that sends signals through a satellite to a computer, indicating the person's whereabouts.

Expungement: The permanent removal of a person's name or other information from a crime or abuse record.

Family Reconciliation: The therapeutic process that ends with a resolution of problems and conflict areas that prevent a family from having a healthy, non-abusive relationship. Family reconciliation must take place before family reunification can occur. Reconciliation may take place without reunification, although reunification should not occur without reconciliation.

Family Reunification: This is the joining again of the family unit in which one member has previously sexual abused another member. It is a step-by-step process with achievable goals and objectives.

Forensic Psychiatrist: A doctor with special, advanced training in assessing whether or not a person is competent to stand trial.

Grooming: The process of manipulation often utilized by individuals who have molested children, intended to reduce a victim's or potential victim's resistance to sexual abuse. Typical grooming activities include gaining the child victim's trust or gradually escalating boundary violations of the child's body in order to desensitize the victim to further abuse.

Guardianship Order: A court order detailing who is appointed guardian of an individual and what authority he or she has. Any program working with a person who is under guardianship should have a copy of the guardianship order in the case file for reference.

Incest: Sexual relations between close relatives, such as father and daughter, mother and son, sister and brother. This also includes other relatives, step children, and children of common-law marriages.

Incompetence to Stand Trial: Inability to be put on trial because of a lack of ability to participate meaningfully in the court trial process.

Indeterminate Sentence: A sentence that sets a minimum and maximum time to serve (for example, a minimum of two years and a maximum of ten years).

Index Offense: The most recent offense known to authorities.

Individual Support Agreement (ISA): An annual treatment plan required for any person who receives Medicaid-funded developmental services. The ISA is developed through a person-centered planning process and defines the goals, supports, and desired outcomes for the individual.

Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act: Enacted in 1994, this federal mandate requires states to establish stringent registration programs for sex offenders—including lifelong registration for offenders classified as "sexual predators" (see Sex Offender Registration).

Job Coach: A person who supports a person with DD at the workplace to assist him with learning the job and meeting the expectations of the employer.

Justification: A psychological defense mechanism by a person in which he attempts to use reasoning to explain abusing behavior.

Lapse: An emotion, fantasy, thought, or behavior that is part of a sexual abuser's cycle and relapse pattern. Lapses are not sex offenses. They are precursors or risk factors for sex offenses. Lapses are not failures and are often considered as valuable learning experiences.

Megan's Law: The first amendment to the Jacob Wetterling Crimes Against Children and Sexually Violent Offenders Registration Act. This was passed in October 1996 and requires states to allow public access to information about sex offenders in the community. This federal mandate was named after Megan Kanka, a seven-year-old girl who was raped and murdered by a twice-convicted child molester in her New Jersey neighborhood (see Community Notification).

Mitigating Circumstances: Conditions that may modify the seriousness of a sex offense. Conditions may include the offender participating in the offense under coercion or duress; a lack of sufficient capacity on the part of the person for judgment due to physical or mental impairment; or sincere remorse and a course of action undertaken to demonstrate restitution, responsibility, and culpability.

Orgasmic Conditioning: A behavioral technique designed to increase appropriate sexual arousal by having the client pair masturbation and orgasm to appropriate sexual fantasies.

Pam Lychner Act: Passed in 1996, this federal amendment to the Jacob Wetterling Act requires the U.S. Department of Justice (DOJ) to establish a National Sex Offender Registry (NSOR) to facilitate state-to-state tracking of sex offenders and lifetime registration and 90-day address verification requirements on violent and habitual sex offenders. This act also requires the Federal Bureau of Investigations (FBI) to handle sex offender registration and notification in states unable to maintain "minimally sufficient" programs on their own.

Paraphilia: A psychosexual disorder. Recurrent, intense, sexually arousing fantasies, urges, and/or thoughts that usually involve humans, but may also include non-human objects. Suffering of one's self or partner, children, or non-consenting persons is common. A deviation in normal sexual interests and behavior that may include:

- **Bestiality (Zoophilia)**: Sexual interest or arousal to animals.
- **Coprophilia**: Sexual interest or arousal to feces.

- **Exhibitionism**: Exposing one's genitalia to others for purposes of sexual arousal.
- **Frotteurism**: Touching or rubbing against a non-consenting person.
- **Fetishism**: Use of nonliving objects (e.g., shoes, undergarments, etc.) for sexual arousal that often involves masturbation.
- **Hebophilia**: Sexual interest in, or arousal to, teens/post-pubescent children.
- **Klismophilia**: Sexual arousal from enemas.
- **Necrophilia**: Sexual interest in, or arousal to, corpses.
- **Pedophilia**: Sexual interest in pre-pubescent child or children (generally age 13 years or younger).
- **Pederast**: Sexual interest in, or arousal to, adolescents.
- **Sexual Masochism**: Sexual arousal/excitement from being humiliated, beaten, bound, or made to suffer.
- **Sexual Sadism**: Sexual arousal/excitement from psychological or physical suffering of another.
- **Telephone Scatologia**: Engaging in uninvited, sexually explicit talk with another person via the telephone. This is often referred to as "obscene phone calling."
- **Transvestic Fetishism**: The wearing of clothing articles and especially undergarments for persons of the opposite sex. This is often referred to as "cross dressing."
- **Voyeurism**: Observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.

Parole: A method of prisoner release on the basis of individual response and progress within the correction institution, providing the necessary controls and guidance while serving the remainder of their sentences within the free community.

Peggy's Law: A Vermont state law that requires full written disclosure of any past history of relevant dangerous behavior to any potential shared living provider or respite provider who will be caring for a person in his or her home.

Penile Plethysmograph: A device used to measure a male's erection response to both appropriate (age appropriate and consenting) and deviant sexual stimulus material. Stimuli can be audio, visual, or a combination.

Presentence Investigation Report: A court ordered report prepared by a supervision officer. This report includes information about an offender's index

offense, criminal record, family and personal history, employment and financial history, substance abuse history, and prior periods of community supervision or incarceration. At the conclusion of the report, the officer assesses the information and often makes a dispositional recommendation to the court.

Private Guardian: A family member or friend of an adult with DD who acts as the individual's guardian. Private guardians are appointed and supervised by the Probate Court.

Probation Conditions: The list of requirements of a probationer typically based on the offender's risk factors, such as alcohol, drugs, pornography, and locations where potential victims (for example, children) tend to be present.

Progress in Treatment: Observable and measurable changes in behavior, thoughts, and attitudes which support treatment goals and healthy, non-abusive sexuality.

Psychopathy: A disorder characterized by high degree of criminality that includes many of the following: glibness and superficial charm; grandiosity; excessive need for stimulation/proneness for boredom; pathological lying; cunning and manipulative; lack of remorse or guilt; shallow affect; parasitic lifestyle; poor behavior controls; promiscuous sexual behavior and many short-term relationships; early behavioral problems; lack of realistic, long-term goals; impulsivity; irresponsibility; history of juvenile delinquency; likelihood of revocation on conditional release; and criminal versatility.

Psychopathy Checklist—Revised: The clinical instrument to assess the degree to which an individual has characteristics of psychopathy. It is a 20-item instrument that is scored by the evaluator based on collateral information and typically an interview of the offender.

Psychopharmacology: The use of prescribed medications to alter behavior, affect, and/or the cognitive process.

Psychosexual Evaluation: A comprehensive evaluation of an alleged or convicted sex offender to determine the risk of recidivism, dangerousness, and necessary treatment. A psychosexual evaluation usually includes psychological testing and detailed history taking with a focus on criminal, sexual, and family history.

Public Guardian: Typically appointed by Family Court and a staff member of the DAIL Office of Public Guardian, a person who acts as the guardian of an individual with DD. Public guardians for people with DD are appointed by Family Court.

Recidivism: Commission of a crime after the individual has been criminally adjudicated for a previous crime; reoffense. In the broadest context, recidivism refers to the multiple occurrence of any of the following key events in the overall criminal justice process: commission of a crime whether or not followed by arrest, charge, conviction, sentencing, or incarceration.

Relapse: A re-occurring sexually abusive behavior or sex offense.

Relapse Prevention: A multidimensional model incorporating cognitive and behavioral techniques to treat sexually abusive/aggressive behavior.

Restitution: A requirement by the court as a condition of community supervision that the offender replaces the loss caused by his/her offense through payment of damages in some form.

Restorative Justice: Focuses on the repair of the harm to the victim and the community, as well as the improvement of pro-social competencies of the person who offended, as a result of a damaging act.

Reunification: A gradual and well-supervised procedure in which a person who has sexually abused (generally incest) is allowed to re-integrate back into the home where children are present. This generally takes place after a clarification process and provides a detailed plan for preventing relapse.

Risk Factors: Characteristics that have been found through scientific study to be associated with increased likelihood of recidivism among individuals known to have committed sexual offenses.

Risk Management: A term used to describe services provided by corrections personnel, treatment providers, community members, and others to manage risk presented by persons who have committed sexual abuse. Risk management approaches include supervision and surveillance in a community settings (risk control) and rehabilitative activities (risk reduction).

Risk Reduction: Activities designed to address the risk factors contributing to the person's sexually abusive behaviors. These activities are rehabilitative in nature and provide the person with the necessary knowledge, skills, and attitudes to reduce his likelihood of reoffense.

Self-Managed Supports: When a person with a DD and/or his family chooses to manage the funds to pay for necessary supports with the oversight of the local DA and monies being passed through a fiscal intermediary. Self-managed supports are not suitable for persons with DD/PSB.

Sexual Abuse Behavior Chain (or Cycle): The pattern of specific thoughts, feelings, and behaviors that often lead up to and immediately follow sexually abusive behavior.

Sexual Abuser: The term most commonly used to described persons who engage in sexual behavior that is considered to be illegal (this term refers to individuals who may have been charged with a sex crime but have not been convicted).

Sexual Act: Contact between "the penis and the vulva, the penis and the anus, the mouth and the penis, the mouth and the vulva, or any intrusion, however slight, by any part of a person's body or any object into the genital or anal opening of another." 13 V.S.A. §3251(1).

Sexual Assault: Forced or manipulated unwanted sexual contact between two or more persons.

Split Sentence: In court sentencing, all or part of a term of imprisonment may be suspended, and the offender placed on probation. A split sentence is where only part of the term of imprisonment is suspended and the offender must serve the rest of the sentence.

Supervised Community Sentence (SCS): A form of imprisonment to be served outside the walls of a correctional facility. The Parole Board, not the court, governs these cases.

Surrogate Parent: A legally-authorized decision-maker for a person's school services. Federal law requires appointment of a surrogate parent for school-aged individuals in the custody of DCF or under the guardianship of OPG.

System of Care Plan: The plan adopted by DAIL every three years describing the nature, extent, allocation, and timing of services that will be provided to people

with DD and their families with state and federal funds. The plan is revised annually based upon fiscal resources and program priorities.
Triggers: An external event that begins the sexual abuse or acting out behavior chain or cycle (i.e., seeing a young child, watching people argue, etc.).

Victim Impact Statement: A statement taken while interviewing the victim during the course of the presentence investigation report, or at the time of pre-release. Its purpose is to discuss the impact of the sexual offense on the victim.

Vulnerable Adult: Any person with a developmental disability whose ability to protect himself from abuse, neglect or exploitation and to care for himself is impaired due to a mental, physical, or developmental disability. 33 V.S.A. §6902(14).

ACRONYMS

ADD	Attention Deficit Disorder
AFL	Authorized Funding Limit
AHS	Agency of Human Services
APS	Adult Protective Services
ARC	Advocacy, Resources and Community (formerly The Association of Retarded Citizens)
CARC	Champlain ARC – see ARC
CS	Communication Specialist
CSS	Correctional Services Specialist
DA	Designated Agency
DAD	Department of Aging and Disabilities – Obsolete, see DAIL
DAIL	Department of Aging and Independent Living
DCF	Department for Children and Families
DD	Developmental Disability or Developmentally Disabled
DD ACT	Developmental Disability Act of 1996
DDAS	Division of Disability and Aging Services, a division of DAIL.
DDMHS	Department of Developmental and Mental Health Services – Obsolete, see DAIL and DOH
DDS	Division of Developmental Services – Obsolete, see Division of Disability and Aging Services
DH	Developmental Homes – see also SLP and HP
DLP	Disability Law Project (formerly DDLP)
DMH	Division of Mental Health
DOC	Department of Corrections (state)
DOE	Department of Education (state)
DOH	Department of Health
DOJ	Department of Justice (federal)
DS	Developmental Services
DSM	Diagnostic and Statistical Manual of Mental Disorders (most current edition)
DSP	Developmental Services Program
FY	Fiscal Year
GMSA	Green Mountain Self Advocates
GS	Guardianship Services – Obsolete, see OPG
GSS	Guardianship Services Specialist – Obsolete, see PG
HCBW	Home and Community-based Waiver

HIPAA	Health Insurance Portability and Accountability Act
HP	Home provider
IEP	Individualized Education Program
ISA	Individual Support Agreement
OPG	Office of Public Guardian
P&A	Protection and Advocacy – see VP&A
PDD	Pervasive Developmental Disorder
PG	Public Guardian
PRC	Professional Review Committee
PSI	Presentence investigation
RARC	Rutland ARC – see ARC
SCS	Supervised Community Sentence
SLH	Shared Living Home
SLP	Shared living provider
SRS	Department of Social and Rehabilitation Services - Obsolete, see DCF
SSA	Specialized Service Agency
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
TXIX	Title XIX of the Social Security Act (Medicaid)
VARC	ARC of Vermont– see ARC
VCIC	Vermont Criminal Information Center
VCIL	Vermont Center for Independent Living
VCPTSA	Vermont Center for Prevention and Treatment of Sexual Abuse
VP&A	Vermont Protection and Advocacy
VR	Vocational Rehabilitation
VSH	Vermont State Hospital

APPENDICES

APPENDIX A: VERMONT DEVELOPMENTAL SERVICES PROVIDERS

(JANUARY 2017)

(CVS) CHAMPLAIN VOCATIONAL SERVICES, INC.

512 Troy Avenue, Suite 1
Colchester, VT 05446
Phone (802) 655-0511 FAX: (802) 655-5207

Exec. Dir: Elizabeth Sightler
County: Chittenden

(CAP) COMMUNITY ACCESS PROGRAM OF RUTLAND MENTAL HEALTH SERVICES (RMHS)

78 South Main Street
Rutland, VT 05701
Phone: (802) 775-0828 FAX: (802) 747-7692

Director: Ellen Malone
County: Rutland

(CA) COMMUNITY ASSOCIATES OF COUNSELING SERVICE OF ADDISON COUNTY (CSAC)

109 Catamount Park
Middlebury, VT 05753
Phone: (802) 388-4021 FAX: (802) 388-1868

Director: Greg Mairs
County: Addison

(CDS) COMMUNITY DEVELOPMENTAL SERVICES OF WASHINGTON COUNTY MENTAL HEALTH SERVICES (WCMHS)

50 Granview Drive
Barre, VT 05641
Phone: (802) 479-2502 FAX: (802) 479-4056

Director: Juliet Martin
County: Washington

(FF) FAMILIES FIRST

PO Box 939
Wilmington, VT 05363
Phone: (802) 464-9633 FAX: (802) 464-3173

Director: Julie Cunningham
Counties: Windham and Bennington

(HCRS) HEALTH CARE and REHABILITATION SERVICES OF SOUTHEASTERN VT

390 River Street, Springfield, VT 05156
Phone: (802) 886-4567 FAX: (802) 886-4570

Director: Theresa Earle
Counties: Windsor and Windham

Regional Offices:

29 Elm Street, Brattleboro, VT 05301
Phone: (802) 257-5537 FAX: (802) 257-5769

14 River Street, Windsor, VT 05089
Phone: (802) 674-2539 FAX: (802) 674-5419

1 Hospital Ct., Ste. 410, Bellows Falls, VT 05101
Phone: (802) 463-3947 FAX: (802) 463-3961

49 School Street, Hartford, VT 05047
Phone: (802) 295-3032 FAX: (802) 295-0820

(HC) HOWARD CENTER, INC., DEVELOPMENTAL AREA

102 South Winooski Ave.
Burlington, VT 05401-3832
Phone: (802) 658-1914 FAX: (802) 860-2360

Director: Marie Zura
County: Chittenden

(LCMH) LAMOILLE COUNTY MENTAL HEALTH SERVICES, INC.

72 Harrel Street, Morrisville, VT 05661
Phone: (802) 888-5026 FAX: (802) 888-6393

Director: Jennifer Stratton
County: Lamoille

(LSI) LINCOLN STREET INCORPORATED

374 River Street
Springfield, VT 05156
Phone: (802) 886-1833 FAX: (802) 886-1835

Executive Director: Cheryl Thrall
County: Windsor

(NCSS) NORTHWESTERN COUNSELING and SUPPORT SERVICES, INC.

107 Fisher Pond Road
St. Albans, VT 05478
Phone (802) 527-8161 FAX: (802) 524-0578

Director: Kathleen Brown
Counties: Franklin and Grand Isle

Regional Office:
130 Fisher Pond Road, St. Albans, VT 05478
Phone (802) 524-6554 x4 FAX (802) 524-0578

(NKHS) NORTHEAST KINGDOM HUMAN SERVICES, INC.

181 Crawford Road
Derby, VT 05855
Phone: (802) 334-6744 FAX: (802) 334-7455

Director: Dixie McFarland
Counties: Caledonia, Orleans and Essex

Regional Office:
PO Box 368, 2225 Portland Street, St. Johnsbury, VT 05819
Phone: (802) 748-3181 FAX: (802) 748-0704

(SCC) SPECIALIZED COMMUNITY CARE

3627 Route 7 South
Middlebury, VT 05753
Phone: (802) 388-6388 FAX: (802) 388-6704

Executive Director: Ray Hathaway
Counties: Addison and Rutland

(GMSS) GREEN MOUNTAIN SUPPORT SERVICES, INC. (was Sterling Area Services)

109 Professional Drive
Morrisville, VT 05661
Phone: (802) 888-7602 FAX: (802) 888-1182

Executive Director: Josh Smith
County: Lamoille and Washington

(UCS) UNITED COUNSELING SERVICES, INC.

PO Box 588, 100 Ledge Hill Drive
Bennington, VT 05201
Phone: (802) 442-5491 FAX: (802) 442-3363

Director: Dawn Danner
County: Bennington

(UVS) UPPER VALLEY SERVICES, INC.

267 Waits River Road
Bradford, VT 05033
Phone: (802) 222-9235 FAX: (802) 222-5864

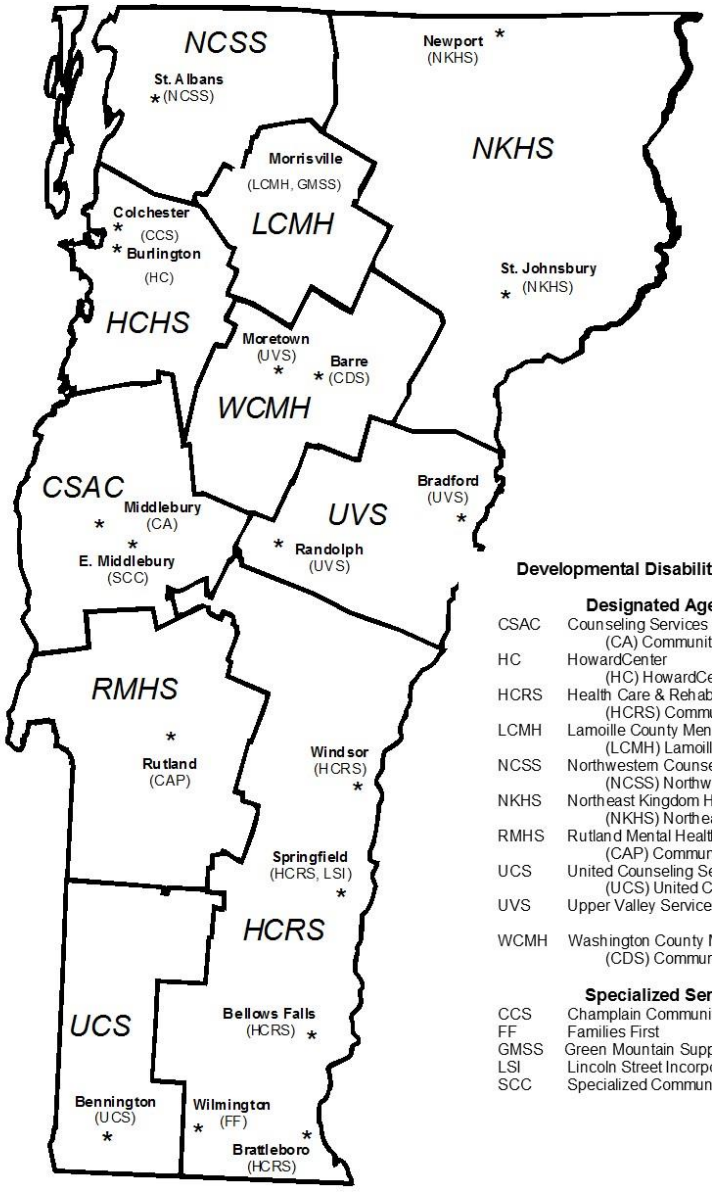
Executive Director: William Ashe
Counties: Orange and Washington

Regional Offices:
2281 VT Rte 66, Randolph, VT 05060
Phone: (802) 728-4476 FAX: (802) 728-6741

PO Box 719, Moretown, VT 05660
Phone: (802) 496-7830 FAX: (802) 496-7833

APPENDIX B: PROVIDER MAP

Vermont Developmental Services Providers



Developmental Disabilities Services Programs

Designated Agencies (DA)

CSAC	Counseling Services of Addison County (CA) Community Associates
HC	HowardCenter (HC) HowardCenter Developmental Services
HCRS	Health Care & Rehabilitation Services of Southeastern VT (HCRS) Community Services Division of HCRS
LCMH	Lamoille County Mental Health (LCMH) Lamoille County Mental Health
NCSS	Northwestern Counseling & Support Services, Inc. (NCSS) Northwestern Counseling & Support Services/DS
NKHS	Northeast Kingdom Human Services, Inc. (NKHS) Northeast Kingdom Human Services, Inc.
RMHS	Rutland Mental Health Services (CAP) Community Access Program of Rutland County
UCS	United Counseling Services, Inc. (UCS) United Counseling Services, Inc.
UVS	Upper Valley Services, Inc. (DS only)
WCMH	Washington County Mental Health Services, Inc. (CDS) Community Developmental Services

Specialized Service Agencies (SSA)

CCS	Champlain Community Services, Inc.
FF	Families First
GMSS	Green Mountain Support Services
LSI	Lincoln Street Incorporated
SCC	Specialized Community Care

(2015)

APPENDIX C
PSYCHOSEXUAL REFERRAL LETTER TEMPLATE

Dear:

I am following up our recent conversation about _____. Thank you for agreeing to conduct a Psychosexual Evaluation to help us develop a plan to best serve him.

As we discussed, the evaluation will (describe and confirm the when, where, and how details of the evaluation and consumer transportation arrangements).

Enclosed are the background records you requested. OR You should have received the background records you requested. If not, or if you need further records, please let me know.

As we also discussed, here are the referral questions we would like you to address in your report.

1. Diagnosis and Problem Formulation. What, if any, are his psychiatric diagnoses? What is a framework to help us understand his sexually abusive behavior?

2. Risk. What is his risk to sexually reoffend? Who are the types of individuals that he would most likely sexually abuse or assault if he were to reoffend? What are the conditions under which he would be most likely to sexually reoffend? As we discussed, we would like you to use the (list instruments, such as Static-99R and VASOR-2) in assessing his risk and provide us with your scoring sheets for these instruments.

3. Treatment Needs. What are his treatment needs? As we discussed, we would like you to use the SOTIPS for assessing his treatment needs and provide us with your scoring sheet for this instrument.

4. Responsivity Issues. What recommendations do you have for how to deliver services that are best matched to his learning style and personality characteristics?

5. Supervision Recommendations. What type of residence, level of supervision, and supervision conditions would you recommend?

6. Treatment. What type of treatment services, if any, would you recommend?

(NOTE. Be sure to include another other questions you would liked answered. If you do not ask specific referral questions, you are unlikely to be satisfied with the evaluation.)

We look forward to the results of your evaluation. Please feel free to contact me if you have any questions.

Sincerely,

APPENDIX D
RESOURCE CURRICULA

The following resource curricula are designed for or can be adapted for use with individuals with developmental disabilities. Service providers need ensure that use of a chosen curriculum is appropriate for the individual who is receiving services.

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APPENDIX E
NATIONAL RESOURCE ORGANIZATIONS

Administration on Intellectual and Developmental Disabilities (AIDD). Governmental agency that seeks to improve and increase services for individuals with developmental disabilities that promote independence and inclusion in society. www.acl.gov/programs/aidd/index.aspx

American Probation and Parole Association (APPA). International association composed of individuals from the United States and Canada actively involved with adult and juvenile probation, parole, and community corrections. www.appa-net.org

American Association on Intellectual and Developmental Disabilities (AAIDD). An interdisciplinary organization of professionals and citizens working to support individuals with disabilities by promoting policy, research, and practice. www.aaidd.org

The Arc. A national, community-based organization advocating for individuals with intellectual and developmental disabilities and their families through public policy and provision of supports and services. www.thearc.org

Association for the Treatment of Sexual Abusers (ATSA). International organization focused on the prevention of sexual assault through the effective management of sex offenders. www.atsa.com

Center for Sex Offender Management (CSOM). A collaborative project of several federal agencies to support state, local, and tribal jurisdictions in the effective management of sex offenders under community supervision. www.csom.org

Council of State Governments Justice Center. A national nonprofit organization that serves policymakers at the local, state, and federal levels by providing advice and evidence-based, consensus-driven strategies to increase public safety. www.csgjusticecenter.org

Corrections Directorate of Canada. Public Safety and Emergency Preparedness Canada. Conducts and publishes research in support of correctional policy development. www.publicsafety.gc.ca

National Association of Councils on Developmental Disabilities (NACDD). An organization that supports state and territorial councils in implementing the Developmental Disabilities Assistance and Bill of Rights Act and promoting the interests and rights of individuals with disabilities and their families. www.nacdd.org

National Adolescent Perpetration Network (NAPN). A cooperative network of multidisciplinary professionals working with sexually abusive youth in the U.S. and abroad. www.ucdenver.edu

National Institute of Corrections (NIC). A division of the United States Department of Justice that responds to the needs of correctional agencies by providing assistance, information, education, and training. www.nicic.org

New England Adolescent Research Institute (NERI). A program providing education and treatment services to at risk children and youth. www.neri.com

Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. (SMART). A United States Department of Justice program that provides jurisdictions with guidance regarding the implementation of the Adam Walsh Act and resources related to the management of sex offenders. www.smart.gov

Safer Society Foundation, Inc. (SSF). National non-profit research, advocacy, and referral center on the prevention and treatment of sexual abuse. Specializes in sexual abuse prevention and treatment publications. www.safersociety.org

Stop It Now! An international public health based organization with a vision of ending the sexual abuse of children through public education, public policy, and research programs. www.stopitnow.org

YAI/National Institute for People with Disabilities Network. Provides resources for persons with developmental disabilities including a video series on friendships, relationships and sexuality. www.yai.org

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