Follow-up to the Brown Bag Thursday webinar, 2/26 @ noon
Tools to Support Convicted Sex Offenders with Developmental Disabilities

The questions in the text below were presented to speakers during the Brown Bag Thursday webinar on February 26, 2015 entitled: Tools to Support Convicted Sex Offenders with Developmental Disabilities.

Since speakers Janet Keeler, PhD, Forensic Liaison and Behavioral Support Services Supervisor of Cuyahoga County Board of Developmental Disabilities, Colleen Mercuri-Johnson, MSW, LISW-S, Director of Problematic Sexual Behavior Team of Butler County Board of Developmental Disabilities and Vicki Jenkins, Associate General Counsel with Ohio Department of Developmental Disabilities were not able to take all questions during the allotted time, they compiled their comments after the webinar and agreed to make them available to post on DODD’s Work Space. The answers below represent the work of Keeler, Mercuri-Johnson and Jenkins as a team.

1. What to do when an individual (own guardian) is getting ready to come off registry and now feels he no longer needs counseling and reduce medication, but the rest of the team disagrees?

This is a very challenging question on many levels as risk tolerance varies from county board to county board based on the community environment, as well as other factors. If they have been in counseling for that any length of time, ask the treating clinician for an updated assessment that identifies further interventions before treatment ends. It would also be helpful to have the assessment look at informed consent to demonstrate that 1. The person is capable of making the decisions you mention above and 2. The person knows that should he/she engage in offending behaviors he/she is knowingly and in full understanding of the illegality of his actions, doing it. If the individual really is so impaired in their decision-making (due to MH/DD) that they cannot understand the ramifications/wrongness of their actions, then more supports may be warranted. On the other hand – and this is where the frequency of these questions are based – the individual can be quite independent and does not require a lot of supports. In that case I would also then consider bolstering as many of the following supports as possible:

- Identify alternatives to supervision that mitigates areas of risk.
- Maintain/review the safety/risk reduction/relapse prevention plans for higher risk contexts.
- Focus on skill development.
- Regular review of provider training and compliance.

Ideally, any medication changes should be led by the doctor involved. This could even mean the individual works with their doctor to slowly decrease medications vs. going “cold turkey”.

A benefit of titrating medication down is that it can give the individual an opportunity to assess their own response to medication with guidance from a medical professional. If the individual has a mental health diagnosis, have the team look at peer support? Peer Support is a process of giving and receiving support and education from individuals with shared life experiences. It is provided by persons in recovery from mental illness and/or addiction who use their “lived experience” as a tool to assist other persons along their personal paths to recovery. You may want to see if there is someone who is not part of the official “team” but who cares about and interested in the person succeeding. This other person may be able to have a talk with the individual about his/her future goals and what they want to accomplish and discuss the consequences of his choices.

Current research is showing that over serving an individual can actually be counterproductive. If you’d like more information on this Google “Risk, Needs, Responsivity and Sex Offending”. By having further understanding of this, it may assist in decision making. Ultimately, the individual has the choice as to whether or not they participate in counseling.
2. How do you handle a situation where you have the trust relationship with the individual, but are unable to get the family (not guardians) to feel comfortable and release some of the restrictions?

Great question. I’m assuming this person lives at home so the strain is that the family can put these in place with very little monitoring. We just had a great example of working through this (almost) exact same scenario. Have a conversation with the family about ‘long term goals for the individual’. Inevitably they state something akin to ‘better decisions, being more independent, be more trustworthy, minimize recidivism, etc’.

Get an accurate assessment that describes the lack of need for said restrictives. Have the person writing the assessment (and the team) frame the rest of the discussions based on the explicitly stated long-term goals. IE: “you’ve let us know that your long-term goal for ___is for him to make better decisions. That is our goal as well.” Try to make the case based on over-serving individuals with more treatment/services/restrictives than assessed as needed has, in almost all of the literature, proven to be counterproductive. It causes the exact behaviors this family is trying to prevent. Overwhelmingly, Individuals with DD – as with most teens/young adults – learn through experiencing the positive and negative consequences of their behavior. This is very hard for many families to do. It may be necessary to have facilitated discussion about how their visions can become a reality and what is necessary on both sides for it to become a reality. You can try and quote the new BS rule or least restrictive language but this usually does not have the impact – especially if the person is living at home.

Finally, it may be necessary to more closely explore the family’s concerns or fears. Families also are impacted when their family member commits an offense. The family may feel guilt, shame, or anger. We worked with a mother that was so shamed by her son’s offense; we felt it important to get a minister involved to support her because her shame was the obstacle. It may be necessary to have a facilitator/mediator (a third party whose is not interested in the outcome but whose sole purpose is to help people have a conversation) guide/lead the discussion.

3. When restrictions are in place for visitations how much information should be shared with the Human Rights Committee. Example: An individual who cannot visit family home due to victim still living there. How much information should the Human Rights Committee have?

I would respond in the way Colleen, Vicki and I did in the webinar. I think it makes sense that the HRC know the basics of the need for the restrictions but do not need to know the specifics of the event. If there is a restraining order or no-contact order in place, the justification for said restriction could be very easily made. If there is no order in place, the team would simply have to demonstrate that there is a health/safety/adverse risk for the individual or the victim should there be a visitation.
4. You may get to this later but how are supports developed when an individual with a history of offending continues to deny offense or offenses? Those persons that don’t respond to treatment?

We get this question quite frequently, actually. There are 2 schools of thought on ‘denial of offense history’. One, the more common I think, that admitting offense is the bedrock on which successful treatment builds. The other believes that admitting ‘isn’t’ the end all be all and just b/c the person does not admit it (shame, guilt, etc) means little for treatment prognosis.

The last part of the Sex Offender Protocol is a list of questions that teams can work through in these types of situations. If the individual really is so impaired in their decision-making (due to MH/DD) that they cannot understand the ramifications/wrongness of their actions, then more supports may be warranted. On the other hand – and this is where the frequency of the questions are based – the person is quite independent and does not require a lot of supports. In these cases, get a good assessment that looks at informed consent to demonstrate that the person knows that should he/she engage in offending behaviors he/she is knowingly and in full understanding of the illegality of his actions, doing it. I would also then consider bolstering as many of the following supports as possible.

Use community control via reporting requirements, probation/parole, local police, courts understanding of developmental disability supports, etc.
Mandate compliance with the notice and reporting requirements for individuals convicted of sex offense in the Ohio Revised Code.
Disclose risk to neighbors, coworkers, etc. as warranted i.e. high risk environments lend to more detailed disclosure vs. low risk environments. Risk environments are identified through a sex offender specific assessment.
Identify alternatives to supervision that mitigates areas of risk.
Maintain/review the safety/risk reduction/relapse prevention plans for higher risk contexts.
Focus on skill development.
Regular review of provider training and compliance.

Reviewed 3.12.15 MMW