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THE ARC
WEBINAR: SEX OFFENDERS WITH INTELLECTUAL AND DEVELOPMENTAL
DISABILITIES
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>> Marc Goldman, we've got to get your audio up and running here. And then Elise as well. So both you we've got to get audio working, so if you can use the -- either audio connection call in number or please use the communicate tab, audio complex, Elise, I see we've got your audio running, so could you unmute yourself, click the red microphone and we'll test it.

Okay. Perfect. And did you have a camera? I can't remember.

>> Yes.

>> Okay. So let's get the camera working as well. I will change your role to presenter. Which should allow you to turn on your camera for now so remember there's a little gear in the top right-hand corner. There you go. Perfect. Okay. So I'm going to have you mute and turn off your camera until it's your turn to present.

>> Okay.

>> Thank you.

>> Thank you.

>> Attendees, your audio is disabled. The actual presentation will start here shortly at 1:30.

Hi, everyone, we'll get started in about two minutes, so there's no audio to hear. We'll get started in two minutes with the content.

All right. Everyone, we're going to go ahead and get started.

Welcome to the Arc national center on criminal justice and disability webinar. My name is Kathryn Walker, and before we begin

our presentation, I'd like to be coring a few basics, especially for those of you who are new to web ex. Participants, you are in listen only mode. If you need help during the presentation, you can post questions in the chat box on the side of your screen, and we'll be happy to help you.

At the end of the session, there will be a time for questions. You can either post questions in the Q and A section or in the chat box.

If you don't want your name shared with your question, type private before your question. You can also email questions to NCCJD info at the Arc.org. If we don't get to your question during the presentation, we'll follow up with you're afterwards.

This webinar is being recorded and will be posted on our website and we'll send you an email letting you know when it's available. You will get one final request. You will receive a session evaluation after the webinar. Please take five minutes to complete it and send it to us. This webinar is stunned funded by the United States Department of Justice bureau of justice assistance. Thanks for your participation. Please welcome program manager of the Arc's justice initiative, Leigh Ann Davis for some opening remarks.

>> LEIGH ANN DAVIS: All right, thank you, Kathryn.

I would like to welcome everyone to the webinar today. We are so excited to bring you this very important information. At the center we've been working since 2014 to really look at the harder issues where there hasn't been information available on topics affecting people with intellectual and developmental disabilities, and this in particular we've been following for a number of years. We actually did a fact sheet on this topic back in 2009, and had it revised by experts so we know this is an issue that we need more research on. We need many more programs looking at how do we support individuals who get involved in the system around sex offenses, and so we are so thrilled to bring this to you today. We recognize that it's a need to fill because looking at the number of people who signed up for this webinar shows that we haven't really addressed this to the extent we need to. So I want to thank all of our amazing panelists today. I want to thank those who have family members who have come to us looking for help. And those who are out in the field every day trying to provide supports and services and answers to some of these really difficult questions.

So with that, I just want to ask you to take all of it in as you can, and please follow up with us with any questions. We hope to get everything -- all of our speakers in today and make sure that we get any questions that you have answered.

So thank you so much for joining us.

>> KATHRYN WALKER: All right. Very quickly, before we get started, there are just a couple of basic things that I want to cover, maybe for people that are new to disabilities. So disability basics. Understand that the challenges people with disabilities face are unique. And that knowing one person with a

disability means you know one person with a disability. And that we treat this as a human rights issue just like race, gender and religion.

And very quickly, just to give you some background about the Arc, we work primarily with people with intellectual and developmental disabilities, and this is kind of a flow chart that talks about the different kinds of disabilities, so the first one is physical and brain based. So physical disabilities often can be a little easier to identify, so for instance paralysis and orthopedic impairment, blind or low vision, deaf or hard of hearing, or someone that might be harder to identify just by looking at someone, heart disease.

And then on the other side, you have brain based disabilities so that can be like mental illness or intellectual or developmental disabilities where the Arc specializes and where today's programming focuses, so today a lot of our presenters are going to talk about intellectual disability which is low IQ and poor adaptive functioning and there will be some mention of autism spectrum disorder and fetal alcohol disorder as well so I want to give you a reference about some of the disabilities we're talking about today.

A couple of points like you to remember. These are hard issues to discuss and are rarely as clear-cut as we would like. People with disabilities should take responsibilities for their actions, and likewise, society should acknowledge true risk. And finally, you don't have to reinvent the wheel around these issues. There are seasoned professionals you are going to hear from today that are doing some really great work.

So with that said, I'm going to introduce our first panelist, Blake and Brian. Blake is a senior at marshal university where he is majoring in psychology with an emphasis in history and journalism. He is also a student in the (inaudible) at marshal university. He is a graduate of (inaudible) high school and in his junior year in high school he was selected as the Glenn Allen gait for the -- delegate (inaudible) Virginia state convention discussing post secondary education and panel member on the autism center. Brian is proud to be Blake's dad. He is a small business owner and also a retired U.S. navy commander. He is a Penn State graduate with an M.B.A. from Troy state university, executive education from Harvard Business School and did his doctoral work at the (inaudible) southeastern university. Brian and his wife have been strong advocates for Blake in his disability since he was born. Brian has been involved with numerous organizations in support of people with disabilities. He just recently presented testimony to the Senate subcommittee on the Constitution's civil rights and human rights for people with disabilities. He is married to Daphne and is the father of three boys, Jordan, Blake and Taylor. So with that I will hand things over to them. You guys have the floor. Make sure you have your camera on and you can

move the slides as well.

Sorry. We're not hearing you guys.

All right. So I think they're having a little trouble on their end so we'll jump ahead to Carol and go back to them as soon as they get their audio figured out.

So with that I'll adjust our slides here. And introduce you to Carol. Adam is 28 years old with moderate mental retardation, now referred to as developmental delay. His life has been special education, special racial activities (inaudible) his parents are his caretakers. He does not date, will never marry or have children and he is a young man with a child's mind. Carol is Adam's mother. They are a middle class Christian family. They've lived in their community for 32 years. They also have a married daughter. Adam's parents have been advocating for him since his diagnosis at age 2. Carol spent all of his school years volunteering in every school he attended. She worked with organizations with people with disabilities. Carol and Robert have worked hard to make sure Adam can become a contributing member to society. So Carol, do you want to go ahead and unmute yourself and talk to us a little bit about Adam?

>> CAROL NESTEIKIS: My name is Carol, and my special needs son is a registered sex offender. It sounds inconceivable but it does happen. We'll give you a short synopsis of our story. Adam with intellectual disabilities was being sexually molested by a close family friend who was also molesting a minor niece. (Inaudible) showed him what he was doing and they often joked about it and Adam unknowing of any of the consequences involved in this, also on a couple of occasions, let this girl touch him. So he was told not to tell another person and he didn't, but when the young girl told an adult, police were notified, and Adam was arrested right along with his molester, and he was charged with numerous felonies and one of them held a six year jail sentence. So he spent the night in jail. He was also taken in handcuffs to the county jail in the morning for a bond hearing. He (inaudible) a year in court. Our lawyers submitted medical reports, teachers and psychologists reports. We had numerous letters from family, friends, from all of the neighbors, supporting Adam. And we also had a (inaudible) assessment done on Adam. It showed he had no sexual perversions and what he was was easily manipulated or taken advantage of and he was not able to get out of uncomfortable relationships. So this all was submitted to the court, and the lawyers did not want to go to trial because as they said, he could be easily manipulated into saying anything by the prosecutor. He has memory problems and cannot articulate and we did not want to take the chance of him going to jail because he would surely become a victim again and again.

So we did accept a plea, for one misdemeanor count of sexual exploitation of a minor child, and that held a sentence of two years probation with an ankle bracelet and ten years on the

registry.

So we began, and I say we, because the probation was my husband's, myself, and Adam, we began the probation. Adam didn't have to leave our home and he didn't live independently so my husband had to go out with him. So I did lose my husband and my son (inaudible) and we spent well over a hundred thousand dollars a year in all lawyers fees, court fees, purchasing another residence and so on and it did cost us a life in finances, and to our health. Adam was no longer able to attend any of his special education activities, and he still cannot to this day because he's a registered sex offender. He had a curfew which we all followed because Adam did everything with us. We couldn't travel. Adam was regressing because he was staying home all the time. And we had just finished probation, but we still have very much restricted. We cannot travel freely, and we cannot move, we cannot retire, and I just -- for Adam, it's just a matter of his regression. He doesn't really know what's going on. So I'm here today to talk about this sector of the population which is punished unfairly by our justice laws, and I think we need to make some changes to protect these vulnerable children of ours. And I hope that everyone watching today can join in and we can make some changes. Thank you so much.

>> KATHRYN WALKER: Thanks, Carol. We're going to head back to Brian and Blake and see if we can hear you guys and if you can get your video started.

Let's see. Can we hear you guys? We're still having trouble. Can you make sure the microphone next to your name is white? It's red right now. We're not hearing you. Let's real fast -- we can use that communicate tab at the top, audio connection. And then you're going to call in with the phone and if you can use that phone number.

Okay. I'm hearing somebody. Oh, no. That was Carol. Sorry.

All right. You guys call in with that communicate tab? Thank you, everyone, watching for your patience. Blake and Brian really have an important message to share, so I'm hoping we can get their audio working here shortly.

All right. Here's what we're going to do. I'm going to go ahead and skip along to Jessica Oppenheim, and we'll see if we can figure this out. I went one too far. Here we go. So I'm going to introduce Jessica Oppenheim, is the director of the criminal justice advocacy program of the Arc of New Jersey, a statewide program which provides advocacy for people with developmental disabilities, who become involved in the criminal justice system. Prior to joining Arc of New Jersey in 2010, she was an assistant prosecutor in the Middlesex county's prosecutors office and a deputy attorney general in the department of law of public safety from 1985 until 2010. In that capacity, she was bureau chief of the prosecutor's supervision and coordination bureau, the unit which oversaw the 21 county prosecutor's offices and 600 law

enforcement agencies on behalf of the attorney general. She also drafted and implemented the attorney general's Megan's law guidelines, prosecutes domestic violence cases and provided training and policies and protocols for law enforcement agencies and prosecutors throughout the state on domestic violence, sexual assault, internal affairs, Megan's law and dealing with diverse populations. She has taught as a professor for the paralegal program and Farley Dickinson university. She is a board member for the New Jersey association for the treatment of sexual abusers. So with that, I would like to welcome Jessica Oppenheim.

>> JESSICA OPPENHEIM: Great. Can you hear me?

>> KATHRYN WALKER: Yes.

>> JESSICA OPPENHEIM: Excellent. Okay. And I know you've turned over control of the Power Point to me, which is always a dangerous thing to do.

>> KATHRYN WALKER: Yes, and if you can make sure the camera next to your name is turned green too. We can't see you right now.

>> JESSICA OPPENHEIM: Oh, you can't? I thought I turned it on. Hang on.

It's green here. It should be green there.

>> KATHRYN WALKER: Don't worry too much about it. Let's just go ahead and get started.

>> JESSICA OPPENHEIM: Yeah, if you can hear me, that's the important part, right?

>> KATHRYN WALKER: Yes.

>> JESSICA OPPENHEIM: I'm going to get started. Then I have a very quick opportunity, about ten minutes here, to give everyone an overview of sex offender notification and community registration laws, and it's hard after that story to move into the dry law. When I refer to sex offender registration and community notification, that's what normally out in the community think of as Megan's law, named after a girl who was raped and murdered in New Jersey in July of 1994, and that was really kind of the genesis of the wave of these registration and community notification laws. One of the first things I do want to talk about, though, is a general topic for everyone, and that's that when we're talking about people with intellectual and developmental disabilities, having a diagnosis like that is not in and of itself a bar to criminal charges. As Carol who just spoke a few if moments ago can attest to, that applies to both juveniles and adults. Regardless of how you identify those in your state. So families do need to be aware that even with a diagnosis like that, this matter can go forward all the way through to a prosecution and a conviction. And as we know as well, in every single state now, a conviction for a sex offense, and we'll talk a little bit about what that means, can carry with it these obligations: To register as a sex offender and to be subject to some level of community notification.

Next. There we with are. Okay. So what do I mean when I say registration? It refers to anybody who has committed what we think

of as a sex offense, which is the kinds of offenses you imagine. Sexual assault, sexual contact, endangering the welfare of a child and what are the results of that. Those are individuals who have been convicted, which means it's an adult's conviction, or adjudicated. Here in New Jersey when I use that term, I mean someone who has been adjudicated at a child. In New Jersey we register sex offenders when they're juveniles. Every state does not do that so you need to be aware of and cognizant of the laws in your particular state.

By registration it literally means filling out a form that looks like a finger print form that goes to your local law enforcement agency. In every state that has to be done on a regular basis, usually annually, sometimes quarterly. It really depends on your state law. And what's the result of that? Once you've registered as a sex offender then you're going to be required to be committed to some sort of community notification. These days in particular, that can be a pretty broad concept. The one that people tend to think of most commonly is that you can find that information on an Internet website. That's the case here in New Jersey. Every state has some version of a sex offender website. As I tell people here in my state, that's not the entire registry. We're currently registering about 15,000 offenders in New Jersey, and only 5 to 6,000 of them have been accessed on the web. But there are other things attendant with that. Not only do we have that Internet website. There's literally a door to door, a lot of leather and paper goes into the notification process. They're going to go door to door in some circumstances. They're going to send out letters to schools and community organizations in some circumstances. And they'll always be notifying local law enforcement agencies.

Now, there are really two purposes behind this statute. To all of these statutes, regardless of what state you're in. The first really addresses this right to know concept. That was the genesis of this process originally, that there's a right to know who's living next door to you. The other piece that's important to law enforcement and that's behind a lot of this is the desire and the impetus to supervise individuals who have committed sex offenses, right? They're at risk to commit a new offense, we want to know where they are and what they're doing. We can discuss at another webinar the effects of these statutes, that's a conversation for a different day, but we do know that was the underpinnings and objectives of these statutes.

So what does that mean? Well, you've got a very small taste of what that can mean for individual families when you heard from Carol earlier. It creates a variety of obstacles. There's no question about that. And one of them relates to housing. In our state, I think it's fair for us to say that we have something of a housing crisis. It particularly is applicable to individuals who have any kind of a conviction, even more so for individuals with sex offense convictions and that add to it that we have individuals

with intellectual and developmental disabilities who are not capable of living on their own out in the community without some level of support services. Having this kind of an offense attached to them really can impact on their ability to access those services. For example, public housing. Always a need for people that don't have enough money to support themselves individually in the community without access to public housing and the voucher system, Section 8 housing things like that is virtually unavailable for this population. For the most part housing authorities will tell you anyone with a sex offense is barred from living in their housing authority housing, so those are off limits.

Often too, and I think Carol touched on this a little bit, if you have offenders who are on some level of parole or community supervision for life, that does impact on where they can live. It will impact on their ability to live in a household for example with minor children and if your family has anyone who falls into that category, that's going to bar them from living in their own home in some circumstances.

There are in fact some states that have statutes that bar offenders from living within a proximity of the schools. We don't have anything like that here in New Jersey. Megan's law itself doesn't limit where you can live. Some states do however.

Another concern is that in supported housing situations, where there are service providers, service providers are not always in a position to care for this population. There's really no benefit if I'm a service provider, a private or a nonprofit company out in the community for me to take on added risk. So it really limits the availability of those support systems and those support services that people with developmental disabilities need to be successful in the community.

So those are the housing issues. What else do we have to worry about? Well, the job market. Individuals with intellectual and developmental disabilities may be able to work, hopefully they're receiving some level of Social Security or some other access to money that helps support them in the community. But nonetheless, if they're looking for job options, they can be particularly limited. It's difficult enough for an individual with an intellectual or developmental disability to obtain a job. Add to that that sex offender registration. I think everybody here is probably aware of the fact that well over 90 percent of companies perform some level of a background check these days.

Sometimes they use private companies that scrape data from all over the place. The data isn't necessarily accurate, but nonetheless, that can form the basis for a refusal to hire someone so it can become very difficult to get even the most basic position that can support you in the community. Think about how these job and housing limitations affect the ability for someone to be successful in the community. We've been talking for 20 and 30 years of the difficulty of this population, people with

intellectual and developmental disabilities generally to support themselves in the community. Now we add these ongoing essentially permanent sex offender consequences and it limits the situation even further.

The last point I'll make with regard to job opportunities is many people are on parole supervision for life. Not all sex offenders, many. It's a subset of the group. If you're under that parole supervision, it is exactly what it sounds like, supervision for life. And a parole officer has the ability and in fact the authority to make decisions about where someone can work and live. Those all have to be approved by a parole officer. Again I think Carol touched on that a little bit when she talked about the inability to leave the state or come back to the state. All of that falls under the auspices of parole and can really make a difference in your ability to get a good job.

And the last consequence that I think we tend to not talk about, but it's particularly important, is that increased anxiety. When you talk about probation or parole supervision, there is inevitably a long list of conditions that have to be met. It can be very difficult for anyone who has an issue with executive functioning or organizing their time or even understanding and reading the conditions that are provided to them to maintain that compliance independently. If they don't have a good family support the way some of the young people, some of the advocates would be speaking on this webinar, the way they do, there are many other people who are out in the community independently and on their own. It can be very difficult to comply with those conditions and obligations. Under those circumstances, not only does it increase that anxiety, make it difficult to comply, but in fact a failure to comply can result in new charges and can result in a new prison sentence. So it literally can become a revolving door for some of these individuals as they come in and out of the system, putting them further back each time that they spend another six months, nine months, or a year back in the county jail or a longer term in state prison.

So that's just a very quick overview of some of the concerns that affect this population. I'm just going to note a quick commercial. I hope that everyone will have an opportunity to read the excellent white paper that the Arc of the United States is putting out. If you want more information just with regard to sex offending in general, the Department of Justice smart office, can be of assistance to you, and also the (inaudible) website. So those are some places if you want more information with regard to sex offender registration and notification across the country.

Thanks Kathryn.

>> KATHRYN WALKER: All right. Thank you, Jessica. We're going to go back now and we're going to try one more time to get Brian and Blake here. Let's test that audio, guys.

>> Can you hear us?

>> KATHRYN WALKER: So I'm only hearing you through my work phone, so you're going to have to be patient with us. What I'm going to do is society them up where they're on the speakerphone in my office and I'll put it near the microphone and hopefully you guys can hear. Be sure to speak loudly. I'll mute myself so you don't hear things twice and if you guys can mute your computer speakers.

>> BRIAN KELMAR: Okay. Can you hear me now?

>> KATHRYN WALKER: Yes.

>> BRIAN KELMAR: Okay. I apologize (inaudible) but I can operate a phone obviously.

The previous presentation I think is very good. Because it hits at a lot of issues that Blake and our family have suffered with. I want to give you a quick background on my son, Blake. He has autism. He has learning disabilities and some auditory processing disorder and he's also borderline ID and he's now a registered violent sex offender for the rest of his life. (Inaudible) about register as a sex offender every 90 days. He's always struggled to make friends and he's always been taken advantage of his entire life. Several months after he met this young lady at my younger son's birthday party (inaudible) started contacting (inaudible) through texting. (Inaudible) never had the experience and he's never been in any situation with either a friend or a girlfriend. (Inaudible) and after several months, Blake started receiving even more increasing sexual texting from here (inaudible) younger than him. (Inaudible) friend with benefits, role playing hookup. All of these it's been evaluated, he didn't even understand what she was talking about. And eventually he met with her and she performed oral sex. Blake with his disabilities in his brain basically shuts down and freezes because (inaudible) and when he realized what was happening he told her to stop. He took her home. After he took her home, in the middle of the night, the police came to our door, and my wife and I were sleeping, and Blake answered the door. Blake thinking that she was in trouble because she was the sexually aggressive one, he told them exactly what happened, and when he didn't realize he was incriminating himself and they took him off to jail.

We had to do (inaudible) in there, and if you know most of the cases in the country, like 94 percent are actually done through plea bargaining and what we didn't know at the time was our lawyer was suffering from mental illness at the time also. He later committed suicide shortly after defending Blake. So he didn't understand the plea charges and then he was charged with two counts of consensual sex with a minor. One of the counts was actually physically impossible for him to do, but he pleaded to it. And now he's a registered sex offender for the rest of his life, and that's just the background. I'd like to turn this over to Blake so he can explain from his point of view how -- what it's done to him.

>> BLAKE KELMAR: Hello, everybody.

I want people to realize that if you hear my story, you can understand that the people who do not understand my story (inaudible) I'm sitting (inaudible) I had a buddy come up to me. And (inaudible) he shows me his phone. (Inaudible) registered sex offender. That hurts more than anything else. It hurts me when people think I'm a creepy bad person, which I'm not. I get bullied, I get harassed on a daily basis at school. I could be out with friends, having a good time, and I still get harassed. I'm treated like an outcast. I have a hard time trusting anybody except for my family (inaudible) every time I go back there, I have flashbacks. And every time (inaudible) handcuffs behind the cop car. It doesn't matter if I'm with my dad or my mother or my brothers, I do not like being in that area. (Inaudible) live and work (inaudible) for me to find a job, it's hard, even with autism spectrum disorder.

Let's see here. I can't even see my grandmother's house because she lives in Florida and every state has different laws. Here in Virginia, I only have seven days to do anything, but even then, it's hard for me to travel to see anybody, my own friends, family, and loved ones.

When it comes to my career, I have a degree in psychology, history and general health. I've always been helpful to friends with their traumatic (inaudible) but even for me to have a career in psychology to help others, such as my friends, it's hard for me to do with this.

Sometimes I don't know why, but I've lost hope. My hopes and dreams (inaudible). It's hard for me every single day dealing with this.

Thank you for hearing my story.

>> BRIAN KELMAR: Hopefully you were all able to hear that.

I want to give a quick perspective from our family. It's been a devastating issue for our family. My family has been harassed, my wife, (inaudible) son on the list. My younger son has also been harassed. It's very depressing. It's very stressful on our family. We're worried about Blake, what will happen to him after we're all gone. He's limited in the types of services that he can get because he's on this list, housing will be difficult. If we even move, it would be difficult to find a place that we all can live. As Jessica pointed out, employment is just about impossible (inaudible) restricted (inaudible) any jobs from a psychological career. We worry about him every day. Even if he's pulled over for a broken taillight, he could still go to jail. We had an incident once where the paperwork was wrong and Blake had accidentally checked the box to send all the information to our home so it wouldn't be lost and go to college. When that was turned into the Virginia state police, the Virginia state police said why isn't he in Virginia? It was because of a clerical error. I had to run up to marshal, which is six hours a way, bring him back, get him reregistered in Virginia, six hours, then take him

back to West Virginia, and get him reregistered in West Virginia, all within two days. Luckily the police were very understanding and he was home anyway because he was (inaudible) finals at the end of the week. But that is just one incident and there's many more. Blake has to register and unregister he goes back and forth between college. That's 12 times a year and then when he's here, the police come to our house every night and day to just look around, because the job, the police have to show up and tell the (inaudible) he's on the list. We worked or hard (inaudible) much help and support in overcoming his disabilities in education so he has a chance like everyone else to fulfill his dreams but with this scarlet letter on him, the family and future generations will bear the brunt of this for the rest of his lives, not because of his disability but because of a one time situation he didn't understand and he got in trouble, he'll never get a second chance (inaudible) and I hope you all understand and will be part of helping us make a change.

Thank you.

>> KATHRYN WALKER: All right, thank you guys very much for being on the webinar today. It's really important to have that perspective. So now we're going to move forward to Dr. Shively, and let me get that slide pulled up because we're a little out of order. There we are. Okay.

Randy is a licensed psychologist in the state of Ohio who has dedicated over 25 years to treating clients with mental health, intellectual disability, sexual risk and offending issues. He is the director of clinical development at (inaudible) house, a community corrections agency in Columbus, Ohio. He has a doctorate in psychology from the Ohio State University, and is an independent chemical dependency counselor in the state of Ohio. He has presented at many state, national and international conferences on topics related to cognitive behavior (inaudible) intellectual disability and clinical issues of offenders. Randy has always been interested in helping direct care staff more effectively work with offenders aid in their recovery and encouraging them to be more responsible. Randy has published articles on clinical approaches on working with offenders. Randy is committed to the challenge of helping difficult offenders who need integrated treatment approaches and a team approach to overcome lifestyle challenges. So with that, I am going to pass the presenter privileges to you, Dr. Shively, and let you get started with us here.

All right. There you are. I'm going to unmute you. There we go.

>> RANDY SHIVELY: Okay. Great. Great.

Welcome. I have quite a few things to share in a short period of time. I do a lot of risk assessments across the state of Ohio in many counties, and assess for risk. A lot of times it's sexual, but it also can be risks for aggression, fire setting, property destruction and other criminal behaviors.

Unfortunately, there's no constant standard that I know of for what goes into a risk assessment, and what training an evaluator must have to do risk assessment. But I can tell you from experience. My background in developmental disabilities. I think it's important for any evaluator to understand disability and have some training in it. And I think it's also important for an evaluator to understand offender issues. And I've worked in the field of corrections, so I understand what a lot of those risk need issues are. There's a wealth of information and literature on -- in the criminal justice system to what consists of (inaudible) responsibility for offenders so I think it's important for somebody to have information about that literature before doing these types of assessments, because as I'll talk about in my presentation several times, unfortunately like we've already heard, there are some folks who are branded that don't need to be branded, if the evaluator had better understood their situation and their disability.

So I want to get started here, and I'll move the slides for you.

In this field, there seems to be proportionally more sex offenders with some developmental disability in this population in comparison to the non-DD offender population. And why is that? I think there's quite a few reasons for that problem. But some of them are this population lacks social skills especially needed to navigate sexuality. They're easily confused about sexual situations. They often let anger and sexual feelings get mixed up and don't have the cognitive abilities always to separate the two. They often have fewer dating opportunities than the average person. There's a belief often within intellectual disability that those with cognitive delays are asexual. They don't have sexual feelings, which we know is not true. But often people that are not well versed believe that. I think in our field there's often less tolerance for sexual deviance, especially in the community. So often I think eager prosecutors may charge people with crimes without having the full story. And there's a lot of poor social skills in poor decision making that goes into the process of dating and basic sexuality.

So what's the million dollar question? Well, is the developmentally disabled person (inaudible) lack of sexuality and his environment or both? I think in my experience, both can often be true. And often there's a misunderstanding about assessment. And we'll talk about that.

I feel that paraphilias are often grossly overestimated with in population, and to label somebody with a paraphilia, such as pedophilia, that's a desire for children, there has to be by definition measures of arousal and fantasy going on with the person to play into their problem and we also know that arousals and fantasies are really hard to measure, especially in our population.

So I want to talk about risk assessment in this population. We know that risk can never be accurately predicted, but it can be

effectively managed. We know there's external factors to risk for the intellectually disabled and there's internal factors. Some of the external factors are need for staff supervision, the quality of the staff that are actually supervising our clients, triggers that play into the environment for the individual, and their structure of schedule, because we know those with disability often need more structure than the average person. Often these external factors are not looked at closely enough by professionals, which these external risk issues are just as important as internal ones.

Now, when we talk about internal risk issues, we're talking about things such as the physical condition of the client, because often medical issues can affect risk, the stability of those on mental health medication. Their daily mood because often mood can play into risk. Thinking errors. There's a whole literature on thinking errors and cognitive behavioral approaches and we know that thinking errors can play into risk and then the current environment that they're found in.

Some of these internal factors are harder to measure, and harder to establish because of our type of population. But it's important to look at some of these internal factors when you're doing a risk assessment. Often true mistakes can be made with this population, when inappropriate sexual behavior is automatically assumed to be present and to be deviant. And obviously if we don't look at these factors or assess them accurately, we may be putting on a label on someone as we've already heard that can affect their whole lifetime.

What are some of the promising instruments? Phoenix and Sreenivasan in 2009, came out and looked at a lot of the literature and came out with some specific DD risk factors and they're social skills deficits, those that commit violent offenses, being unemployed, having a strong psychiatric history, having substance use disorder, being easily susceptible to the influence of others, having a history of delinquency, having poor response to treatment, having an antisocial attitude, having low self-esteem, having impulsivity in regards to sexual acting out, and having a lot of high static risk factors. These all can play into our population's risk and need to be looked at.

There are some promising instruments out there that I've used in my risk assessments. I wanted to mention a few of them. The first is the sociosexual -- let me go back a slide here. Hold on.

I guess I'm on the slide. I'm fine.

Is the sociosexual knowledge and attitudes assessment tool revised or the SKATR authored by Griffiths and Lunsky. Its a really good instrument for our population. It identifies with concrete pictures, their understandings and preferences in the areas of anatomy, men's and women's bodies, intimacy, pregnancy, birth control, and healthy boundaries. And it really shows you their understanding or lack of understanding in those areas.

Another promising instrument, the ARMIDILOS, it understands the

assessment of risk and manageability of individuals with developmental and intellectual limitations who sexually offend. I like this instrument because it correlates well with current instruments in the general criminal world and it talks about those stable and dynamic factors. Some of the stable factors are supervision compliance, treatment compliance, sexual deviance, sexual preoccupations, emotional coping, relationships, and some of the acute factors are look (inaudible) changes in sexual preoccupation, and victim related issues, emotional coping, use of coping strategies, changes in monitoring, changes in social relationships, situational changes, and changes in victim access.

I'm going to run out of time, but I'm going to go quickly through a model that I put together that I think you need to have if you're going to do a very thorough evaluation of this population. We need to assess intellectual delays that may be related to risk. We need to look at mental health problems that are related to risk. And we need to look at offending behaviors or history that are related to risk.

There are some questions I'm not going to go through all of them that I often ask when I look at intelligence level in this population. But the bottom key questions we want to know, is do these cognitive delays help explain some of the bad decisions related to sexual offending behaviors.

Second, we want to look at what concrete learning strategies might help manage the risk of this person.

Next we look at mental health. And there's quite a few mental health questions, I'm not going to read them all. But I try to get those answered when I do a risk assessment, because often the mental health systems can impact how the developmentally delayed person processes the situation. So the key questions we want to be looking at, how does the client's current mental health symptoms impact their risk, what can be done to stabilize the client's negative symptoms and were there any delusions or hallucinations associated with the offending behaviors.

And then the third area which often evaluators don't have enough training in is offender risk in general. So there's many questions here. I'm going to go through a few of them with you really quickly. Is the client motivated to stay out of trouble or do they have an antisocial attitude. That can be looked at because we know antisocial attitudes and behaviors are a huge risk factor.

Are they fully aware of the consequences of their behaviors. What types of thinking errors do they use when they discuss their offending? Because often in treatment, that's a very important question.

Is there a history of violence? Because violence can add a lot of risk for a person. Family role models. Do we have some good family role models to draw from and what is the history of the family related to risk? And we look at current behavior support plans and how they're addressing risk, or not addressing it.

In closing, I want to talk about staff issues real quickly. We need to look at external factors for risk. It's so important. But staffing is a very important question for those DD individuals that are in supported living settings or in a (inaudible) setting so we need to be careful that the staff are well versed in the risk issues. (Inaudible) we may be setting up the client to fail. It's important not to argue with those that have sex offending issues. And it's important for dignity purposes to separate the sexual behavior from the person. We only look and attack behaviors, never the person.

We got to realize that many of our clients don't know who they are. They struggle with identity. Because of their offending issues. And we have to help them establish identity. And then community with other staff is vital for the success of the program. 'Cause often those that have serious sexual issues try to split staff up and staff need to communicate effectively. It's important for staff to be consistent, professional, firm and fair, and to be a good resource.

I talked about a lot of issues in my presentation, and I welcome questions later, but in closing, I love this quote. It really shows the importance of staff in this equation of risk.

I've come to the frightening conclusion that I am the decisive element in the consumer's life. It's my personal approach that creates the climate. It's my daily mood that makes the weather. I possess a tremendous power to make a consumer's life miserable or joyous. I can be a tool of torture or an instrument of inspiration. I can humiliate or humor, hurt or heal. In all situations, it is my response that decides whether a crisis will be escalated or deescalated, and a consumer humanized or dehumanized.

This quote really summarizes the need to have staff that are compassionate and really know the risk of the client.

And with that, I'll end my presentation. Thank you.

>> KATHRYN WALKER: Thank you, Dr. Shively. I really like that quote. It's a good take away, and if anyone has questions, this is Dr. Shively's email address. You can also post to the chat box or the Q and A section, and we will follow up after the webinar with anybody whose questions we don't get to.

So moving right along, our next speaker is Dr. Magnuson, and she earned an MSW from NYU and a doctorate in psychology from university of the Rockies. She has been working with and evaluating sex offenders for the last 19 years in a variety of contexts. In the last ten years she's been working extensively with people with developmental disabilities. She has presented nationally and locally on issues related to developmental disabilities and mental health issues. She currently lives in Maine, where she works at John F. Murphy homes and has a private practice. So with that, I would like to pass the presenter privileges to Dr. Magnuson, and we will get started.

All right. We need you to click the microphone next to your

name and make sure that it is not red (inaudible) we can't hear you right now. There we go.

>> ELISE MAGNUSON: Good afternoon, and thank you for this chance to talk about psycho sexual evaluations and assessment. I think this is a really important topic because a lot of times people will call and say I want a psycho sexual, but they won't know what they're asking for and they won't know the pitfalls. They won't know the benefits they can get from one, so I think having a well informed team about what can -- what a psycho sexual can tell you about a person, what it can't tell you, and to be aware that these have legs and travel, and so you need to be really careful with them.

So first of all, I want to talk about what a psycho sexual is. It's an evaluation of a person who is charged with a sex offense or has committed one. It can provide a lot of information to legal decision makers like a judge or jury or a probation officer, as well as the team supporting the person in question. It can be pivotal and really important in helping develop a risk management plan, which is sort of what do you do with this person who's done this crime, and now we need to figure out how to help them.

There are a couple of things that are really important to think about when considering psycho sexual. And part of that is what they won't do. They won't tell you if somebody has committed a sex offense. I've gotten referrals to do a psycho sexual, and they say, well, we need you to talk to them and find out if they've done it. That is an inappropriate use of psycho sexual. That is an effective role. You can't expect your psycho sexual to figure out whether or not it happened.

It can also not tell you if they're going to do it again. They can't tell you if somebody is going to commit a sex offense for the first time because in large part nobody can tell the future. Nobody can tell what is going to happen or what is not going to happen. Even if I could tell you that if left alone, this person would absolutely commit another sex offense, what I can't tell you is if they're ever going to be left alone or if they'll have good staff who is always right with them. Even if I was, you know, we've heard lots of stories this afternoon about people who did not set out to commit a sex offense, sort of found themselves in that way over their heads, never intending it. And my guess is that nobody could have predicted that either. So it's really important to understand the limits around what people can predict and what they can't.

So when you're assessing risk, and you're asking your evaluator what's their risk level, there are a couple of -- the main way you do it, since you can't predict the future, since our crystal balls don't work, is to compare one individual, the person in question, to a group of other people who we know whether or not they're likely to offend or not or how likely they are. There is an actuarial method which works much like your car insurance does,

they put in a bunch of factors, the static 99 is the name of the tool, and it's called static because most of the factors don't change. They're based on history and age and you really can't make it better. It can't get better over time. Except as you get older. And there's some problems with the tool, but it's still used very, very widely.

The other way that you can compare an individual to a group of people is through structured clinical judgments. These serve as sort of a checklist to make sure that you've looked at all the areas. And they're really pretty good. The Armadillo which was just mentioned is a very promising tool and one of the things that is particularly nice about it is in the assessment, it looks for staff and team behaviors. So it takes into account that this person is in a context and has resources and people to help them that many other people don't.

The other thing you need to know is that a team can increase the risk if it's not working well, so that's something to be aware of.

So there are some risks and there are some benefits that I think the team should consider carefully as they're moving forward. One of the big risks and mistakes that I've seen in psycho sexuals of people with an intellectual disability is to either overestimate the role of an intellectual disability or to underestimate it. To say the only reason this happened was because they had an intellectual disability and to ignore the rest of the risk factors, or to ignore the fact that somebody doesn't have the skills, doesn't have the tools that other people have to help them navigate situations.

Another big thing that I've seen it the over or underestimating of risk, of saying, well, they're in a group home, so everything's fine, or, you know, taking a look at them and saying, well, they're developmentally disabled, they have to be a much higher risk. Again these off the cuff assumptions without looking at things closely can be really problematic. And I think my personal biggest annoyance is that a lot of times in risk assessments, particularly with this field, I've seen where people blame either the person or the system, and I don't find that helpful, and I don't think it's helpful to the person. I don't think it's helpful to the team. I don't think it's helpful to the legal decision maker. A good psycho sexual should just explain to you what it is, what are the risk levels, why are those risk levels, what kind of treatment does the person need, why do they need it, without blaming them, without blaming the team, without blaming the system, just keeping it very impartial.

So those are a number of the risks. The benefits though, I think are very important, and pretty significant. You can really get a clear understanding of the person you're trying to support and work with. And for people who aren't -- who don't spend most of their time working with sex offenders, and understanding this, this can be particularly important because there are a lot of

things that are often counter-intuitive with sex offending and sex offenders and don't seem to make sense, so getting a good understanding of that is really critical. Helping the team develop a plan to help support the person can also be pretty important. A lot of it, you know, if you've been hearing all afternoon, there are issues around where you can live, around where you can work, around what sorts of curfews and special conditions you have. And so the team can sort of come together and now that they have a good understanding of what's going on, really develop a good cohesive plan to help support the person as they move through.

It can also be very helpful for -- to provide information to decision makers. I was testifying last week about a person who had -- with a developmental disability who had committed a sex offense and talked about how they could in fact benefit from treatment and that would be helpful for them, because the judge thought that, you know, he had an intellectual disability, he couldn't learn anything, and so there was nothing that could be done. So in these cases, psycho sexuals can be very, very important and helpful.

I want to talk about a few minutes about risk factors and what makes somebody more or less likely to reoffend, and I think it's really important to remember that risk factors -- the bulk of the risk factors are the same whether somebody has an intellectual disability or not. It's important for a team not to discount a risk because it's not the person's fault that they have -- because of their intellectual disability. So things like being impulsive, having poor social skills, poor problem solving, a hard time regulating your emotions are all things that people with an intellectual difficulty are struggling with, but they're also risk factors for reoffending, so you need to be aware of those, and please, please, please do not discount the importance of managing an environment managing risk, so really being aware of the staff, there was a wonderful quote at the end, how they impact them, where you are, in the community, are huge factors.

In treatment planning, sort of what does this person need to help address some of these issues, you -- is where you see the biggest difference in terms of risk and need, with somebody with an intellectual disability and somebody who doesn't have one. So it's very important to make sure that the treatment is tailored to the person and takes into account their cognitive functioning.

I've seen people be put in a group with ten other people, and expected to participate in the group process, when they couldn't track that level of social interaction. They couldn't keep up with that speed. That caused problems because they weren't participating appropriately in treatment. Treatment may need to be a lot more repetitive. Taking in all of the accounts about stuff we know about how to help somebody with a developmental disability learn, needs to get applied. And so you really need to make sure that supports that they need are in place, or you need to help them

get more supports so that they can move forward.

So before I wrap up, 'cause I foe I'm starting to run -- because I know I'm starting to run out of time, I've got a couple of tips for the team as you move forward. Don't over or under estimate the risk. That's my one take away message, because I've seen teams do it so poorly elsewhere. Communicate among team members, among the direct supports, among case managers, people who are living with them, all of that becomes highly critical. Communication among the team members cannot estimate its importance. Everybody working with somebody needs to be informed of the risk and the plans for supporting them. It is not helpful to have a staff coming in who doesn't know the specifics of the plan. It's not helpful to have somebody coming in who doesn't know what's going on. And finally consistency in the message to the person about how to move forward, about the team being there to support them, because it's a difficult time and it requires a lot of work. And so that is all I have, and I'll be happy to take questions later.

Thank you.

>> KATHRYN WALKER: Thank you. That was great.

And just as a reminder to everyone, it is now available on our website, the white paper where all of our esteemed presenters today have written articles with a little bit more information than what's been on the webinar, so don't forget to go and download the white paper.

So our next presenter is Marc Goldman, and after earning a master's degree in psychology in 1981, Marc Goldman embarked on a career in community mental health, working with children, adolescents and adults with psychiatric impairment. He (inaudible) in a large residential facility. His experience and training with psychiatric issues evolved into an interest in the treatment of individuals who had intellectual disabilities and mental health needs. In this specialty area, he was responsible for the design and programmatic implementation of one of the first treatment centers in the Midwest for people charged with criminal offenses who had intellectual disabilities. He is currently in private practice, devoting most of his professional time to the assessment and treatment of people with intellectual disabilities at risk of engaging in a variety of challenging behavior. Marc Goldman's professional services include psychological evaluation, risk assessments, behavior support and intervention plans, individual treatment for people with dual diagnosis, staff training, and treatment for individuals at risk of engaging in aberrant sexual expression. Mark works closely with support staff and collaborates with staff and administrators in development and administration of therapeutic intervention. He consults with various public and private agencies and serves at an expert witness. Marc has presented (inaudible) in Europe, (inaudible) an association for person with intellectual disabilities and mental health needs. So with that I am going to pass privileges to Marc and hope that we

can hear you.

>> MARC GOLDMAN: I hope that you can hear me, Kathryn.

>> KATHRYN WALKER: I can, great. You can.

>> MARC GOLDMAN: Terrific. I want to thank Leigh Ann Davis and Kathryn Walker for putting the white paper and this big project together. I hope you continue with this topic. I also want to thank (inaudible) while I was panicking trying to get my microphone on earlier today.

If you're committed to providing support for someone at risk of aberrant sexual expression, you're also committing to providing safety. You're providing safety to the individual at risk, to help them refrain from engaging in further aberrant sexual behaviors. You're also committing to the community. You're saying that you can help the community, you can protect the community from this individual harming someone. I think the number one thing is no more victims.

Treatment of people at risk really kind of questions some of our attitudes and values. Some of our system values within the human service system, and some of our personal values and attitudes. You know, we have a system that has a high emphasis on confidentiality, but when the stakes are as high as the issues that we're discussing this afternoon, we have to make some adjustments. You know, one of the key things that I have found in treatment is no more secrets. The agency is aware of the person at risk. The staff is aware. Just yesterday, I was giving an in service to a staff on another topic and they asked me about a different client and noted that they didn't even know that the man was at risk of pedophilia, of engaging in aberrant acts with children. So we have to stop with the secrets about this. And the other thing we have to really consider is, as Americans, how uptight we are in dealing with aberrant sexual issues or sex in general, and we have to remember that as we work with teens, as we work with parents, as we work with staff, when we talk about these things and try to develop some safety measures.

You know, people hate sex offenders. And yet we don't seem to hate them when they have intellectual disability, and that's a question I've struggled with, was why don't we hate them? And I had no empirical evidence, but my conclusion is we don't hate them because we minimize what they have done. By that I mean we view what they did as not so bad, not so tragic to the victim, and we don't think they're going to do it again. It was just an accident, and I believe that's a very, very dangerous attitude to have and I think we all have to check our own biases as we develop safety, treatment, and support for folks at risk.

You know, regardless of the reasons for the aberrant act, whether it's counterfeit deviance, a person who did it out of ignorance, lack of social skills, because their housing situation restricted them from having sex in a private place with another consenting adult, or whether it's criminally driven, we have to

develop some kind of systematic way of keeping the person and the community safe. When I talk about developing safety plans, it takes me three parts of the day to get to this point. I'm down to seven minutes and I'm going to do my best and I hope I cover the major, major topics here.

It's also very hard to get a good assessment. Most people don't have Dr. Shively or Dr. Magnuson hanging out in their neighborhood. I find so many assessments, risk assessments, really lacking in taking into account the person's intellectual disability. If you can get an assessment professional who is aware of those things, terrific, that's going to help a lot. But quite often the team, the team that's supporting the person is going to have to look at it very hard themselves. So in addition to the risk assessment, they're going to have to look at risk factors and what to do about it. In very, very simple terms, the first thing you need to think about is controlling the environmental risk, the social risk, for the particular individual that you're supporting.

Who are their potential victims? Now, we don't -- we with can't predict who the next victim will be. If the person has a pattern of a certain type of victim, that doesn't mean that other people are not at risk. So we really have to be careful about is it just children? Is it just females, or is it just males? We have to determine who that is, and figure out a way to restrict that individual from access to those folks.

We have to be very careful about it. I've seen a staff going to the bathroom. However, the staff had taken the person to a place where they are at risk of engaging in an act, and it doesn't take more than a very few minutes for an aberrant act to occur. So we have to understand who we need to restrict the individual from and how we're going to do it in a very detailed, written out way. We also have to think about restricting the person's access to other high risk settings or situations. We don't go to a movie matinee on a Saturday that's showing a child's film that the individual is at risk of engaging in a problematic behavior with a child. We also have to -- if destabilizers, alcohol, drugs, or other destabilizers can influence the behavior, we have to restrict those, and we have to determine what level of supervision we're going to have with the person.

I recently was asked to leave a case, I was recently asked to provide a (inaudible) withdrawal from a case on a man who had a 25 year history of offending, and elopement, and I said (inaudible) contact has to be made with this man every 15 minutes and the housing provide said, well, we can't do that. What if this man wants to have sex with somebody? And they were missing the whole point of what we needed to do to get this man and people around him safe.

Now, you know, we can go on and on about other social and environmental factors, things like not having access to going into stores where children are typically present, children's stores,

bookstores, whatever children's department, you're going to have to figure out how you're going to deal with that if a person wants to enter a store like that. I personally just restrict and explain why and deal with human rights committees about that.

You also need to consider your proactive interventions. These are your teaching interventions and a lot of teams say that's treatment, that's not something that we do. Well, if a person is even -- even if a person is getting good treatment, they're getting it once a week. Even if a person is getting good treatment, you know as providers that we have to teach daily. We have to review skills daily or the skill will be lost, it will be forgotten and we start all over again. So you become the teachers and the teachers, we teach things like what to do when you're in a high risk situation. And you go over it with the individual. You might write a story about what to do.

I'm big on having, if the individual can read, giving them a three by five card for what to do in high risk situations, four or five items, we practice it, they carry it and when staff are with them, when the time is right, with they're in that -- when they're in that situation, we (inaudible) to pull the cards and we follow it. There are a variety of ways to do that.

But we're teaching what to do, in conjunction with a good therapist, or on our own. We really, really have to figure these things out very thoroughly.

You might need to get help. You get help with the therapist. You get help with someone in your community that's familiar with people with ID and risk of aberrant sexual expression, but you create this document and you follow this document and you train it and retrain it with staff.

Kathryn, I have no idea how to get to my next slide. Can you help me with that?

>> KATHRYN WALKER: Got you.

>> MARC GOLDMAN: Thank you.

Something else that I think is very important, is be aware of practice indicators. When is a person at increased risk of engaging in aberrant sexual expression. For some people it is when they're under additional did stress. When they lost a job, when they can't -- when their family is on vacation, when they have less support than they typically have, when they have a mood state that puts them at high risk. And then also (inaudible) within this safety plan, what will the team do in terms of increased supervision, what will the team do in terms of increased support for the individual while they seem to be at increased risk of engaging in problematic behavior. Dr. Shively and I also believe Dr. Magnuson talked about risk factors. There's nothing we can do about those. Those never change. Those are in the person's history. But there's dynamic factors, there's some dynamic factors, changeable factors that we as experts all of you in the ID field know about and can teach and work with.

Can I have the next slide, please?

Well, within that slide, yeah, we have to look at -- I want to focus on the first six or seven of those. We can -- we look at anger versus hostility, and can the person control their emotions. We can do some teaching. It's not easy. We can do some teaching on emotional control. When we see poor personal hygiene, even poor care in terms of a person taking responsibility in keeping their room picked up. That tells us if the person seems to be at risk of continued aberrant sexual expression and we can again do something about that. We can provide incentives to make a person -- encourage a person to engage in better hygiene and domestic skills. We can hold the person responsible for their behaviors. We can teach positive coping skills. And my time is up, so I want to stop here. Please feel free to ask me questions or email me or call me. I'll be glad to talk to you all you want, because this is a subject that's near and dear to my heart.

Thank you for your time.

>> KATHRYN WALKER: Thank you, Marc. And just again with the white paper, there is actually a fully written out community safety plan written by Marc Goldman in the white paper, so if you're looking for examples, that is available on the website.

So our next presenter, and let me get my video up here, our next presenter is Colleen Mercuri-Johnson, who is employed by butler county board of developmental disabilities, that's BCBDD as a mental health specialist in their behavioral health program. Part of her duties include being director of the problematic (inaudible) developed and certified the Ohio Department of Rehabilitation and corrections to provide treatment for individuals identified with having sexually offending behavior. She specializes in working with individuals with co-occurring mental health and intellectual developmental disabilities, and she has been an instructor of human sexuality courses at Sinclair community college. She is a certified sexuality educator from through (inaudible) and therapists. So with that, I would like to welcome Colleen Mercuri-Johnson.

>> COLLEEN MERCURI-JOHNSON: Okay. Are we good to go?

>> KATHRYN WALKER: We are, thank you.

>> COLLEEN MERCURI-JOHNSON: So I am from Ohio, and back in late 2013, our safety department of DD services really became aware of the fact that we needed to put some resources together to assist the county boards who are working with individuals who have a conviction for a sexual offense. So we put together some guidelines through a group of member -- okay. Sorry, looking at my screen.

So here's a list of the individuals that were on our work group. And these individuals were picked because they have experience with serving individuals that have been charged for sexual offenses within the DD population.

And Kathryn, I'm having trouble advancing. Can you pull --

there. Okay.

So here's a slide that goes over some of the focus areas that the group had, and we wanted to really give some functional tools to teams, to the support coordinators, which are our case managers or the service and support administrators. We wanted to give again some functional tools for the providers, and we're talking not only residential but day program and work site providers, and we wanted to give the teams some guidelines on how to have discussion around setting up effective service and support plans.

So we developed a sex offender protocol, and all of this is available on the Ohio DD website, and in the white paper, if you look up the article that I wrote, at the end of that will be the website that you can go to to download all of the offender protocol and all of these assessment tools or guidelines and check sheets that I'm going to be talking about.

So we did set up a protocol, and these are just suggestions for the county boards to follow. We came up with some checklists for teams to go down through. We talked about an environmental assessment which can be used to follow along with what court restrictions there might be, and recommendations from the assessments, and then we had a sheet that was pulled together to -- for teams to talk about how to develop relapse prevention plans or whatever the name of the safety plan or success plan that the teams are using, whatever that name is.

And the team or the work group went into this work with some basic assumptions. Sorry. I'm having trouble with my slides.

And we realized that everybody comes to this with very unique histories and understandings of what led up to their offense and we heard that throughout this presentation and there really is no one size fits all to every person who is convicted of a sexual offense.

We did realize or assume that there are different levels of risks, and that we went with the assumption that someone who is considered to be at higher risk would need to have more scrutiny, supervision, oversight, than somebody who would be at a lower risk. And again when we think about risk, we know that there's no 100 percent accurate way to talk about risk. We can really just look at the person's history, look at some of the research statistics, and come up with an idea one way or the other as far as high or low risk. But we did feel that risk could be mitigated within the community setting, that people can be very effective without a containment model around them.

So the overall purpose of the protocol was to give us as the team, as the support system, a better understanding of the individual, and it really is to develop effective strategies and plans to work with the person. And we thought that it was very important to put forth that all of our plans center around assessment recommendations, and would be grounded in that. We strongly encourage collaborations with any support system that is around the system, and if you could build a strong team, it leads

to more effective outcome for the individual, so if we can get the probation officers on board, the county board, the various provider agencies, and if we can get the treatment provider, if the person is in treatment, in therapy, if we can get them to be an active voice on the team, that led to great success for many of our individuals, and of course you get the guardians and any natural supports around the table.

So the guidelines for the assessments, and we've talked about assessments already today, that there are a variety of them out there. With this work group, what we wanted to focus on was not assessment tools, but just the idea that there should be some sort of a sexual offender specific assessment done on any individual that we are working with that has a convicted sexual offense. Those assessment tools would be chosen by the assessment provider. And they would gather some of the information towards which tools after talking with the team to figure out what would be the best bet.

We did think it was important to go into what the qualifications of the assessor are, and we felt that somebody who had an advanced degree in mental health, who held an independent license within the state, and most importantly had experience evaluating sexual and violent risk with persons with intellectual and developmental disability. We also recognize that sometimes that's very hard to find, especially in some of the more rural areas. So we also gave some guidelines for the team, and especially the case managers who tend to be the ones who will contact the assessor. We gave some guidelines as to how can we as a system educate some of the providers for the assessments on what the needs for the system itself is.

So we came up with some preparing for the assessment guidelines and strongly encourage each board to have at least a general idea of who the service providers are that are within their area, because like you said, sometimes it's very difficult to find somebody who has had experience with this population. And some of those providers don't have any experience working with our DD system. And it is the case manager or another member of the team that might do some education to that provider. And that provider might (inaudible) collateral information would even be available to them if it comes from our system, so some of the collateral information that's helpful is maybe some information on residential history, the social and medical and psychiatric or mental health treatment, of the older psych evals. ISPs, what staffing ratios have been. Information that is pretty common for us to know within the system, but others might not necessarily understand what we do and what is available.

And another important piece is to really factor in which would be a good time of the day for the person to be assessed. Some of our individuals, they do better in the mornings, some in the afternoons. So to help that person have the best experience and

outcome with the assessment, sometimes it's nice if somebody who knows them can give the case manager and the provider of the assessment an idea about which would be the best time of day.

Again if the communication between the team and the assessor is good, it's well connected, you get a better outcome. And it's important to help that assessor know what -- how this assessment tool will be used, what their recommendations will be and how they will be applied to our system, and to the individual that we are working on a plan with. So if you can let them know, we want information on what their suggestions are for staffing and supervision, what type of day program or residential is most effective, what could be the vocational choices, and what kind of media is this person best able to be around.

And all of this information will then go into the service plan itself, and during that development, we strongly encourage that the individual is there as an active participant in developing their plan. That you have as many people around the table as possible that know the person. And you have that diversity of perspectives from the other team members. That the service plans are used -- they use a structured reasoning process. The assessment is brought into that development, and that service plans are reviewed frequently, and they're updated as needed. And we have talked a little bit throughout this about some relapse prevention plans that are developed. As those -- as the individual progresses in treatment, those automatically start to change and those changes should be reflected into the service plans. So review them often and update as needed, and when it comes time to start to fade any restrictions, our recommendation is those restriction are faded slowly and with the consensus of the support team. So it's very important that it's not just one person making the decision, that it's spread out over the team itself.

Some of the considerations for plan development, we've talked about throughout this presentation, and the previous ones. But if you've looked at the person's cooperation with treatment and supervision, that they already have in place, if the person -- is the person willing to engage in change? That's very important, and we'll go into that plan development. You know, what is the person's capacity for independent living. If someone was living very independently before the charge, does that mean that the person has to come in for 24/7 almost hip to hip supervision after the charge, so really being mindful of what type of supervision we set up, again based on the assessment that comes in and the assessment recommendations, but looking at that person's ability to be independent. And also looking at the legal status. What is the reporting status? What do they have to do, and what are the requirements? I've seen some of the individuals I've worked with over the years, they've been violated on their parole because they didn't have transportation to become registered at the time that they were supposed to. It wasn't included in their service plan

and no one knew about it, so they were the ones that got violated for that.

What are the implications of rights restrictions. That's another conversation that has been coming up more and more within our systems, is as we put in restrictions, are we restricting that person's rights, and if so, do we have valid, grounded reasoning behind that. And then we've also talked a lot about what kinds of information gets disclosed and where.

I think those last two are probably the more complicated discussions that teams have and decisions to make.

Supervision levels should be guided by the assessments. And also follow court orders.

Relapse prevention plans or whatever you choose to call them in your systems is really designed to help the person be successful out in the community. And to look at what their strengths are as well as what are the deficits that can be worked on.

And kind of in closing, 'cause I believe I'm getting to the end, I wanted to show you a little bit of an example from one of the treatment plans that I've done, and this is an individual who has committed a -- what in Ohio is a tier 2 sexual offense, and when I sit with him and I asked him what his primary goals are, we use very person centered language because this is about him ultimately, and it also centers on prevention for the community and safety for himself. So his primary goals were to stay out of jail and prison, to work on his anger, to feel good, have a girlfriend, and get a job. And we looked at what his strengths are, and those were I'm funny, people like me, I have my mom, who is a very strong support in his life, and he's got a good work ethic, so he's good at work. When he asked him what it was that he really needed to work on for himself or the things that get in his way, he really was able to identify his past, the criminal behavior that he's done, and he was honest about sometimes he can't control himself, and he says things that get people mad. We used these to really come around and develop a plan for him, and he has been very successful and is very well integrated out in the community, has independent time, and is maintaining a community job very well. And this is a good example of how working with a team that is strong and has a passion for helping people move forward, you can really get some good success.

Some of the challenges also that come up really do center around what if the person declines services, so those are some of the discussions that this work group had. And there are community controls already in place for many of the individuals, so allowing other systems to also step in to help with some of the monitoring is very important. The DD system doesn't have to hold all of the services, because they are spread out. But getting the criminal justice system in, mandating compliances with notices and reporting skills, those are all pieces that are also part of supervision. Do what we can to maximize any kind of treatment compliance, being able to provide that transportation that's needed, and then really

focusing in on skill development.

And that's my part. So thank you very much for listening.

>> KATHRYN WALKER: Thank you. All right. So we are coming up on the end here. So Chris and Elizabeth, I'm going to task you both with staying right at your ten minute mark. Chris you're next. Chris Snell has been the director of the treatment program at class and has been working and supporting individuals with intellectual and developmental disabilities (inaudible) support professional, clinical support and administrative for residential and day programs supporting individuals from the Massachusetts department of developmental services, department of mental health, and Massachusetts rehabilitation commission. Since coming to the tree program, Chris has been collaborating with (inaudible) as they conduct data collection regarding the system's mapping of individuals in the program, and who have been involved in the development of a community task force with membership including state agencies, first responders, (inaudible) and the Lawrence police department. So with that I'd like to welcome Chris.

>> CHRIS SNELL: Thank you, Kathryn. Can you hear me okay?

>> KATHRYN WALKER: Yes. You sound great.

>> CHRIS SNELL: Thanks.

So thank you, Kathryn and Leigh Ann for this opportunity to talk about our program. So we've actually -- we're still on the slides, it's a specialized employment services program, and we've just changed our name to the tree program. As our services evolve, we really want to focus on treatment, responsibility, empowerment and employment, and I'm glad I have the opportunity to go after some of our esteemed presenters so I can just kind of piggyback on a lot of the issues they talked about. One of the things we really focus on is this issue about the difficulty of some of these folks being able to secure jobs. And that's really what we focus on, is having a program that allows people to safely, with supervision, trained staff, and a structure that we have some oversight with, so enjoy some success and a paycheck.

Let's see if I can move this.

So one of the things that we have is we've set up a program model in an environmental setting that really allows us to do some pretty significant work. On the white paper, Kathryn has provided, we have a nice floor plan of what our structure is. When the floor level of an old mill and what we have is we have seven home based structure that we break down based on people's specific needs, supervision, their compatibility with others and their vocational skills and any new individuals we bring in, we bring into the intake home base, which is a little bit offset from the other programs within our setting. So we have 61 individuals that come to us on a daily basis. They range from 22 years old to 65 years old. The majority of them are (inaudible) of the Massachusetts department of developmental services, and we utilize this program setting to really identify new folks, what their needs are, what

their vocational skills are, and really using a lot of these other elements that people have talked about today. Some of the folks coming to us have not really enjoyed either the opportunity to become employed in the community or success in the community in employment. They have been targeted as people and labeled as their behaviors and not as the people that are struggling but maybe some issues and they're attempting to work on those issues. We have a high staffing ratio in the program. We carry a one to four staffing ratio. We have a significant level of expertise within the staffing ratios. So we want to focus on the people and what they need on an individual basis.

When we're talking about how do we do that, we're talking about how do we assess a person's needs, how do we treat that need, and how do we incorporate therapeutic work into that. We really assess people on the ongoing basis within our intake home base. We have five therapists that come on a weekly basis to see our individuals within our setting that we can work with. And to really do a lot of these things that folks have been talking about, doing these collaborations, being able to individualize treatment plans, work plans so the people can succeed and improve on their quality of life.

Some of the more newer things that we have in place right now is we developed a partnership in U Mass Lowell, their criminal justice department (inaudible) working on some research within our population of folks. They've taken a sample size of 20 of our individuals and we're really looking at identifying the systems mapping within our folks' experiences. So we've targeted some folks that are older and some of our newer folks to really identify how they're working through both the psychiatric services in the community but also the forensic involvement.

We also through U Mass, we have -- some of us on the team have either completed or are pursuing graduate degrees in criminal justice and in (inaudible) studies, so that's been a very effective relationship that we're going to continue to build.

We also, as an agency, have just recently become part of a task force within the community that involves membership of the large police department, the department of mental health, the department of youth services, and the department of (inaudible) services to really work on identifying ways to educate first responders, so that we can help people understand some of the issues that our folks have in interacting with those first responders. So we're going to work on trainings. We're also going to look at data of how they're being captured in the systems on the common issues coming up so we can help address those.

So we're really looking at the work that's something that again is a significant issue with folks that have some struggles. Might be identified, might have some misperceptions within the community. We want to be able to provide them with opportunities to succeed and maybe go home with some money in their pocket where they might

not always have that opportunity. Something that Kathryn touched upon early on is how sensitive of a topic that this is. We have a significant portion of our folks that have sexuality issues. We have some that are registered. And so we have to be very careful how we disseminate our information, so what we've done is we've provided a landing page that if people are interested in learning more about our model of operations, how we provide the supports in the communities for this challenging population of folks, you can click on this landing page that will then allow you to sign up, it's a password protected website. It's going to allow us to elaborate a little bit more than we would be able to on a public page, and we're really interested in spreading the word so that more people can indeed provide employment opportunities to this population of folks.

So we really look forward to being able to do that, and again thank you very much for this time.

>> KATHRYN WALKER: Thanks, Chris.

So (inaudible) survey that pops up, and there is the opportunity there to check yes, I would like more information about the tree program, and that password protected information we can get you on a list for them as well. So yet another reason to fill out the post webinar survey.

All right. We are on to our anchor, our final presenter of the day, Elizabeth Kelly is a criminal defense lawyer based in Washington. She travels around the country working on cases involving people with mental illness and intellectual disabilities, she is serving her third term on the board of the national association of criminal defense lawyers and chairs its mental health committee, has chaired the membership committee and is a life member. She has served on the problem solving court task force and currently serves on the body camera task force. She had been appointed (inaudible). We are thrilled to have you, and she lectures across the U.S. on representing persons with mental disabilities and frequently provides legal commentary for radio and television, her book reviews appear in the federal lawyer and she hosts two radio shows, one titled (inaudible) court (inaudible). So welcome, Elizabeth Kelley.

>> ELIZABETH KELLEY: Can you hear me?

>> KATHRYN WALKER: We can.

>> ELIZABETH KELLEY: Thank you. I'm very sensitive to the fact that the final speaker of a lengthy and substantive program is often at a disadvantage, so given all of that, I'm going to be very brief, and I'm going to address three points that are not contained in the materials.

In terms of those materials, it falls at the very end of your white paper. And it's basically a two page guide for family members of persons with some type of intellectual or developmental disability who are charged with a sexually oriented offense, and I would encourage all of you to make copies of that handout and give

it to family members. It's important to realize that most families, thankfully, have very little dealings with the criminal justice systems. They don't know how to act. They don't know what to expect. And most importantly, they really don't know what their criminal defense lawyer needs. So this is meant to be a helpful guide, a helpful first step.

The first point I want to emphasize is that many of you have probably heard in recent weeks and recent months that there is support on both sides of the aisle for fixing our criminal justice system, a criminal justice system that is broken. We have discovered that mass incarceration does not work, that criminalizing all sorts of behavior does not work, that the war on drugs is a miserable failure, and all of this is tremendously expensive in an economy which is strapped. There are large (inaudible) to reduce mandatory sentencing, particularly for non-violent drug offenders. There is also a movement in some circles to reduce the penalties for non-violent white collar offenders. There is also a movement to reduce the collateral consequences that we saddle people with even after their prison term is finished, but what no one is talking about, what no one is advocating, is lessening Draconian penalties that we have for people who are accused and convicted of sexually oriented offenses. So the challenge for all of us is as the months and years continue, while we modify our criminal justice system, is to make sure that there are responsible sentencing for people who are convicted of sexually oriented offenses, and in particular, penalties and even charging decisions for people who have intellectual or developmental disabilities. Charging decisions and penalties that at the same time protect the community while also ensuring that that offender, if that offender is in fact guilty, never repeats the behavior that got him or sometimes her into that difficult situation.

The second point I'd like to emphasize is that of understanding your criminal defense lawyer and his or her obligations to convey any plea offers to you or to the family. This is a point that I emphasize in the two page handout, but as I have heard the discussion today, as I have reviewed the white paper, there is an additional point that I would like to put in that paragraph that I've written. You must remember, families must remember, that we as criminal defense lawyers are trained that the most important thing, the paramount goal, is to minimize or eliminate a prison or a jail sentence for our clients. However, it's important to realize that in terms of sexually oriented offenses, even if a prison sentence or a jail sentence is reduced or eliminated, there can still be the mandatory reporting requirements, and what you as advocates for people with intellectual and developmental disabilities must do, what families must do when working with the criminal defense lawyer, is emphasize that to the degree there is any discretion in the sentence that the judge imposes, to the

degree that there is any wiggle room, if you will, in the plea bargain that is hammered out between the prosecutor and the defense lawyer, the reporting requirement should be taken out. We know that clients who have intellectual/developmental disabilities find many of these requirements almost impossible to meet, and as a result, they're often hit with yet another violation, and they are in this extremely endless black hole from which they never can get out.

Beyond that, if people have sexually oriented offender registration requirements, they can also be excluded from a host of different employment opportunities, as well as housing options. So please, please, I implore you, paint the picture for the criminal defense lawyer that to the degree there is any negotiation, that the registration requirement needs to be taken off the table.

And the final point that I'd like to raise which is above and beyond the handout in the back of the white paper, and maybe Kathryn, you can pull up the graphic of the roadmap?

Beautiful. Thank you.

This talks about the importance of a roadmap. When fashioning a sentence which will on the one hand prevent the offender from reoffending, and at the same time keep the community safer. The handout that I put together is all about how families can help the criminal defense lawyer, how the families can be an integral part of the team in order to help their loved one, in order to help the client. But this particular graphic grows out of a conversation that I had with a very caring judge, a number of years ago, and he said, Elizabeth, we don't want to put your clients in jail. We don't want to send your clients to prison. But you've got to design a roadmap for us. You've got to show us in detail what your client is going to be doing 24/7, where he or she is going to work, if he or she does have a job, what sort of transportation he or she will have, where that person will live, what type of supervision that person will have, if that person needs medication, how that person will get the medication, if that person needs therapy, what type of therapy the person will have, and how often that person will get it. Keep in mind that many of our judges in this country are elected officials. Beyond that, many of them, I like to think most of them are conscientious, and the last thing they want to hear about or read about is that they took a chance on a particular defendant who appeared before him or her. They gave him or her a break. They gave him or her probation, but unfortunately that client or that defendant has reoffended. So thank you all for joining us today. I hope you learned a good deal from the other speakers. I know I have. And if you think of anything after this webinar is over, which you would like to ask me, feel free to shoot me an email. My email address is (inaudible) advocacy, at AOL.com.

>> KATHRYN WALKER: Thank you. So I know we came up right to the end of our session today. And so I don't think we're going to have time for questions today. But I just want to make a quick

announcement that you can register for our next webinar on September 30, and that's justice involved use with IDD and we'll have an accompanying white paper that we're in the process of developing on that topic as well. In the post webinar survey, you can sign up to receive email alerts and use our information referral and technical assistance service and also refer others, so if you know anyone that is having any disability and criminal justice issue, please feel free to contact us.

You can download the white paper that has more information from our excellent presenters at [www \(inaudible\)](http://www.inaudible.com) and you can contact a us at [NCCJD info at the Arc.org](mailto:NCCJD_info@Arc.org). And just one more time, before we all disconnect here, I would like to thank all of our presenters, both for their authorship on the white paper and taking their time out of their day today to present and for all of the questions that I'm sure you are all going to send that our esteemed authors are going to answer for you.

So thank you for your participation. I'll send an email out from the recording is availability so you can share this information with anyone in your network that is interested and beyond that we hope you enjoy the paper and we look to hearing your questions.

Thank you.

(End of webinar.)

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