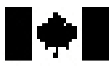

Addressing the Needs of

Developmentally Delayed Sex Offenders

A GUIDE

Canada

Addressing the Needs of

Developmentally Delayed Sex Offenders

A GUIDE

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Addressing the Needs of Developmentally Delayed Sex Offenders – A Guide was prepared by Judy Tudiver, Shirley Broekstra, Sheena Josselyn and Howard Barbaree for the Family Violence Prevention Unit, Health Canada.

Également en français sous le titre Comment répondre aux besoins des délinquants sexuels ayant un retard de développement – Un guide

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Preface

In the fall of 1993, the Forensic Division of the Clarke Institute of Psychiatry initiated a survey to assess the need for services in community-based assessment and treatment programs for sex offenders. A broad range of mental health, social service and correctional agencies that interface with this target population were surveyed.

Respondents noted that services for sex offenders who are developmentally delayed were extremely limited. Agencies reported that they were faced with an increasing demand for services for this population. Furthermore, they felt that they could not meet the demand with the existing levels of knowledge, training and resources.

As a result, in the fall of 1995, the principal authors received funding from Health Canada (Family Violence Prevention Division) to develop a guide focusing on developmentally delayed sex offenders.

To provide direction for development of this guide, an Advisory Committee was convened. This committee was comprised of a variety of professionals who work with sex offenders or who provide services to developmentally delayed individuals. In addition, two subcommittees were formed. The task of one subcommittee was to develop a set of Clinical Practice Guidelines for the assessment and treatment of developmentally delayed sex offenders. The task of the second subcommittee was to explore the interactions with the criminal justice system experienced by developmentally delayed individuals who have committed sex offences.

A one-day community consultation was also held to identify currently available resources and gaps in service provision. The community identified strengths in the availability of assessment resources for this population. However, treatment and management options were identified as very limited. The community also expressed serious concern about the lack of residential settings for individuals at high risk to re-offend. The transitional youth group (ages 18-21) and developmentally delayed persons with major mental illnesses were noted to be poorly served.

In addition, the need for specialized education and training for staff working in residential and sheltered workshops was identified, along with the need for better case management and coordination.

Introduction

One goal of this project was to obtain a better understanding of developmentally delayed sex offenders, and to describe their offences and the victims of their offences. To this end, a survey was conducted and the results are presented in the guide.

Overview of The Guide

Intended Audience

This guide is intended for individuals who work with developmentally delayed persons, including service providers, mental health professionals, lawyers, police, court officials, child welfare workers, and volunteers, as well as clients and their families.*

Goals of the guide

The main goals of the guide are:

- To provide a conceptual framework in which to view the problematic sexual behaviour of developmentally delayed individuals;
- To review the research literature on developmentally delayed persons who have committed sexual offences;
- To describe the characteristics of developmentally delayed individuals who demonstrate sexually inappropriate and/or offensive behaviour;
- To describe the types of sexually inappropriate or offensive behaviour committed by developmentally delayed individuals;
- To describe Clinical Practice Guidelines for the assessment and treatment of developmentally delayed individuals involved in sexual offending behaviour; and
- To explore the role of the criminal justice system in dealing with developmentally delayed sex offenders.

Background

The normal sexuality of developmentally delayed individuals has been poorly understood by society. All too often, myths and stereotypes about the sexuality of the developmentally delayed person have pervaded the mental health and legal systems. Historically, both systems are ill-equipped to deal with individuals with developmental delay who show inappropriate or offensive sexual behaviour. A quote by Swanson & Garwick (1990) may reflect the current attitudes of our communities toward developmentally delayed individuals who commit sexual offences: "…sexual offences by individuals with mental retardation will be ignored as long as possible and then approached in a crisis-oriented, fragmentary and intrusive manner" (p.155).[1]

As with any other group of people, the vast majority of developmentally delayed persons are law-abiding citizens. There is, however, a small percentage who show sexual behaviour that is considered inappropriate in the social context or is defined as a criminal offence under the Criminal Code of Canada.

This guide identifies some societal misunderstandings and misinformation regarding the sexual behaviour of developmentally delayed individuals. In addition, this guide provides recommendations for assessment and treatment approaches which are proactive and respectful of the developmentally delayed individual. Furthermore, this guide provides an overview of the way in which developmentally delayed sex offenders are processed within the criminal justice system, and makes recommendations for interventions that may better meet the needs of developmentally delayed persons.

* The male gender is utilized in this publication to allow easier reading but includes women and men who work with developmentally delayed persons as well as clients and their families.

Definition of Terms

Developmental Delay

There are many terms used to refer to the population of individuals with limited intellectual functioning, including developmentally delayed, developmentally handicapped, intellectually challenged and mentally retarded. There is little consensus on which term is most appropriate. For the purpose of this guide, the term "developmentally delayed" will be used. This term is synonymous with mental retardation as defined by the American Association on Mental Retardation (AAMR).

Developmental delay refers to substantial limitations in present functioning with onset prior to age 18. It is manifested as significantly below average intellectual functioning, expressed concurrently with related disabilities in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work.[2]

It is important to include adaptive functioning levels in addition to an IQ level when describing people with developmental delay, as two individuals with identical IQs may be quite different in terms of their social functioning and behaviour.

The prevalence of developmental delay is approximately 2.5 to 3% of the general population.[2]

Sexual Offender

In this guide, the term "sex offender" is used to describe individuals who have committed a sexual act that is against the law.

Included in this definition are:

- sexual contact(s) with another person without that person's consent, and
- all adult sexual contacts with children.

The prevalence of sex offending behaviour among the developmentally delayed population is not known. This may be due, in part, to the reluctance of service providers to accurately label this behaviour. It is our experience that many service providers and others often do not label sexual assaults perpetrated by individuals with developmental delay as sexual "offences" because the label may significantly hinder access to housing and other support services.

Several reports[3, 4] have suggested that sexual offending is as prevalent, or even more prevalent, among individuals with developmental delay than among non-delayed individuals. For example, Day (1994) recently found an over-representation of sex offending in the developmentally delayed population that was not accounted for by differential arrest and conviction rates.

It is clear that the scope of the problem will not be ascertained without an appropriate definition of the problem, accurate reporting and further research.

Myths and Stereotypes Related to the Sexuality of Individuals with Developmental Delay

There are many myths and stereotypes about the sexuality of individuals with developmental delay. Acceptance and endorsement of these myths has tremendous implications with respect to acknowledging and changing the sexually offending behaviour of developmentally delayed persons.

Myth #1

Individuals with developmental delay are often viewed as either sexually impulsive or child-like and asexual.

Reality Behind Myth #1

Sexual behaviour falls on a continuum and the above categories represent two extremes. Most sexual behaviour, including the sexual behaviour of developmentally delayed persons, is somewhere between these two extremes.

Consequence of Myth #1

The false dichotomization of the developmentally delayed individual into two extremes has important implications. If society and service providers view this individual as highly sexually impulsive, the offending behaviour is seen as uncontrollable. In these situations, a solution would be to incarcerate the offender or provide one-on-one supervision. Not only are these expensive options, but they also deny the offender an opportunity to change his or her behaviour.

Conversely, if the individual is viewed as child-like and asexual, the sexual offending behaviour is likely to be denied or minimized. It may be difficult to acknowl-[illegible]ge an incident such as sexual [illegible] because of the view that the person, like a child, is quite powerless. If the sexual incident is denied or minimized, then it follows that intervention is not considered necessary as no serious problem seem to exist.

Denying and minimizing the impact of the individual's offensive behaviour effectively removes the consequence for his or her actions and robs the individual of a chance to learn more appropriate sexual behaviour. In addition, this strategy also ignores the safety needs of the community.

Myth #2

Individuals with developmental delay who sexually offend against children are simply interacting with their emotional or intellectual peers.

Reality Behind Myth #2

Although some people refer to developmentally delayed individuals as having a young "mental age", developmentally delayed persons are not equivalent to children. Adults with developmental delay differ from children in size, past life events and available life choices.

Consequence of Myth #2

Adoption of Myth #2 leads to the corollary that the developmentally delayed individual who sexually offends against children is interacting with a peer and, therefore, is not doing anything wrong. Again, in these circumstances the developmentally delayed individual is not held accountable for his or her offending behaviour and is not offered a chance to change that behaviour. Furthermore, the risk to the community may again be ignored.

Reality Behind Myth #3

Most developmentally delayed individuals are able to distinguish between right and wrong in most areas of their lives.

Consequence of Myth #3

Myth #3

An individual with developmental delay who has sexually offended cannot understand that he or she has done something wrong.

If it is believed that developmentally delayed individuals are unable to distinguish between right and wrong, then it is unlikely that they would benefit from being held accountable and from interventions that address their offending behaviour. Treatment that may reduce the risk of reoffence, therefore, would not be offered. Like the preceding myths, this myth denies developmentally delayed sex offenders the opportunity to change their behaviour. This myth leads to a restrictive rather than a rehabilitative solution.

Myth #4

Treatment cannot benefit a developmentally delayed individual who engages in sex offending behaviour.

Reality Behind Myth #4

Research has shown that specialized sex offender treatment reduces recidivism rates in non-delayed sex offenders. While there is limited research, clinical evidence suggests that specialized sex offender treatment may also reduce recidivism rates for developmentally delayed sex offenders. Effective interventions may enable the developmentally delayed offender to better manage his or her life with the goal of being re-integrated in the community.

Consequence of Myth #4

If the view is held that treatment cannot benefit developmentally delayed sex offenders, then it again follows that intervention would be limited and treatment would not be offered to them. This may result in increased danger to the community as well as to the developmentally delayed offender. Acceptance of this myth may also limit the opportunities for the developmentally delayed individual to be re-integrated into the community.

Problematic Sexual Behaviour

An Overview of Problematic Sexual Behaviours of Individuals with Developmental Delay[5]

Sexuality is an integral part of every person's life. However, sexual expression by developmentally delayed individuals often evokes strong reactions from many people, including professionals. This is evidenced by examining the attitudes of residential staff toward the legally acceptable sexual expression of the developmentally delayed clients in their care. The results of one study indicated that only 25% of the staff reported that they would allow sexual interactions between their developmentally delayed residents. Another 50% of staff felt that sexual interactions between residents should be limited, while 25% of staff felt that sexual interactions should not be allowed.[6]

Often these restrictive and conflicting attitudes of caregivers cause confusion for developmentally delayed persons. In addition, these attitudes make it very difficult for the service providers to consistently distinguish between normal, inappropriate, illegal and other problematic sexual behaviours. The following is a framework for categorizing or labelling the sexual behaviours of individuals with developmental delay.

"Normal" Sexual Behaviour

Normal sexual behaviour is sexual activity to which participants freely consent, which is carried out within the bounds of ordinary standards of social propriety concerning time and place, and which does not exploit or demean any person. However, as noted above, misinformation and generally restrictive attitudes toward the sexuality of developmentally delayed individuals may result in a view that all sexual expression by individuals with developmental delay is "abnormal" or in need of professional attention. For instance, it is not unusual for residences for developmentally delayed individuals to have general policies that restrict all sexual interactions between developmentally delayed adults. Therefore, consensual and lawful sexual interactions are prohibited, along with exploitative, coercive and illegal sexual interactions. When all sexual behaviours are classified as wrong, individuals with developmental delay are not taught to discriminate between appropriate and inappropriate sexual activities.

The social appropriateness of sexual expression is contingent, to some degree, on the location in which the act takes place. A sexual behaviour such as masturbation performed in private may be viewed as socially appropriate, whereas the same behaviour performed in public may be viewed as inappropriate.

Given that many developmentally delayed persons are not provided with opportunities for privacy, it makes sense that sexual activities performed in "inappropriate" places are fairly common among developmentally delayed individuals.

This highlights the importance of interpreting any problematic sexual behaviour presented by an individual with developmental delay within its context. An appropriate assessment, for example, can differentiate between a developmentally delayed individual who masturbates in public because of a lack of privacy and one who does so for other reasons.

Inappropriate Sexual Behaviour

Inappropriate sexual behaviour is sexual activity which violates ordinary standards of social propriety and typically reveals a need for social or sexual education, but for which intent to harm is not an issue.

Sexually inappropriate behaviour may result from environmental restrictions, lack of limit-setting, poorly developed social skills, lack of information on appropriate sexual expression or segregation. This behaviour may stem from the way an individual with developmental delay was educated or raised, rather than from a motivation or desire to offend. If the sexually inappropriate behaviour is not addressed adequately, in some instances it can escalate to offending behaviour.

Sexual Offending Behaviour

Sexual offending behaviour includes sexual contacts with another person without that person's consent, and all adult sexual contacts with children. This category of behaviour is illegal and harmful to the victim. Acts of unwanted contact and activities in which there is no physical contact between perpetrator and victim, as in the case of exhibitionism and voyeurism, are also included within the category of offending behaviours. Sexually offensive behaviour of developmentally delayed individuals should not be ignored or minimized. Individuals with developmental delay who sexually offend should be held accountable for their behaviour and have access to appropriate sex offence-specific assessment, treatment and support.

Self Harm and Other Problematic Sexual Behaviours

This category encompasses unusual behaviours such as self-injurious sexual behaviour. An example of this type of behaviour includes insertion of objects or choking oneself when masturbating. In addition, "excessive" masturbation may fall under this category. Masturbation may be considered excessive if it interferes with the individual's work or other life events. Appropriate assessment and treatment is also recommended for problematic sexual behaviours exhibited by individuals with developmental delay.

Conclusions

In presenting these definitions, we stress the importance of carefully examining the context in which sexual behaviour occurs and of recognizing the many obstacles to healthy sexuality for developmentally delayed individuals. Defining sexual behaviour requires careful assessment, both of the person and the context in which the behaviour has occurred. Consider, for example, the developmentally delayed person who masturbates in the common room of his group home. Does this behaviour reflect an intent to act out aggressively toward those who witness the act or does it reflect the person's poor sense of social propriety and/or limited capacity to delay gratification? Or perhaps it arises simply because the person is not allowed time and space alone when he or she needs it.

Ryan suggests: "In considering the range of behaviour…it becomes clear that most of these behaviours are not deviant in our culture. It is the relationship and interaction that define sexual abuse – rather than isolated behaviour occurring out of context" (Ryan, 1991: p 397).[7]

In summary, this section provides a conceptual framework that may be used to distinguish among problematic sexual behaviours exhibited by individuals with developmental delay. The results of sex-specific assessment will help determine the most appropriate intervention or treatment for problematic sexual behaviours. These interventions could range from providing adequate privacy to sex offender-specific treatment.

Literature Review

Few clinical and research studies have focused on developmentally delayed sex offenders. Therefore, information about the characteristics of developmentally delayed sex offenders and their offence behaviour is limited. Mental health professionals are faced with increased demands to treat this population despite the lack of information.

The few available studies suggest that developmentally delayed sex offenders have an overall offence pattern that is similar to non-delayed sex offenders. Furthermore, based on their clinical experience, Murphy and colleagues (1983)[8] report that developmentally delayed sex offenders are likely to hold views that correspond to the acceptance of sexual offending, e.g., hold negative and aggressive attitudes toward women, accept rape myths, and have stereotyped perceptions of women. A few key differences have been noted. Compared to adult non-delayed sex offenders, adult developmentally delayed sex offenders tend to:

- have fewer victims;[9]
- commit fewer "serious" sex offences but more "minor"or "nuisance" offences;[10] and
- have a smaller proportion of female victims – females represent 50% of victims of developmentally delayed sex offenders and 89% of victims of non-delayed sex offenders.[9]

Developmentally delayed sex offenders have also been distinguished from non-delayed offenders in that they:

- display significantly more social skill deficits;[9]
- are sexually naive, lack interpersonal skills and have difficulties interacting with the opposite sex;[10.3]
- have a higher incidence of family psychopathology, psychosocial deprivation, school adjustment and other behavioural problems;[10] and
- have more psychiatric illness and delinquent or criminal behaviour.[10]

In addition, developmentally delayed sex offenders who reoffend tend to have committed many different types of offences in the past and showed a low degree of specificity in terms of offence type, age and sex of victim.[10]

This finding is in marked contrast to the profile of non-delayed sex offenders who show consistency in choice of victim over time. This suggests that opportunity may be an important factor in the sexual offending committed by developmentally delayed persons.

Low IQ individuals who sexually offend may be at greater risk of re-offending than their non-delayed counterparts. Barbaree and Marshall (1988)[11] grouped offenders based on IQ and found that low IQ was associated with more repeat offences and more severe offences. While the finding that low IQ is associated with more severe offences may seem to contradict the previous findings, it should be noted that, in the Barbaree and Marshall study, the low IQ group included developmentally delayed offenders as well as offenders who were too high functioning to be classified as developmentally delayed although their IQ scores were below normal.

Adolescent developmentally delayed sex offenders have also been reported to show an overall pattern similar to that of non-delayed adolescents. However, compared to their non-delayed counterparts, male developmentally delayed adolescents tend to:

- be more likely to show inappropriate, non-assaultive, nuisance sexual behaviour such as voyeurism and exhibitionism;[12]
- offend equally against male and female victims, whereas non-delayed adolescent sex offenders chose primarily female victims;[12] and
- show fewer delinquent behaviours other than sexual offending.[12]

In summary, the research to date concerning the characteristics and behaviours of developmentally delayed sex offenders suggests that developmentally delayed sex offenders display some similarities and differences in comparison to their non-delayed counterparts. However, the conclusions that can be drawn are limited. Clearly, more research in the area is indicated.

Survey Results

A study was conducted in an attempt to obtain a better understanding of developmentally delayed sex offenders, their offences, and the victims of these offences.

Questionnaires were mailed to a wide variety of organizations which provide services to developmentally delayed individuals and/or services to sex offenders. It was requested that questionnaires be completed with respect to clients who were known or suspected to have committed sexually inappropriate or abusive behaviour. Questions were designed to elicit information about the characteristics of these clients, the nature of their inappropriate and/or abusive behaviours, interventions for these behaviours, actions taken by clinical staff, and the characteristics of the victims.

Responding Agencies

Twenty-seven agencies responded, completing questionnaires regarding 85 clients. Questionnaires were received from a cross-section of agencies which included psychiatric facilities, outpatient mental health facilities, correctional facilities, associations for community living, and residential and group home facilities from both rural and urban settings.

Of these agencies, 44% indicated that they had specific policies or procedures for dealing with sexually inappropriate behaviour exhibited by clients. These policies included reporting and management procedures, protocols for treatment referrals and, in some cases, specific treatment guidelines.

The respondents reported that approximately 7 to 33% of the developmentally delayed clients they worked with had demonstrated inappropriate or offensive sexual behaviour.

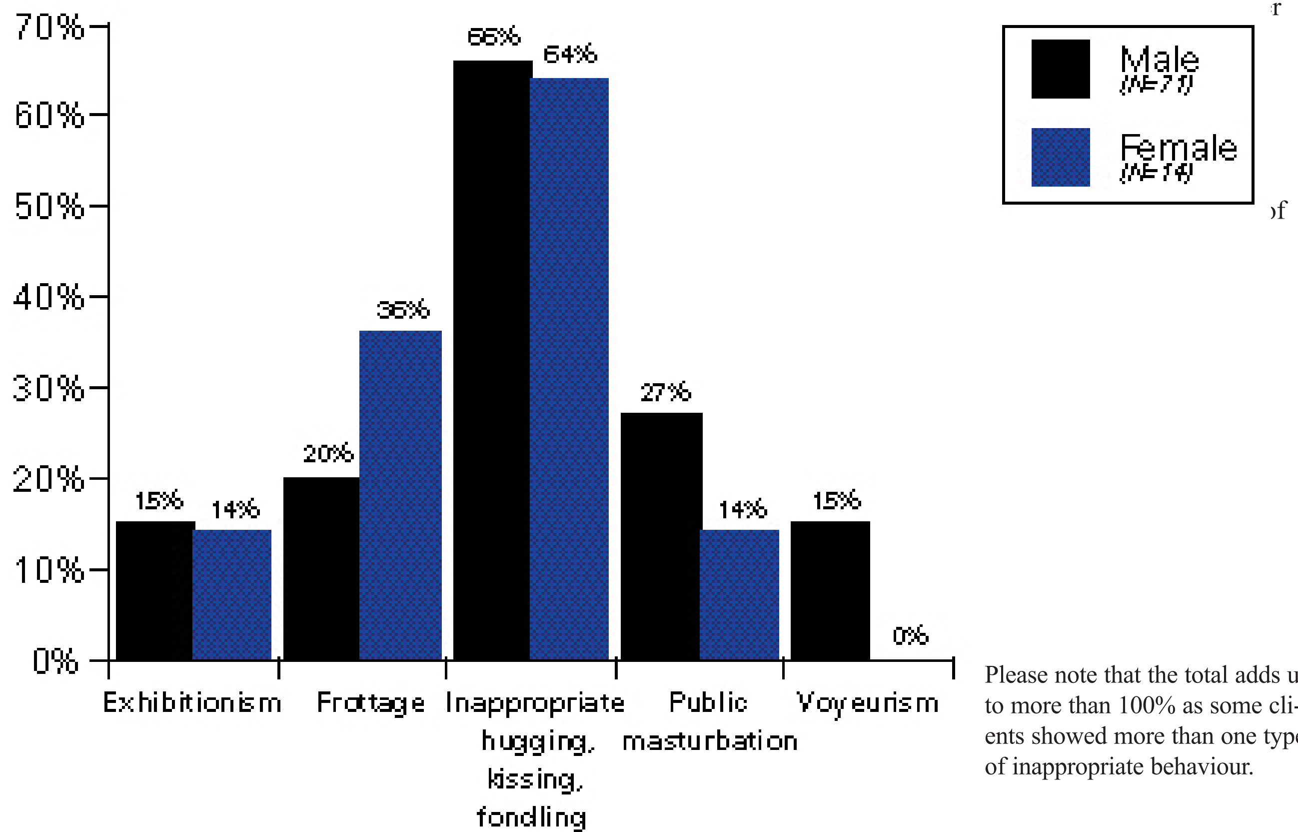
Client Sample

The client sample consisted of 71 (83.5%) males and 14 (16.5%) females ranging in age from 13 to 78 years, the average age being 33.5 years. It is not known how representative of the developmentally delayed population this sample is.

As one would expect, males outnumber females in this sample of perpetrators. However, the number of female prepetrators in our sample is much higher than in the non-delayed population, with official sources suggesting that approximately 1% of sex offenders are female.[13] In some studies of sibling incest, the incidence for female perpetrators increases to approximately 20%.[13] In this survey, however, sibling abuse does not account for the relatively high incidence of female perpetrators.

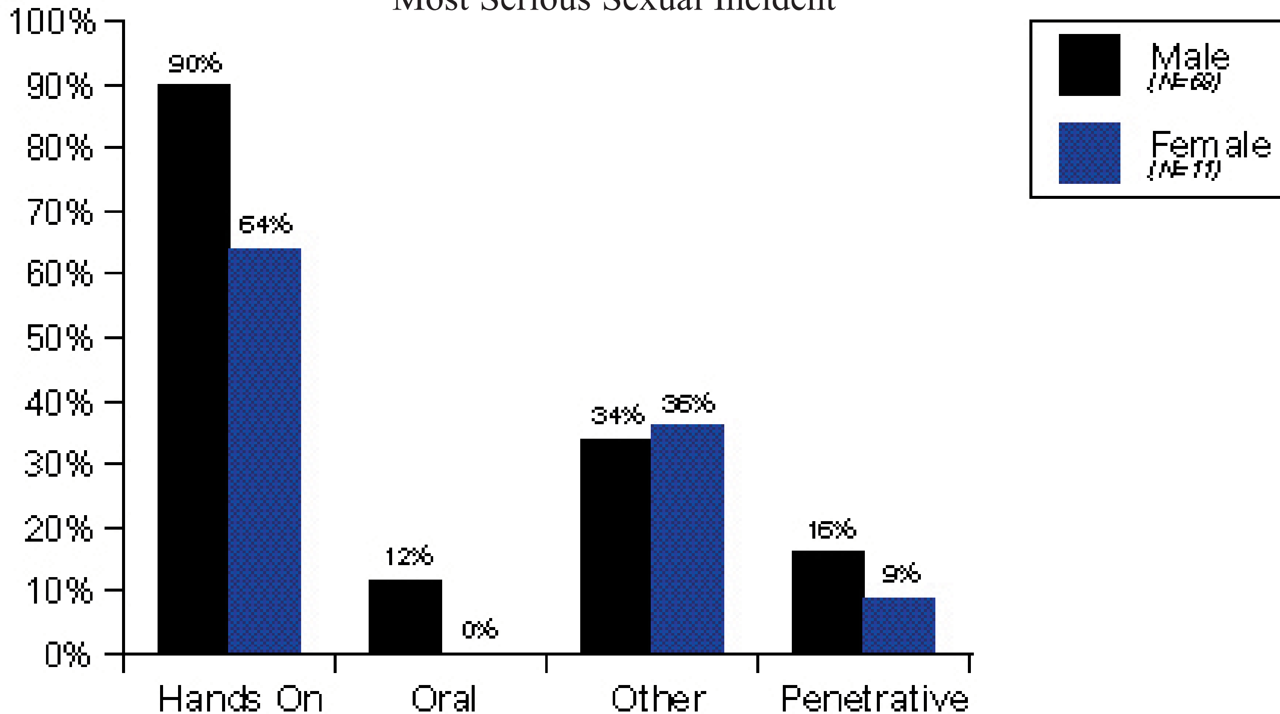
Graph 1

Typical Sexually Inappropriate Behaviour



Please note that the total adds up to more than 100% as some clients showed more than one type of inappropriate behaviour.

Graph 2
Most Serious Sexual Incident



Most Serious Sexual Incident

Respondents were also asked to indicate the most serious sexual incident performed by the client. The incidents were categorized as follows:

- "Hands On" offence (i.e., fondled or grabbed victim's breast or genitalia, masturbated victim, forced victim to masturbate client),
- "Oral" offence (i.e., performed oral sex on victim, forced victim to perform oral sex on client),
- "Penetrative" offence (i.e., attempted or actual vaginal or anal penetration of the victim with penis, finger or object), and
- "Other" offences.

While all clients in the study were reported to have had sexually inappropriate behaviours, not all clients had a sexual incident which was classified as serious. Eleven females and sixty-eight males were reported to have committed a serious sexual incident. See Graph 2.

Both females and males were involved in a considerably high rate of "hands on" offences, with the rate for males being somewhat higher than for females. Although both females and males were engaged in comparable levels of "other" behaviour, this behaviour differed depending on the gender of the person.

For females the behaviours in the "other" category involved stalking and soliciting behaviours, while for males these behaviours involved public masturbation and exhibitionism.

In terms of involvement in more than one type of serious sexual incident, only one female engaged in more than one type of serious sexually offensive behaviour. It is interesting to note that this client had the only incident of penetration for a female in the study. Ten males (14%) engaged in more than one type of serious sexual behaviour.

Action was taken with respect to many of the serious sexual incidents. In almost half of the cases (44%) the incident was reported to the police. In 11.8% of the cases a report was made to a child welfare agency. Charges were laid in 34% of these reported incidents. In most cases the respondents indicated they were not aware of the outcome of the charges. This finding seems to speak to the need for increased communication between the justice system and community agencies.

Reasons for not filing charges included: it was not considered a crime (35%), the victim was too young to give evidence (5%), the victim refused to give evidence and/or the parents did not wish to pursue charges (15%), the client denied, and there was no other evidence (10%).

In the cases in which a serious sexual incident is not considered a crime, as discussed previously, concerns arise about the reluctance of many service providers to acknowledge the sexually abusive behaviour of developmentally delayed persons as criminal.

At the time of the most serious incident, the majority of perpetrators (80%) were living in community settings. Thirty three percent of these perpetrators were living with family or in their own homes, while 47% were in group homes or foster care.

Characteristics of the Victims

Of the serious sexual incidents, 85% involved victims. Approximately 1/3 of the victims were male, while 2/3 were female. In this study only 1.4% of the perpetrators had both male and female victims.

In the majority of these incidents (75%) the victim was known to the client, and in approximately 5% of the incidents the victim was a sibling of the perpetrator. Respondents reported that approximately 50% of the victims were also developmentally delayed.

There did not appear to be a relationship between the age of the victim and the age of the perpetrator. The ages of the victims seemed to be spread evenly across age ranges, with the exception that there were very few victims below the age of 5 years.

Characteristics of the Client Sample

Intellectual Functioning

The functioning level of the majority of the clients in the study was reported to be in the mild to moderate range of developmental delay, with the range as follows: low/average (5.9%), borderline (18.8%), mild (34.1%), moderate (32.9%) and severe/profound (5.9%).

Sexual Knowledge

The majority of our sample was rated as having limited sexual knowledge. Only 10% were seen as being well-informed about sexual matters, 44% seemed to have a moderate level of correct sex information, 19% had little correct information, while 27% were rated as being not well informed.

In order to assist developmentally delayed persons to be more informed and in charge of their own sexuality, a greater emphasis on sexual education is needed.

Impulse Control

Respondents were asked to rate their clients on a scale from 1 to 10 in terms of how capable the clients were of controlling their sexual behaviours. Respondents indicated that, with supervision, 7.06 was the mean score for their clients while, without supervision, 3.81 was the mean score for clients. This difference was highly significant ($T=11.744, df=78, p<.000$).

Respondents suggested that, with supervision, their clients have a considerable degree of control over their sexual behaviour but that, without supervision, the degree of control was considerably less.

There was no relationship between clients' level of functioning and the perceived degree of control over sexual behaviour with or without supervision.

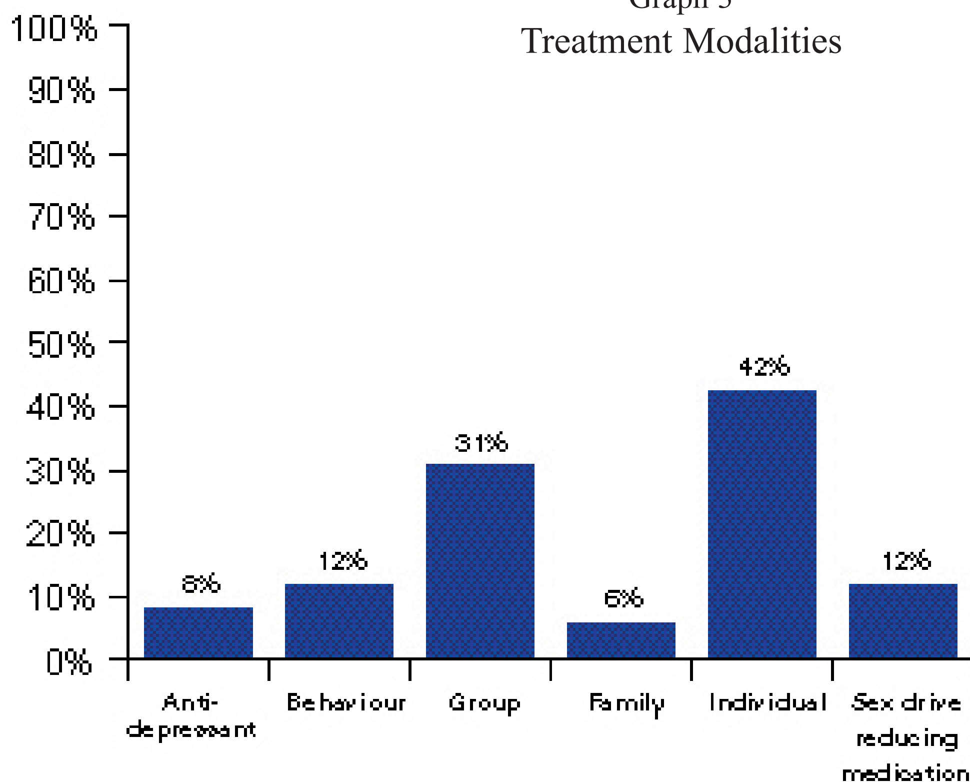
Employment

Approximately half of our client sample (48%) were unemployed, while 24% were in the work force and 26% were in school.

Abuse History

The questionnaire included items to explore the relationship between the clients' abuse history and their inappropriate and/or abusive behaviour. In most cases, however, respondents did not complete the relevant sections. Unfortunately this leaves many unanswered questions related to the vulnerability of these clients and perhaps about the willingness and/or comfort level of service providers to explore these issues with developmentally delayed individuals.

Graph 3
Treatment Modalities



Substance Use

Roughly one-fifth (17.6%) of the sample used alcohol; 4.7% used other drugs. Alcohol and drugs played an instrumental role in the commission of the sexual incidences in 3.5% and 1.2% of the total incidents, respectively. This finding would suggest that substance abuse is a less important factor in the commission of sexual offences for developmentally delayed individuals than for non-delayed offenders.[14]

Treatment Modalities

Treatment for sexually inappropriate or abusive behaviour was reported to have been received by 60% of our sample. Fifty-seven percent of females and 63% of males received treatment. While clients were referred to treatment to address their sexually inappropriate or offensive behaviour, it was not clear if the treatment interventions were tailored to deal specifically with the sexual behaviours. This high treatment response rate was in marked contrast to the information obtained from our community consultation process which indicated that treatment services were very limited.

The relatively high number of clients receiving treatment may, in part, reflect that the agencies who participated in our survey did so because they are already very interested and involved in the treatment of these clients.

Sixty-three percent of the clients who received treatment were involved in more than one type of treatment, with combinations of individual, group, behavioural interventions and medication.

When a client was involved in only one type of treatment it was most often individual (47%) or group therapy (32%). For 16% of the clients, medication was the only type of treatment received.

Both females and males were found to participate in a variety of treatment approaches, ranging from individual to pharmacological. Only one female was on medication (an antidepressant) and this was in combination with another type of treatment. See Graph 3.

Summary of Results

In summary, the results of this survey suggest that the typical developmentally delayed client who was involved in sexually inappropriate or abusive behaviour was in his or her early thirties, was functioning in the mild to moderate range of intellectual ability and was living in the community.

While the police may have been contacted following the sexual incident, it is likely that charges were not filed. A considerable number of the perpetrators were involved in some type of treatment to address the sexually inappropriate or offending behaviour. The victims of their offences were likely to be female and known to them. Many of the victims were also developmentally delayed.

The findings of this study, with respect to female clients, were particularly interesting, although the numbers were very small, making any conclusions premature. These findings do, however, warrant further discussion and research. To our knowledge there is
no literature on developmentally delayed females who are sexual perpetrators. There is a small body of preliminary research on non-delayed female perpetrators. The research is still at a descriptive level without the comparative data to help determine how women who perpetrate offences differ from women
who do not sexually abuse others.[15]

A recent study examined gender issues in relation to diagnosis and treatment outcomes for persons with developmental delay who were treated at a Special Needs Clinic.[16] It is interesting to note that in all the problems presented at this clinic there was not one mention of sexually inappropriate or abusive behaviour for women. This finding only reiterates the great need for further investigation of these gender differences.

Clinical Practice Guidelines

Introduction

The following guidelines are based on the clinical consensus of the members of the Clinical Practice subcommittee. They are intended to assist practitioners in the assessment, treatment and support of developmentally delayed
sex offenders. It is important to note, however, that these guidelines have not yet been validated by research on treatment outcome.

Individuals with developmental delay, like other members of the community, have a right to healthy sexuality. With this right, however, comes responsibility.

This responsibility includes recognition that:

- sexual behaviour with another person must be consensual;
- sexual behaviour must not be harmful to the other person; and
- sexual behaviour must respect community standards regarding privacy.

It is the responsibility of families, caregivers and service providers to support a developmentally delayed person's right to a healthy sexuality.

Developmentally delayed individuals who act in a sexual way toward persons who have not consented or who cannot provide consent, have broken the law. They are considered to be sexual offenders and, as such, require sex offender-specific assessment, treatment and long-term support to change their behaviours and to protect others in the community.

Methods of working with developmentally delayed
sex offenders are based on those developed for non-delayed sex offenders, and are adapted for use with developmentally delayed persons. Assessment, treatment and long-term follow-up should be carried out by professionals with expertise in working with sex offenders and developmentally delayed persons.

The primary goals of treatment are:

- to minimize the risk to the community;
- to facilitate the offender's control over his or her sexual impulses and reduce his or her sexual offending behaviours;
- to facilitate the offender's development of appropriate social skills, including sexual expression; and
- to reintegrate the offender into the community to enjoy a lifestyle that is as independent as practical given the limits of his or her developmental delay.

Principles and Guidelines for Working with Individuals with Developmental Delay who have Committed Sexual Offences[17]

I. Minimizing Risk

All interventions with individuals who have committed sexual offences should be viewed as a means of ensuring community safety. The safety of potential victims should always be the first consideration in decision making. We believe that minimizing the risk of reoffence is also in the best interest of the developmentally delayed offender. Appropriate assessment, management and support for developmentally delayed sex offenders serves both the community and the offender.

a) Policies and procedures should be in place to ensure the safety of the offender, the staff working with the offender, and others, both in the setting and in the community.

b) Removal of an offender from a home in which children are at risk is the recommended action. In balancing the needs of the offender against the safety of the children, the safety of the children is always paramount.

c) Clear communication should be established between the offender's treatment team and his or her residential staff so that supervision and monitoring of the individual is commensurate with the assessed level of risk to reoffend.

d) It is crucial that an effective plan to prevent relapse and reoffence is developed for each individual who has committed a sexual offence.

e) The inclusion of a victim of a sexual offence in the offender's treatment should only be considered if steps are taken to ensure the safety of the victim. The risk of physical or emotional trauma for the victim should outweigh any potential therapeutic benefits to the individual who committed a sexual offence.

f) Program planning and treatment decisions that appear to address the needs of an offender but, in fact, increase his or her risk of a reoffence are not in the offender's best interest. For example, some employment or volunteer opportunities may be unwise (e.g., working unsupervised with children).

g) It may be necessary for a clinician to refuse to treat an offender if supports and supervision which are essential to providing the appropriate safeguards and ensuring community safety do not exist.

II. Recognizing the Vulnerability of Individuals with Developmental Delay

When working with individuals with developmental delay who have committed a sexual offence, it is necessary to recognize their vulnerabilities.

a) To deny that offenders with developmental delay have, in fact, committed sexual offences contributes to the risk of reoffence and undermines the offender's right to assistance in developing appropriate sexuality. Denial and minimization of the sexual offence by the offender, his/her service providers, or society should always be challenged.

b) Integrating individuals who are developmentally delayed with non-delayed sexual offenders, without specific safeguards, may place developmentally delayed individuals at risk of victimization.

c) Individuals with developmental delay may be more vulnerable to the negative impacts of labelling than are non-delayed persons.

- They may be more likely to be labelled "sex offender" without being convicted of a criminal offence.
- They are less able to repudiate the label when it has been applied to them.
- The label may have a greater impact on their lives because of their reliance on support services (e.g., residential and vocational services) that require disclosure of past offence history.

d) The sexual offences committed by some individuals with developmental delay may be understood as resulting, at least in part, from living in settings in which opportunities for learning about healthy relationships and for sexual expression are unavailable. Although these factors in no way excuse their behaviour, recognition of them through careful assessment can assist in determining the most appropriate intervention plan.

e) Service providers should be aware of the difficulties with communication and comprehension experienced by individuals with developmental delay. For example, an individual with developmental delay might admit that he or she sexually assaulted someone but see no contradiction in describing the contact as accidental. Similarly, some developmentally delayed individuals may confuse their thoughts with their actions, and report sexual fantasies as if they had actually occurred.

f) Individuals with developmental delay may show increased compliance with persons in authority in an attempt to please them. Therefore, these individuals may be vulnerable to undue influence during an investigative process and in providing informed consent to treatment.

III. Informed Consent

Legally individuals with developmental delay who have sexually offended must be given the opportunity to exercise their right to make a voluntary and informed decision to participate in treatment. This process may require the assistance of an advocate or other helping professional.

a) Informed voluntary consent should always be obtained prior to any therapeutic intervention. An individual must be fully informed of the nature of the treatment, the possible risks and benefits of participating in treatment, as well as the alternative options, including no treatment. Individuals with developmental delay have the right to refuse treatment.

b) Due to difficulties with communication and/or comprehension, developmentally delayed persons may require further assistance in order to provide informed consent. Abstract concepts, such as the consequences of accepting or refusing treatment, should be presented in a clear and concrete manner, using simple language. A thorough discussion of the guidelines for assessing an individual's capacity to provide informed consent is provided in Appelbaum & Grisso (1988).[18]

c) When consent is being sought for a particularly intrusive assessment or treatment option, such as phallometric testing (measuring sexual preference via changes in penile circumference), or when it is felt that the individual is overly compliant with the treatment team, an advocate (e.g., family member, adult protection service worker) should be available to discuss the relevant issues with the individual.

d) If the individual is not able to provide informed consent for reasons of age or competence, consent must be obtained from an appropriate substitute decision maker (e.g., parent or guardian).

IV. Assessment

Any comprehensive intervention plan should be based on a broad, sex offender-specific assessment of the developmentally delayed individual. Assessments should be conducted by professionals who are trained to work with developmentally delayed persons and are knowledgeable in the area of sex offender assessment and treatment.

a) In general, assessments should be tailored to the specific cognitive abilities of the offender.

Given the potential language difficulties the assessment should include information from collateral sources such as:

- police
- victim
- witnesses
- offender's family
- caregivers
- other professionals involved.

b) Assessements should not minimize or excuse the offender's responsibility for the offence but attempt to understand the offending behaviour and its implications for treatment.

Thus the assessment should:

- consider the environmental or contextual factors that contribute to, or help maintain, sexually problematic or

offending behaviour, and

- address and acknowledge the offender's own victimization, if applicable.

c) Assessments should facilitate the development of a treatment plan to:

- address risk for reoffence, supervision and possible placement needs of the offender; and
- address clinical and treatment needs of the offender.

More specificly, assessments should include:

a) Offence Description:

- age and relationship to victim
- details of present offence
- past criminal and/or sexually inappropriate behaviour
- deviant sexual interests
- extent of denial, minimization, and cognitive distortions (thinking errors) surrounding the offence(s)

b) Current Functioning:

- social and adaptive skills
- sexual knowledge
- personality
- cognitive and behavioural functioning
- the individual's ability to understand cause and effect relationships
- level of moral reasoning
- degree of responsibility the individual is capable of taking for his/her behaviour

c) Pertinent History:

- developmental history
- family and personal background
- medical, psychological and/or psychiatric history
- educational history
- occupational history
- drug/alcohol use

d) Other:

- sources of support in the community

Related Issues:

a) All psychometric tests used should be specified and their applicability for use with developmentally delayed individuals noted.

b) Assessment techniques such as polygraphic and phallometric testing should be used cautiously with individuals with developmental delay, given the lack of normative data for this group and the invasiveness of these techniques.

c) Permission for the release of pertinent information from all collateral sources should be obtained at the earliest possible time so that necessary psychological, medical and offence information is available for assessment purposes.

d) If the offender does not already have one, a "case manager" should be assigned at the earliest point, to ensure continuity of services for the developmentally delayed offender. The role of the case manager includes the collection and discrimination of relevant information to appropriate parties.

e) Feedback should be provided to all relevant parties in a timely fashion and in a manner that is respectful to the offender.

The ultimate goals for the offender in treatment are:

- to gain control over and eliminate offending behaviour,
- to develop appropriate social skills, including sexual expression, and
- to reintegrate safely into the community.

The immediate goals of treatment are to facilitate the offender's:

- acknowledgement of his or her sexually offending behaviour, and
- demonstration of some commitment to change his or her behaviour.

V. Treatment Methods and Requirements

Treatment methods for developmentally delayed offenders are based on those used in treating non-delayed offenders and are tailored to address the learning needs and special issues facing developmentally delayed individuals. Treatment time frames may need to be extended in order to meet the needs of individuals with developmental delay.

a) Treatment begins by consistently challenging the offender's inaccurate statements and beliefs about his or her offences. This strategy helps offenders confront the seriousness of their actions.

b) Current knowledge suggests that one of the most effective forms of treatment for sex offenders is relapse prevention. In this form of treatment, offenders are assisted in identifying their "cycle of abuse"; that is, the series of life events, thoughts and feelings that have been associated with their offending in the past. Offenders are then taught to intervene in order to break the chain of antecedent events and avoid a potential relapse. This treatment should occur in the context of a systemic approach involving the offender and his or her family and support systems.

c) Treatment programs should recognize and address the particular obstacles in attaining the treatment goals that face an offender with developmental delay, such as:

- lack of opportunity to learn appropriate sexual behaviour through experimentation and trial-and-error at an early age,
- high probability of having been sexually victimized,
- social isolation,
- poor community acceptance of healthy sexual behaviour,
- lack of opportunities for age-appropriate sexuality, and
- difficulty learning complex social rules and norms relating to dating, intimacy and sex.

d) Individuals with developmental delay can benefit from standard treatment groups and cognitively oriented therapeutic approaches when these approaches are adapted to their cognitive strengths and weaknesses. Treatments may be relatively ineffective if they rely on verbal techniques for teaching abstract concepts.

e) The development of appropriate social and sexual skills is a critical step in reducing the offender's risk to reoffend. Education and training should include:

- concrete skill-building techniques relating to social interaction (e.g., how to initiate appropriate social contact and deal with rejection or respond to mutual interest),
- concrete skill-building relating to sexual behaviour (e.g., how to put on a condom), and
- information about sexuality.

f) Structured activities and opportunities to practice basic social-sexual skills may be required to facilitate the offender's development of healthy, responsible sexuality and positive, non-sexual social relationships with peers.

g) The active involvement of the offender's case manager and collateral supports in the development of a treatment plan is essential. Determining treatment goals in a case conference format helps ensure that open communication among all involved parties is maintained.

h) Treatment providers working with sexual offenders must be comfortable talking about sex and sexual offending, and express clear and appropriate beliefs about sexual behaviour.

i) Treatment providers should not work with persons who have committed sexual offences if they have confused or inappropriate beliefs and attitudes about sex and sexual offending, or have a history of criminal or sexually exploitive behaviour.

j) Pharmacological intervention that suppresses sex drive may be an integral part of the treatment of developmentally delayed sex offenders. This intervention should only be used with informed consent and in conjunction with sex offender specific counselling. Relying on pharmacological intervention alone without related counselling raises ethical concerns and may suggest increased risk to reoffend. Any changes to the

prescribed medication regime should be relayed to the treatment team and to others involved.

VI. Using External Consequences and Leverage in Treatment

Internal motivation facilitates treatment, but it is not a prerequisite for entrance into treatment or a guarantee of success. Most non-delayed sex offenders participate in treatment because of their involvement with the courts. Court-ordered treatment may also facilitate the treatment and management of developmentally delayed sex offenders.

a) Criminal investigation, prosecution and court-ordered treatment may serve as effective supports for the treatment and management of developmentally delayed sex offenders.

b) Criminal investigation and court-ordered intervention may serve as effective and concrete consequences for developmentally delayed sex offenders, particularly for those who do not accept or readily understand the connection between their behaviour and involvement in the criminal justice system.

c) Treatment providers should notify the appropriate authority if an offender fails to attend court-mandated treatment. Referral back to the criminal justice system may be warranted if the offender violates the conditions of his or her treatment.

VII. Monitoring Progress

In treatment, progress may be demonstrated by behavioural, cognitive and attitudinal changes such as the offender's acceptance of responsibility for his or her behaviour and the development of an understanding of the consequences his or her actions have for others. These changes have been known to lead to the reduction of an offender's risk to reoffend.

a) In treatment records there should be clear documentation of the offender's progress, or lack thereof.

b) Service providers have an obligation to notify members of the offender's treatment team if the offender does not demonstrate progress in treatment or his or her risk to reoffend is assessed to have increased.

c) Lack of progress may indicate that specific treatment goals or intervention strategies need to be re-evaluated. It may be necessary to explore more intensive intervention at this time.

VIII. Follow Up

Effective treatment should include aftercare in order to increase the likelihood that changes made during treatment will be maintained.

a) Aftercare may be ongoing and the offender should always have an option to return to treatment at any time.

b) Follow-up may be accompanied by a gradual reduction in the level of supervision, if deemed appropriate.

c) The offender's safe reintegration into the community should be gradual and closely monitored.

d) If the offender's level of risk increases in the community, he or she should re-enter more intensive treatment and have increased supervision.

Conclusions

The above guidelines are based on the clinical literature and the clinical knowledge and experience of the subcommittee members. These guidelines can be considered a preliminary step in the standardization of assessment and treatment practices for developmentally delayed sex offenders. Each community, however, may need to modify and adapt these guidelines to meet their particular needs.

Criminal Justice Issues

Introduction

This section reviews the various stages of interaction between developmentally delayed sex offenders and the criminal justice system.

Historically, the criminal justice system has been ill-equipped to address the particular problems posed by individuals with developmental delay. Near the turn of the century, individuals with developmental delay were demonized and believed by some courts to be criminally dangerous.[19]

The criminal justice system has made progress in recognizing and addressing the unique needs of developmentally delayed individuals who find themselves in conflict with the law.

A review of the literature reveals that, in comparison to non-delayed defendants, those with developmental delay:

- confessed and pled guilty more often,
- plea bargained less often,
- were defended by court-appointed counsel more often,
- made fewer appeals, and
- served longer sentences, were denied parole more often and received less time off for good behaviour.[20]

An offender's developmental delay cannot be introduced as a mitigating factor in judicial proceedings unless the individual is identified as such.

Research suggests that developmentally delayed individuals frequently go through the justice system unrecognized. For instance, only 2% of individuals with developmental delay received a pre-trial psychological evaluation that might have identified a delay[21] and, in the US, 38% of states were reported to make no effort to identify criminal defendants who may have been developmentally delayed.[22]

Because of the intellectual and functioning limitations of these defendants, complex issues can arise when individuals with developmental delay enter the criminal justice system. This indicates a need for the criminal justice system to recognize these individuals in order to adequately address their unique needs.

There are some generalizations about developmentally delayed individuals that may be particularly cogent with respect to their interactions with the criminal justice system. These include:

- because of limited communication skills, developmentally delayed persons may be predisposed to "biased responding" (answering in the affirmative or negative given the demands of the question) and may acquiesce to leading questions;
- they may be reluctant to disclose that some questions are beyond their ability or knowledge;
- they may have difficulty processing large 'chunks' of information; and
- they may assume blame in an attempt to please the questioner.

Principles

The following discussion is based on these assumptions:

1. Sex offenders, including developmentally delayed sex offenders, who are held accountable for their behaviour and receive appropriate intervention are less likely to re-commit a sexual offence.
2. The criminal justice system serves a significant role in:
   - identifying sex offenders,
   - holding them accountable for their behaviour,
   - directing them to counselling, treatment and support services, and
   - supporting treatment and case management by encouraging compliance and providing treatment motivation.
3. The criminal justice system serves a role in ensuring community safety. Society is best served when the criminal justice system identifies sexual offenders, holds them accountable for their behaviour and assigns them to services and treatments that meet their needs. Community safety takes precedence over all other interests.
4. It is in the best interest of a developmentally delayed sexual offender to be identified, be held accountable for his or her behaviour and receive appropriate assessment, treatment and support.

In general, sex offender treatment is a difficult process that requires the support of many systems, one of which is the legal system. The majority of non-developmentally delayed people who participate in sex offender treatment do so because of their involvement with the criminal justice system. It is equally important that the justice system provides the same support to developmentally delayed sex offenders.

Decision Points

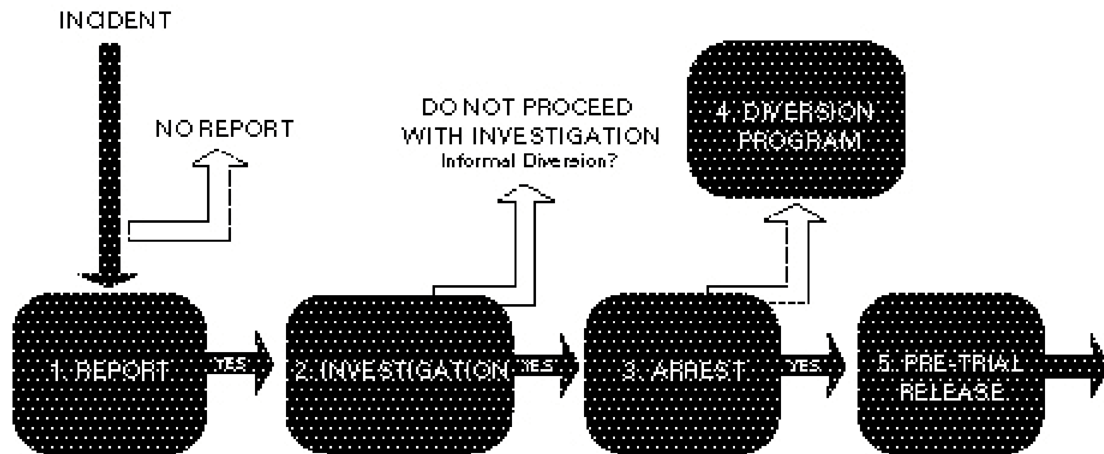
Decisions that determine the specific path an offender will follow are made at various points in this process. These decision points are common to the overall justice system and are not unique to the experience of developmentally delayed persons. The following is a presentation of the decision points within the criminal justice system
and a discussion of each decision with respect to developmentally delayed sex offenders.

Reporting:

The first decision point in this process involves whether to report a developmentally delayed individual suspected (or known) to have committed a sexual offence.

Mandatory Reporting

When an abusive incident is reported, the criminal justice system protects society from further harmful acts and sets
out consequences for the offender. Provincial and territorial* reporting statutes entrust all persons who believe on reasonable grounds that a child is, may, or has been sexually abused, to report their suspicions to an agency designated by the region's Minister in charge of protective services, e.g., Children's Aid Society. In most jurisdictions, reports are received by social workers on duty at a Children's Aid Society or in a protection office. If an individual is unsure of their responsibilities to report, they can obtain clarification without identifying the persons involved.



* In the Yukon, it is not an offence to fail to report but those who report in good faith are entitled to civil immunity.

Decision Point #1

To Report or Not to Report

Ethical Dilemmas related to reporting:

Within the context of working with developmentally delayed individuals, service providers may have to make decisions that entail a tension between protecting their clients' rights to confidentiality and
the need to report suspected child abuse. Clinicians may fear that reporting would affect the therapeutic alliance.

If the incident is reported to the proper authorities, the criminal justice system may serve as a means of holding the individual accountable for his or her behaviour and linking him or her with the appropriate intervention. As lack of reporting may dramatically hinder (or preclude) appropriate evaluation and treatment of these individuals, it is crucial that all types of sexual offences are reported.

Decision not to report incident:

Some jurisdictions specify penalties for failing to report a sexual offence. This could apply to members of the general population as well as professionals and officials. For professionals regulated by professional governing organizations, penalties including fines,
and disciplinary measures may be issued if abuse is not reported.

Recommendation:

All agencies and organizations that serve developmentally delayed individuals should become thoroughly familiar with the regulations and actual steps involved in reporting abusive incidents
according to the statutes. Policies and procedural guidelines should reflect the jurisdictional requirements.

Introducing a developmentally delayed sex offender into the criminal justice system may enhance treatment participation and compliance. Thus, if the behaviour is not reported, there are no consequences and the offensive behaviour could escalate.

● INVESTIGATION:

Police investigations follow specific procedures determined by local, provincial or territorial practices. When an incident of child sexual abuse is investigated, it is most often conducted in collaboration with child protection personnel.

The purpose of a police investigation is to gather information regarding the occurrence of an offence,
the circumstances surrounding it, and the likely perpetrator. The police have a responsibility to obtain as much information about the incident as possible. This may include soliciting information from the

Flow Chart of Decision Points in the Criminal Justice System

Please note that this diagram is based on the Ontario Criminal Justice System and may differ in other provinces.

victim, witnesses and the accused. If the accused is identified as being developmentally delayed, then this process may benefit from consultation with the accused's family members, support agencies and/or mental health care professionals.

Investigating police officers have some discretion to determine whether the investigation proceeds from an exploratory field investigation to a more intense investigation. A police investigation, for instance, may determine that the sexual incident in question could be best described as simply inappropriate in the social context and, therefore, not proceed to the next stage of investigation.

The following are two examples which illustrate this point. The first is an incident in which a developmentally delayed individual was charged with multiple sexual offences related to exposing himself to children in a park on a number of occasions. Upon closer examination of the circumstances of this case, it was revealed that the accused's daily routine included being picked up by a group home worker at a park near the end of the day. The accused, unable to wait until he arrived home, would relieve himself by urinating in the park as he awaited his ride. Instead of proceeding to a more intense investigation leading to the arrest of the accused, the best plan of action might have involved a referral to an appropriate agency where the behaviour may have been assessed and an intervention plan formulated. It is important to note, however, that not all sexual behaviours manifested by developmentally delayed individuals are as benign as this.

The second example describes a situation in which the police did not investigate a more serious incident perpetrated by an individual with developmental delay. The developmentally delayed individual was reported to the police after seriously physically assaulting a family member on numerous occasions. Upon the investigator's recognition that the suspect was developmentally delayed, the investigation was halted. Consequently, this abusive individual was not held legally accountable and did not receive the consequences for his or her actions.

The above examples illustrate the need for law enforcement personnel to understand developmentally delayed individuals. Consequences and interventions are important for individuals who exhibit abusive behaviour. A law enforcement official may be one of the first decision-makers who can help link these individuals with appropriate assessment and intervention.

Decision Point #2

To Proceed with Investigation or
Not to Proceed with Investigation

Decision to Proceed with Investigation:

Law enforcement personnel have partial discretion in deciding whether or not to proceed with an investigation. A suspect's developmental delay should have no direct bearing on this decision. A decision to proceed with the investigation of a sexual offence perpetrated by a developmentally delayed individual introduces the suspect into the criminal justice system where they may be held accountable for his or her actions. A complete investigation should examine the environmental circumstances surrounding the incident.

Decision not to Proceed with Investigation:

A decision not to proceed with the investigation based solely on the knowledge that the suspect is developmentally delayed fails to hold the individual accountable for his or her behaviour. In addition, the individual is not identified as a sex offender and may not gain access to necessary assessment and treatment resources. Consequently, community safety could be compromised.

Recommendation:

Special training dealing with the following issues could be provided to police personnel:

- recognition of the indicators of developmental delay,
- effective communication strategies for dealing with developmentally delayed individuals,
- misconceptions about persons with developmental delay, and
- accessibility of community resources and family supports for individuals with developmental delay that may aid in investigations.

Recommendation:

Wallet-sized cards could be developed for law enforcement personnel, listing important information on the recognition of individuals with developmental delay, strategies for effective communication, and a phone number of an agency that can provide assistance in dealing with individuals with evelopmental delay.

Recommendation:

Collateral information on the individual's level of functioning and other pertinent background information from various sources should be available to the investigators with consent.

OTHER ISSUES:

Inculpatory Statements

Courts have long recognized that inculpatory statements (such as confessions) made by developmentally delayed individuals may be somewhat suspect. Individuals with developmental delay, as a group, may be more suggestible and predisposed to biased responding.[23] Questions that require yes/no responses may be particularly vulnerable to these response biases. Research has shown, for instance, that developmentally delayed individuals are more likely to answer such questions in the affirmative, even if the question posed does not make sense.

Inculpatory statements must be made voluntarily; the judge can and may rule inculpatory statements to be inadmissible if the judge has reasonable doubt as to whether the statements were made freely or voluntary and represented the operating mind of the accused. The judge will determine whether the accused can, of his or her free will, make a statement that unequivocally represents his or her rational view of what took place, fully appreciating his or her legal predicament and the consequences of providing such a statement.[24]

As a consequence of these court decisions, the police must consider the circumstances that might lead to a false confession. An inculpatory statement may be inadmissible in court if it can be shown that circumstances exist that made it reasonable to infer that the accused did not understand or appreciate his or her rights under Section 10(b) of the Canadian Charter of Rights and Freedoms "to retain and instruct counsel without delay and to be informed of that right." Individuals with developmental delay may have particular difficulty understanding their rights. A study in the U.S. has shown that juveniles less than 14 years of age and individuals with an IQ less than 80 are likely to have poor comprehension of the meaning of their rights.[25]

In Canada, it has been ruled that the duty of the police to inform the detainee of his or her right to counsel includes the duty to explain this right in a manner in which the detainee can understand. However, where "there is a positive indication that the accused does not understand his or her right to counsel, the police cannot rely on their mechanical recitation of the right to the accused; they must take steps to facilitate that understanding" (R. V. Evans).[26] Therefore the police have an obligation not only to inform a developmentally delayed accused of his or her rights but also to ensure that the accused understands these rights.

Recommendation:

The police should receive specialized training about informing developmentally delayed suspects of their Charter rights and determining if they understand these rights. A protocol should be developed, to be followed in the event that the individual does not understand their rights.

Arrest:

The purposes of arresting a sex offender include:

- the protection of the community,
- the demonstration that sexually offensive behaviour is unacceptable, and
- the documentation that a sexual offence has occurred.

Police officers have some discretionary decision-making power with respect to charging an individual with a crime, although established protocols must be followed. For instance, police may choose not to charge an individual if charging that individual would not be to the betterment of the victim or the accused.

Decision to Arrest:

Decision Point #3

To Arrest or Not to Arrest

If appropriate and sufficient evidence that implicates the suspect in the commission of a sexual offence is obtained, the decision to arrest provides legal accountability and responsibility for the suspect's actions. Experiencing the consequences of his or her actions may be particularly important for developmentally delayed suspects who may not always receive consequences for their actions. Furthermore, the documentation of a sexual offence charge may be critical in order to obtain the necessary sex offender-specific assessment, treatment and support. In addition, arrest may address the denial and minimization issues that may be displayed by the offender, the offender's family, and supporting agencies or organizations.

Decision not to Arrest:

The decision not to arrest a developmentally delayed individual may be made even though there may be sufficient evidence that an offence occurred. Failure to arrest does not provide a process for offenders to accept responsibility for their

behaviour and may reinforce developmentally delayed offenders' perceived notion that their behaviour is excused because of their disability and that they will suffer no consequences as a result of it.

Recommendation:

The purpose of the arrest, the seriousness of the offender's behaviour or the impact of this offence on the victim and the community do not differ because the offender is developmentally delayed. Thus, if appropriate and sufficient evidence exists implicating the suspect, it is recommended that the suspect be arrested.

Diversion Programs:

Diversions are typically pre-trial procedures where crown counsel uses his or her discretion not to prosecute the charges against the person. Instead, the accused is referred to a mental health professional, service or hospital for treatment. Usually the criminal proceedings against the suspect are stayed. 'Diversion agreements' call for good ommunication and cooperation between the crown and defence counsel as well as adequate community support services and treatment options.

The criteria for a diversion are:

- the crown must be satisfied that there is a reasonable prospect of conviction,
- it is not contrary to public safety,
- discretion is used if the offender has prior criminal record or prior diversion, and
- diversion is not applicable for an offence that includes a weapon or violence (Class 1 and 2 offences can be diverted, but usually Class 3 offences cannot)

  Class 1 (theft under, joyriding)
  Class 2 (uttering threats, break and enter, theft, forgery)
  Class 3 (sexual assault, murder, robbery).[27]

The Crown Policy Manual[27] states that a diversion program is an appropriate response for mentally disordered offenders who may find themselves in conflict with the criminal justice system primarily because of their mental disorder.

Decision Point #4

To Divert or Not to Divert

Decision to Divert:

A diversion program can convey the concern of the courts in the absence of prosecution and incarceration. In addition, a diversionary program may provide a means of linking a developmentally delayed sex offender with rehabilitative services. There appear to be very few diversionary programs suitable for developmentally delayed individuals. This is unfortunate, given that these individuals may not be well served by incarceration where they are often victimized and where their rehabilitative needs are often not addressed.

Decision not to Divert:

Developmentally delayed individuals who commit a violent sexual offence, like their non-delayed counterparts, are not likely eligible for a diversionary program.

Recommendation:

Communities should work closely with the judicial system to ensure that appropriate diversionary programs are available to developmentally delayed individuals.

Recommendation:

The minimum requirement for allowing a developmentally delayed sex offender to be diverted from the criminal justice system should be the individual's admission of guilt and their willingness to participate in sex offender-specific treatment.

Participation in the diversionary program should be closely monitored and failure to comply with treatment should result in prosecution.

Recommendation:

A protocol for assessing the suitability of developmentally delayed sex offenders for diversion programs should be developed and implemented.

Judicial Interim Release (Pre-Trial Release):

Accused persons who are not a danger to the public and can provide assurance of their attendance at trial, are typically not detained in custody. For most offences, the accused is brought before a Justice of the Peace for a judicial interim release hearing.

Decision Point #5

To Release or Not to Release

Decision to Release:

The Criminal Code sets out the criteria governing pre-trail release. If the developmentally delayed individuals do not pose a danger to the community and that their attendance at the trial is ensured, then it seems reasonable that they should be released before the trial.

Decision not to Release:

If the developmentally delayed suspect poses a direct threat to the community or their attendance cannot be ensured, then they should not be granted pre-trial release.

Fitness to Stand Trial:

The concept of fitness to stand trial was born out of concern that the mentally ill or disabled accused may not have requisite mental capacity to participate in their trial and resultant convictions may be unfair. An accused must be aware of, and able to participate in, the court proceedings. The Criminal Code of Canada Sections 672.22 to 672.33 codified the law with respect to fitness to stand trial: "An accused is presumed fit to stand trial unless the court is satisfied on the balance of probabilities that the accused is unfit to stand trial".

Section 2 defines unfit as "…unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so and, in particular, unable on account of mental disorder to

a) understand the nature or object of proceedings
b) understand the consequences of proceedings
c) communicate with counsel".

At present, individuals suspected of being unfit may be ordered to undergo an assessment to determine their fitness for trial. The Criminal Code does not specifically outline the procedural guidelines for a fitness assessment. The accused is required only to have minimal knowledge of the judicial process and is not required to demonstrate an ability to act in his or her best interest.

In Canada, assessment to determine an accused's fitness to stand trial must be conducted by a medical practitioner.

Many developmentally delayed individuals are fit to stand trial; that is, they have the requisite minimal knowledge of the judicial process and/or are able to instruct counsel to act on their behalf. But, given the range of cognitive abilities of developmentally delayed persons, there would also be some individuals who could not do these tasks. It is unclear, however, if these accused persons with developmental delay would be identified as such in the court process and assessed for fitness to stand trial.

Accused found Fit:

If the accused is found fit to stand trial, the accused continues through the criminal justice system.

Decision Point #6

Found Fit to Stand Trial or
Not Fit to Stand Trial

Accused found Unfit:

Where the accused is found to be unfit to stand trial, the court or the Review Board will make a disposition for the accused in accordance with the criteria set out in the Criminal Code. The court or Review Board must consider the mental condition of the accused, the need to protect the public from dangerous persons, the reintegration of the accused into society and the other needs of the accused and make one of two possible dispositions that is the least onerous and least restrictive to the accused. The court or Review Board will generally order a conditional discharge [that is a discharge with conditions – for example to attend at their doctor regularly to live in a particular facility or community]. Where the accused is a significant threat to the safety of the public, the disposition will generally be that the accused be detained in custody in a hospital.

Upon finding an accused unfit, the court may, instead of making a disposition, order that the accused receive treatment. The court must be satisfied that the proposed treatment will likely make the accused fit to stand trial. The period of treatment cannot exceed 60 days. At the end of the treatment period, the court will again determine whether the accused is fit.

Where there is a change in the unfit accused's mental condition, the accused can apply to the court to have the issue of fitness determined. In addition, every two years the court must hold an inquiry to determine if sufficient evidence exists to put the accused on trial. If the Crown fails to satisfy the court that such evidence exists, the court will direct that an acquittal be entered.

An unfit accused must be represented by counsel. Where the accused does not have counsel, the court will appoint counsel to ensure the unfit accused's interests are protected.

Recommendation:

The requirement that the fitness assessment be performed by a medical practitioner should be re-examined. Ideally this evaluation should be conducted by a qualified professional (such as psychologist, social worker or nurse) with experience in working with developmentally delayed clients.

Recommendation:

Court officials, including judges and lawyers, should receive training on identification of individuals with developmental delay. This may help ensure that developmentally delayed individuals are identified and their particular needs addressed.

Recommendation:

Many developmentally delayed individuals may be very anxious and overwhelmed by the legal process. These emotions may interfere with their ability to understand and communicate about this process.

In some cases where a developmentally delayed accused is determined unfit to stand trial, it may be that a simple and concrete explanation of the court process, provided in a relaxed atmosphere by someone familiar with the accused, could assist that person in becoming fit to stand trial.

Plea Bargaining:

The Crown and counsel for the accused may reach a plea agreement in some circumstances and following careful consideration, and the accused will plead guilty to a lesser or included offence. In general, research has shown that defendants with developmental delay are less likely to be offered and/or accept plea bargains.[20]

Decision Point #7

To Plea Bargain or Not to Plea Bargain

Decision to Plea Bargain:

A successful plea bargain decreases an accused's incarceration time. In some instances, a sex offender may plead guilty to a lesser non-sexual assault or property crime. Such a plea bargain agreement may be conceptually confusing for a developmentally delayed person who has sexually offended. This type of plea bargain agreement may reinforce the denial or minimization of the nature and extent of the sexual offence for the accused, the accused's family and/or supporting agency or organization.

Decision not to Plea Bargain:

The decision not to offer or accept a plea bargain may result in the accused serving a longer sentence than if a plea bargain were negotiated. However, the accused will be identified as a sex offender congruent with his or her offending behaviour and may be linked with appropriate rehabilitative services.

Trial:

If the accused is found fit to stand trial, a trial is held to determine whether the accused is guilty or not guilty. If the accused is found guilty, a pre-sentence report may be requested to assist the court in considering whether a non-penal disposition may be imposed appropriately. Typically this report is prepared by a probation officer and provides information about the offender's resources within the community and other relevant information. At this time, a psychological or psychiatric assessment of the offender may also be ordered.

Recommendation:

As noted previously, developmentally delayed accused persons may find the legal process, including the trial, somewhat overwhelming. An informed, supportive approach should be provided in order to decrease their anxiety and to allow them to participate in the trial to the best of their abilities.

Sentencing:

The requirements of the Criminal Code, as well as aggravating and mitigating factors, are taken into consideration when determining sentencing options.

Decision Point #8

Sentencing

Decision for a Sentence of Incarceration:

Imposing a sentence of incarceration may be appropriate if

the developmentally delayed offender poses a danger to the community. As indicated previously, however, the developmentally delayed offender may not always be well served by incarceration. Rehabilitative services appropriate for developmentally delayed offenders are not available in many correctional centres. In addition, research suggests that developmentally delayed individuals in prison are "more likely to be victimized, exploited and injured than other inmates. They are also more likely to be charged with disciplinary violations and…to serve longer sentences." [21]

If an offender is sentenced to incarceration, an assessment of his or her needs, including security needs, is performed. Within the federal system, the specific objectives of the assessment are to:

- collect relevant information on the offender,
- identify and address immediate needs of the offender,
- describe and analyze the offender's behaviour, and
- identify the offender's needs and treatment targets.

In some federal centres the needs of developmentally delayed sex offenders are specifically addressed. For example, in the North Star program[28] at the Regional Health Centre (Pacific) in B.C., a wide variety of assessment and treatment methods are used to specifically address the learning needs of developmentally delayed offenders.

In the Ontario provincial system, a developmentally delayed sex offender may be recommended to the Guelph Assessment and Treatment Unit (GATU) following an initial classification. Offenders may be referred to GATU for a variety of reasons, including the offence type (sexual or arson) and limited cognitive functioning. Upon admission, the offender's needs are determined by an assessment that includes interviews, behavioural observation, review of previous assessments and, if indicated, intellectual, personality and neuropsychological tests. While at GATU, offenders may participate in a number of treatment programs which are specifically tailored to address their cognitive abilities.

Decision for Community Supervision:

If community supervision is chosen, the offender is supervised by probation or parole officers. The probation order may contain conditions of attendance or participation at various community treatment or support services.

There are two conditions under which an offender can be directed to community supervision. In the first instance, an offender found guilty may receive an order of probation in the community for up to three years. In the second instance, an offender may be given an order for probation following the completion of the sentence.

Recommendation:

Special training should be provided for probation and parole officers in issues involving:

- recognition of the indicators of developmental delay,
- effective communication strategies for dealing with developmentally delayed individuals,
- misconceptions about persons with developmental delay, and
- the availability of community or family supports for indivicuals with developmental delay that may aid in community supervision.

Recommendation:

Strategies for ensuring the safety and protection of developmentally delayed sex offenders in correctional facilities should be considered.

Recommendation:

If a developmentally delayed sex offender is sentenced to serve time in a correctional facility, appropriate rehabilitative services should be available upon entry.

Recommendation:

Mechanisms should be in place to ensure a flow of relevant information between probation officers and treatment providers.

Not Criminally Responsible on Account of Mental Disorder (NCR-MD):

It is generally accepted that a person should not be punished if that person is found not to be responsible. Early common law allowed for mentally ill or developmentally delayed individuals who had committed criminal acts to be found not guilty by reason of insanity (NGRI).

The concept of "insanity" has been replaced by "not criminally responsible while suffering from a mental disorder" (NCR-MD). Section 16 of the Criminal Code states:

"No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong."

The Criminal Code defines "mental disorder" as "a disease of the mind" (section 2). This is an imprecise definition and the scope of mental disorders subsumed by this category is unclear. Theoretically, a developmental delay is subsumed within the category of mental disorder. However, a developmental delay is a condition characterized by learning and cognitive limitations, rather than a mental illness/disorder.

Decision Point #9

Not Criminally Responsible on Account of Mental Disorder

Decision for NCR-MD:

If an accused is found not criminally responsible on account of mental disorder, the court or Review Board will make the appropriate disposition in accordance with the criteria set out in s. 672.54 of the Criminal Code. The court or Review Board may make one of three dispositions – absolute discharge, conditional discharge or custody in hospital. The court or Review Board must consider the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and other needs of the accused and then must make the disposition that is the least onerous and least restrictive to the accused. The court or Review Board will generally order detention in hospital only where satisfied that the accused is a significant threat to the safety of the public. The disposition (other than an absolute discharge) is reviewed annually (or in some cases more frequently).

Legislation to cap the outer limits of a disposition has never been proclaimed.

As indicated previously, a developmental delay pertains to learning and cognitive limitations rather than to mental illness. It is not a condition amenable to treatment; hospital detention will not normally change the functioning level of a developmentally delayed person. Although developmentally delayed persons are amenable to treatment to address a variety of problematic behaviours and mental disorders, treatment will not typically change their developmental delay.

Decision against NCR-MD:

If an accused is found guilty and criminally responsible, a sentence is imposed.

Conclusions

The above discussion highlights the many questions raised about developmentally delayed sex offenders within the criminal justice system. There is a need for further exploration and research to clarify issues and provide directions which may better serve the needs of developmentally delayed persons and society.

It is very important that individuals with developmental delay be identified as such early in the justice system process. If not identified, these individuals may be misunderstood, and face many injustices in the system, and their rehabilitative needs may not be addressed.

Training strategies in disabilities and capabilities of individuals with developmental delay should be provided to defence lawyers, crowns, judges, court personnel, probation and parole officers, law enforcement personnel and criminal justice policy makers in order to increase the likelihood that individuals with developmental delay will be identified and treated appropriately within the system. There is need for ongoing collaboration between the criminal justice system and professionals and agencies serving developmentally delayed persons to ensure access to rehabilitative services for these offenders.

In addition, an advisory body with expertise in the special issues and needs of developmentally delayed persons should be established. This body would provide consultation and resource information to judges, crowns, police and defence attorneys.

The Ontario Mental Disorder and Justice Review Project suggests that some courts, judges, justices of the peace, defence counsels and crown attorneys should specialize in dealing with mentally ill accused. We support this initiative and further suggest that there should be specialization which focuses on developmentally delayed individuals as well.

Broad Recommendations

One of the most important issues arising from all committee discussions was the need for early prevention of sexually inappropriate and offending behaviour by developmentally delayed individuals. To this end, we recommend that education programs should be widely available for developmentally delayed persons of all ages to assist them in developing healthy and responsible expressions of sexuality. In addition, service providers, parents, teachers and others need training to identify and intervene in early manifestations of sexually inappropriate or offensive behaviours by individuals with developmental delay.

Sexual offending by individuals with developmental delay is a community problem. The occurrence and investigation of these behaviours, and the apprehension, prosecution and treatment of these individuals fall under the umbrella of many different agencies and organizations, each with its own philosophy and mandate. The ultimate goal should be to develop a common philosophy and approach for addressing this problem. In addition, the roles of the various agencies need to be co-ordinated so that there is a comprehensive continuum of services and care for the developmentally delayed individuals who sexually offend. We hope that the work of this project will make a contribution to this process.

We began this project with a certain degree of enthusiasm, determination and, perhaps, naïveté. We wanted to examine developmentally delayed individuals who had committed sexual offences and their interactions with the mental health and legal systems. As the project evolved we were awed by the scope of this task and the project seemed to get bigger the longer we thought about it. In the end, we believe that the guide we have created is a starting point for a discussion about the needs of developmentally delayed sex offenders. The issues are many and complex and they vary from community to community. It goes without saying that more research is badly needed. In the meantime, we have a responsibility to our clients to be creative and develop options that both maintain their quality of life and ensure the safety of our communities.

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Notes