ADULTS WITH DEVELOPMENTAL DISABILITIES WHO SEXUALLY OFFEND:
A QUALITATIVE EXAMINATION

BY CHARMAYNE DUBÉ

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Abstract

The sexuality of individuals with developmental disabilities has been poorly understood. Myths and negative perceptions about individuals who sexually offend over-shadow mental health and legal systems. Ensuring safety for the greater public while effectively treating behaviour is paramount for both internal and external stakeholders including care-providers, community services and society. While research among men who sexually offend is relatively well developed, the issues for those with a developmental disability have received little attention in the literature. This study explored the experiences of community life for adults with developmental disabilities who have been involved in sexual offending behaviour. Ten semi-structured interviews which focused on the needs and challenges in areas of relationships and living arrangements were completed with participants who attend programs based in a local community agency. Content analysis techniques were used to analyze the data which found that individuals have significant involvement with family, value being productive in the community and have experienced discrimination of culture and disability. Results of the study contribute to the continued development of services to improve overall quality of life for adults with cognitive impairments who sexually offend.

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CHAPTER I: INTRODUCTION

Many myths and misconceptions exist about the nature of sexuality among individuals who have disabilities, which serve to exacerbate the challenges they face. While some individuals with an intellectual disability struggle to develop and maintain a healthy sexual identity, many can and do have satisfying sexual experiences. However, there is a small percentage for whom sexual behaviour becomes problematic for others. Some of these cases are reported to authorities and individuals can become involved in the justice system. Once inside the system, their risk for re-offending becomes a concern, and they require special consideration for assessment and treatment (Schilling & Schinke, 1989; Tudiver, Broekstra, Josselyn, & Barbaree, 2000).

Sensitive assessment protocols and suitable intervention approaches that reduce likelihood of re-offending for individuals with an intellectual disability are needed. Indeed, issues of compromised family involvement, low self-esteem, reduced opportunities to develop and practice appropriate social interactions for relationship building secondary to cognitive disabilities, may have a significant effect on intervention efforts. These factors, in combination with lack of independence and autonomy as a result of reduced privacy in group or institutional settings are primary barriers for acquiring habilitative skills. Therefore, extending intervention principles developed for individuals without cognitive impairments to those with disabilities is challenging.

For intervention to be successful, the needs of clients must be well-understood. However, very little research has focused on the realities of living

outside of institutions in the community, from the individual's perspective. The main questions driving this study are: 1) What are the experiences of community living among individuals with developmental disabilities who have been involved in sexual offending behaviour?

2) What are their needs and challenges in the areas of relationships and living arrangements?

Research Purpose

The purpose of this study was to describe the experiences of community living from the perspectives of men who have borderline to mild intellectual disabilities and who have been involved in sexual offending. Exploring the perspective of younger adults who have resided primarily in the community is a relatively new phenomenon as residential placements have typically involved substantial stays within institutional settings. This shift in policy and practice in the 1980s and 90s changed to the community system becoming responsible for both residential and day treatment programming. As a result, society became exposed to these previously hidden citizens and has had both a direct and indirect impact on people living with a developmental disability. The combination of these systemic effects is what guided this research.

The cohort referred to throughout this document is participants who attend a specifically designed community-based program in Winnipeg for individuals with developmental disabilities who have been involved in these types of offenses.

Definitions

The term "developmental disability" is used interchangeably with the terms "cognitive impairment" and "intellectual disability" throughout this document. The clinical term of "mental retardation" within the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) is defined as "significantly sub average general intellectual functioning" (p. 41). This is typically described by an intelligence quotient (IQ) obtained through an assessment with one or more of the standardized, individually administered intelligence tests such as the Wechsler Adult Intelligence Scale. The four degrees or levels of severity of mental retardation are: 1) mild indicated by an IQ level of 50-55 to approximately 70, 2) moderate indicated by an IQ level of 35-40 to 50-55, 3) severe indicated by an IQ level of 20-25 to 35-40 and, 4) profound indicated by an IQ level below 20 or 25 (American Psychiatric Association, 2000). Despite this term being used to define the presence of a cognitive impairment within the diagnostic manual, this author prefers to not refer to people with developmental disabilities using this description, and therefore substituted the terms with "developmental disability", "cognitive impairment", and "intellectual disability" to describe this group.

A sexual offense is defined within a Canadian guide designed for the specific needs of this cohort and described as "individuals who have committed a sexual act that is against the law" (Tudiver et al., 2000, p. 3). These authors also included the definition to encompass sexual contact with other people without their consent and any adult sexual contact with children. "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" (Tudiver et al., 2000, p. 7). Throughout the study, the terms "sexual offender" and "sex offender" are used interchangeably.

CHAPTER II: REVIEW OF THE LITERATURE

A human ecological framework informs this study. "Human ecology is concerned with interaction and interdependence of humans (as individuals, groups, and societies) with the environment" (Bubolz & Sontag, 1993, p. 421). As evidenced throughout the literature, the history for most adults with developmental disabilities includes institutionalization at a young age, followed by a process of re-integration into community settings. Throughout this author's 20-year career within the field of developmental disabilities, it has been noted that biological family is rarely involved in the direct care of an adult who has a cognitive impairment. Instead, adults who have an intellectual disability often reside in formal care situations with foster families or in group arrangement settings which is consistent with the literature.

Therefore, the term "family" is defined inclusively, to refer to care-providers as well as immediate or more commonly, extended family. Ecological theory acknowledges these variations in definitions with "family" as having an "inclusive sense to be composed not only of persons related by blood, marriage, or adoption, but also sets of interdependent persons who share some common goals, resources, and a commitment to each other over time" (Bubolz & Sontag, 1993, p. 435).

Effects of not being raised within the biological family may extend to not having a sense of belonging, receiving unconditional love or enculturation of family behaviours such as cooperation and development of basic social skills. One possible consequence of not having these basic needs met may be seeking out

these feelings in an inappropriate manner. According to human ecological theory, an "individual becomes progressively more able to interact with more differentiated and complex environments on physical, social, emotional and cognitive levels" (Bubolz & Sontag, 1993, p. 437).

Families are represented by the microsystem in the human ecological model, while other relationships including the home and school are represented within the mesosystem. Exosystem settings include work environments while macrosystem areas pertain to cultural beliefs and values. Larger institutions such as formal care facilities and social setting systems, which play significant roles within peoples' lives who have disabilities, are also incorporated within the macrosystem (Bubolz & Sontag, 1993).

Despite the majority of people with developmental disabilities having limited ongoing contact with their families, many have a sense of 'family' through their immediate or extended biological families, or by adoption, as well as formal and peer supports. Throughout the study, concepts of support for individuals who were involved in sexual offending encompassed the multi-systems and subjective descriptions of their families.

The following sections review the literature relevant to people with developmental disabilities involved in sexually offending behaviour. Concepts of cognitive disability, sexual behavior, and assessment, as well as various intervention approaches for individuals to manage their problematic sexual behavior, are discussed.

Intellectual Disability

Timms and Goreczny (2002) describe an intellectual disability, as "an individual, social, and cultural phenomenon for which there is no foreseeable cure" (p. 1). Prevalence rate is approximated from 1% to 2.5 - 3% (p. 1) of the general population with a male to female ratio of 1.5:1 (Timms & Goreczny, 2002; Tudiver et al., 2000). Socioeconomic class is not related to developmental disability stemming from known biological factors. However, lower socioeconomic status is implicated in cases of intellectual disability related to environmental deprivation. Some studies have reported psychosocial adversity in childhood that considers parental social class and an unstable family background due to changes in care-givers, and abuse and/or neglect largely contributes to mild but not severe cognitive impairments (Holland, Clare, & Mukhopadhyay, 2002).

Inconsistencies are cited as a major drawback within the current body of research as various definitions of intellectual disability are used throughout the literature. Although the term "developmental delay" is recognized by the American Association on Mental Retardation (AAMR), McBrien (2003) found the following classifications to be synonymous when describing a person with an intellectual disability: "learning disability", "mental retardation," "mental impairment," "mental disorder," and "mental handicap." Tudiver et al. (2000) additionally recognized other terms such as "developmentally handicapped," "intellectually challenged" and "mentally retarded." As a result, there is no consensus on the most appropriate term to use when researching or discussing the needs of this specific population.

Variations on criteria to determine what constitutes an intellectual disability are apparent. Measures noted within the literature include substantial functional limitations prior to the age of eighteen, manifested as significantly below average intellect with related disabilities in adaptive skills such as self-care, leisure, communication, basic life and social skills, community exposure, self-direction, personal health and safety, functional academics, and vocational pursuits. Use of one criterion is not sufficient as identification of adaptive functioning in combination with intelligence levels needs to be considered. It is recognized that any two people with identical IQ's may have differences in social skills and basic behavior (Herrington, Hunter, & Harvey, 2005; Holland et al., 2002; Tudiver et al., 2000).

McBrien (2003) indicated that despite broad definitions in the literature, a consistent standard of an intellectual disability is that it is characterized by a significant impairment of intelligence based on an established test. The Wechsler Adult Intelligence Scale (WAIS) is the most recognized instrument used to determine intellectual disability as indicated by an IQ score of 70 or under in addition to impaired adaptive social functioning (American Psychiatric Association, 2000). Classifications of intellectual disability have also utilized alternate methods to measure level of impairment and include the following: receipt of support services, a psychiatric diagnosis, attendance in special education classes, and self reporting of intellectual disability.

Continuum of Sexual Behavior

Within the literature, rates of sexual offending behaviour among individuals with developmental disabilities fall into a broad range. Furthermore, definitions of what constitutes sexual offending vs. sexual type behaviors that are challenging skew frequency reports of sexual offenses committed by people with an intellectual disability. The continuum of sexual behaviors is described within the following sections.

Appropriate Sexual Behavior

Consensual sexual activity is considered appropriate when it happens within the bounds of normative social standards regarding person, place and time. Despite sexuality being acknowledged as an important aspect of each person's life, sexual expression by individuals with an intellectual disability can evoke oppressive and conflicting reactions not only from the general public but also from families, care-providers, staff and professionals directly involved in their lives. These inconsistent attitudes and broad definitions make it extremely difficult to accurately distinguish between normal, inappropriate, challenging, illegal and other problematic sexual behaviors (Tudiver et al., 2000).

When deciding on whether the behavior is 'normal' or 'inappropriate', diligence during the decision making process needs to be ensured as sexual behaviors are socially constructed and may be judged as challenging and/or inappropriate by some but not others. It is imperative to consider how the individual's behavior affects his or her community presence, choices, autonomy, status, respect and/or social participation (Herrington et al., 2005).

Challenging Behavior

Definitions of challenging behavior incorporate acts of self-injury, self-stimulation, physical and verbal aggression, sexually inappropriate behavior, and property destruction. Challenging behavior interferes with acquiring and learning new skills. This behavior can be seen as a maladaptive response to the person's environment and/or lack of basic skills in functional areas of communication, educational attainment and social factors. Even though this definition includes illegal behaviors, responses must be tailored for each specific issue. Indeed, approaches for addressing challenging behavior should be sufficient in all but the most severe situations to address the complex needs of an individual with a developmental disability who has been convicted of a sexual offense (Doyle, 2004).

Tudiver et al., (2000) defined inappropriate sexual behavior as actions that violate ordinary social standards thereby revealing a need for sexual education. Challenging behavior can arise as a result of a segregated, restrictive environment, lack of limit setting, poor social skills, and/or a lack of education regarding appropriate sexual expression due to the way an individual with a developmental disability was educated or raised.

It is of primary importance to determine whether the person intentionally harmed another person. If intent to harm is not present, then the act in question is more accurately described as challenging (Holland et al., 2002; Wheeler & Jenkins, 2004). Behavior should be considered problematic if it is inappropriate considering the person's age, is dangerous, causes stress for other people, creates

an additional handicap for the individual or disregards social norms (Herrington et al., 2005).

When a service provider inaccurately defines sexual behavior as potentially illegal, individuals may be wrongly protected or inappropriately responded to by police and the criminal justice system when they would be better served in the community. On the other hand, under-reporting of illegal behavior exemplifies a need for those working within this field to define what is sexual, what is challenging, and what may be considered illegal about the behavior within the context of social norms. By following a consistent process, data collection on prevalence of sex offending within this population will be more accurate and relevant (Herrington et al., 2005).

Escalation of inappropriate behavior to that which is deemed illegal can occur if it is not addressed in an adequate and direct manner. Transformation of challenging behaviors into offences is dependent on a series of complex decision-making processes including an underlying intent to harm. Therefore, it is vital for families, care-providers, staff and professionals to accurately label, assess and offer interventions that are behaviour specific (Holland et al., 2002; Tudiver et al., 2000; Wheeler & Jenkins, 2004).

Sexual Offending Behavior

"Sexual offenses" and "challenging sexual behaviors" are not synonymous. Sexual offenses, by definition, are illegal behaviors that may also have more serious consequences for the individuals involved. The seriousness of this type of

behavior warrants that protection of society be primary when the expression of sexual behavior is accompanied with a clear intent to harm (Doyle, 2004).

Sexual offenses include acts that are clearly against other people such as rape, incest, molestation, often involving children or others who are vulnerable to sexual advances. Conversely, sexually inappropriate behavior such as public disrobing, exposure and voyeurism, violate societal standards of decency but do not constitute a threat of direct harm to a person. Peeping, stealing underwear, and making obscene phone calls are also included in definitions of this type of offense. These behaviors provide little information regarding the situational context of each action; therefore, further investigation must be considered (Schilling & Schinke; 1989; Tudiver et al., 2000).

Tudiver et al. (2000) additionally proposed illegal behavior not be ignored or minimized. Individuals with intellectual disabilities who offend sexually are accountable for their behavior, thereby acknowledging the need for appropriate assessment, treatment and follow-up. Many service providers and others involved in decision-making do not label sexual behaviors that could be illegal by individuals with intellectual disabilities as offences. This may stem from attempting to minimize the significant negative history of mass institutionalization and assumptions of deviance among people with developmental disabilities and/or potential future negative impacts of having a criminal record when attempting to procure housing and employment.

Intellectual Impairment and Criminality

Long-standing experiences for people with intellectual impairments involve societal ignorance, mistreatment, and massive institutionalization. Individual and collective rights were only recognized after information on negative effects from childhood deprivation and lack of attachment as a result of institutionalization were acknowledged by professionals working within the field (Timms & Goreczny, 2002). A basic assumption of an inherent tendency to be sexually deviant was also considered standard within a definition of cognitive disability.

Presently, ongoing concerns regarding prevalence of illegal behavior among people with developmental disabilities and characteristics of men and women who have had contact with the criminal justice system demonstrate the need to further examine prevalence and recidivism rates based on assumptions of criminality. These misconceptions of a direct link between cognitive disability and criminal behaviour historically led to institutionalization, often justified on the premise of ensuring safety for society from the criminal. As the majority of this population was economically and socially disadvantaged, these men and women were seen as easy targets to place responsibility on for rising crime and moral disarray (Holland et al., 2002).

Recent research conducted by Cantor, Robichaud, Blanchard and Christensen (2005) found adult males who commit sexual offences scored lower in IQ testing than adult males who are nonsexual offenders, thereby linking disturbed cognitive functioning to poor decision making and/or impaired ability to

comprehend consequences. An explanation of why people with developmental disabilities are more often re-arrested can be partially linked to high levels of ongoing supervision or socially visible behaviors. This bias perpetuates unfair treatment throughout the judicial process (Cockram, 2005; Holland et al., 2002).

Sexual Offenses Among Individuals with Developmental Disabilities

There are large variances in prevalence estimates. These differing conclusions stem from a result of negative history, ill-defined concepts of developmental disabilities and offending behavior, and challenges within the administrative systems that oversee disability and criminal justice services. Evidence that individuals with intellectual disabilities who engage in criminal activity have less complex strategies for avoiding detection and are therefore more easily identified in comparison to mainstream offenders is also available (Herrington et al., 2005; McBrien, 2003).

Within one study on developmentally delayed individuals, incidences of sexual offenses were reported to be approximately 5%, with 15% (p. 12) of the individuals having served a prison sentence (Ward et al. 2001). McBrien (2003) found great variance in studies of clients in contact with the criminal justice system, falling in a range of .5% to over 55%, (p. 95) dependent on the type of information asked and from where the sample was taken. As discussed in prevalence rates solely for developmental disability, these differences are again related to the varied methods used to identify cognitive impairment such as self-report, full-scale intelligence tests, school records and contact with intellectual disability service records.

When exploring victim choice, research has shown that men with cognitive disabilities have a more varied pattern, and are more likely to commit less serious offenses than other individuals who have sexually offended. Comparisons between individuals who had been convicted of a sexual offense with or without an intellectual disability indicate differences in attitudes toward women and variation in offense history (Hayes, 1991; Lindsay, 2002; Tudiver et al., 2000; Wheeler & Jenkins, 2004). Individuals with disabilities had significantly less specificity in terms of type of offence and age and sex of victims, which is strikingly different from the profile among those who do not have a disability. Those individuals who do not have a disability showed greater consistency in victim choice and behavior. These findings suggest that opportunity may be more salient among individuals with disabilities who have sexually offended (Hayes, 1991; Tudiver et al., 2000).

Davis (2002) reported on a nationwide survey of 243 community agencies which found the most common offenses among men with developmental disabilities were inappropriate public sexual behavior (62.2%), sexual behaviors and stimulation inappropriately involving others (42.6%), sexual activity with minors (42.6%) and assaultive/nonconsensual sexual activity that did not involve minors (34.5%) (Davis, 2002, p. 1).

Contributing and Protective Factors

Contributing factors to sexual offending include low self esteem, reduced abilities to develop and practice appropriate relationships within the family or other social circumstances, and limited independence and autonomy due to

reduced privacy in group homes or institutional settings (Davis, 2002; Ward, Trigler, & Pfeiffer, 2001). Lack of comprehension regarding why the behavior is inappropriate can be related to limited sexual education or denial by significant others as they are unsure how to manage the situation. Underlying factors that perpetuate these actions are related to societal prejudice and ongoing sexual victimization of people with developmental disabilities (Davis, 2002; Ward, Trigler, & Pfeiffer, 2001).

Presence of a cognitive impairment may contribute to an individual who commits a sexual offense due to deficits in comprehending abstract concepts, more compromised ability to empathize and understand the victim's point of view, less skill at avoiding detection, and less consideration of consequences (Barlow, 2003; Davis, 2002; Lindsay & Smith, 1998; Schilling & Schinke, 1989). Within the DSM IV-TR, the presence of a cognitive disability is noted as a differential diagnosis related to sexual offending behavior. Characteristics of impaired judgment or lack of social skills or impulse control are listed as possibilities for unusual sexual behavior. However, it is distinguished from a clinical diagnosis of 'paraphilia' as the "unusual sexual behavior is not the individual's preferred or obligatory pattern" (American Psychiatric Association, 2000, p. 568).

Institutionalization

Individuals with an intellectual disability who are convicted of sexual offenses are typically older than others who are convicted of sexual offenses. Some of the reasons provided for this difference in age may be related to the

person with an intellectual impairment residing with his parents until their death typically later in life, and as a result, the individual's interactions within the larger environment may have been restricted Thus the sexual behavior that may have been previously prevented or managed by the parents becomes apparent (Lindsay et al., 2004). The impact of deinstitutionalization in the 1980s and 1990s prompted mass movement to community settings. Relocation into the community may have caused sexual behavior to become more visible as institutions allowed for reduced or no opportunity to offend within the supervised living arrangements, and/or inappropriate behavior was tolerated or mismanaged due to lack of staff training and resources (Lindsay & Smith, 1998).

Hinsburger, Chaplin, Hirstwood, Tough, Nethercott, and Roberts-Spence (1999) further outlined that the process of deinstitutionalization in the 1980s and 1990s led to agencies dealing not only with individuals who exhibited sexually inappropriate behavior but also with people who lacked general sexual information. Ongoing struggles to distinguish sexually appropriate from inappropriate behavior are significant for the responses of agency personnel and care-providers. Many individuals with disabilities have resided in and continue to live in non-normative settings. Their needs should be acknowledged when attempting to understand culture and values which have an impact on each person. Long-term effects must be considered when working towards changing beliefs and behaviors that have been accumulated by people who have been institutionalized for decades.

Counterfeit deviance is a term that proposes sexual offenses occur as a result of the structural environment in which the person lives (Hinsburger et al., 1999). Contributing factors are inappropriate social behaviors learned within the residential/home environment. These may include attention seeking or attempting to avoid a task, limited or inappropriate partner selection when trying to form a sexual relationship of any kind, inappropriate courtships when attempting to demonstrate sexual interest in another person, lack of sexual education/ information, perpetual arousal as a result of the inability or unwillingness to complete a sexual behavior, lack of understanding of cultural norms, in addition to medical problems and potential side effects of medication (Hinsburger et al., 1999).

Delayed Sexual Development

Barron, Hassiotis and Banes (2004) relayed that demographic characteristics of individuals who have a developmental disability and also have been convicted of a sexual offense, including social disadvantage, early delinquency, conduct disorder, and contact with health and social services are early indicators of illegal behavior. Simpson and Hogg (2001) agreed with the above statement; however, they cautioned these statements do not address the range of highly complex and varied individual social processes that require consideration. Thus a simple link between developmental disability and offending is not advised, as there are many indirect indicators.

Tudiver et al., (2000) and Hayes (1991) found that individuals who have a developmental disability are different from others convicted of a sexual offense in

that they display more social skill deficits. They are more likely to be are sexually naïve, lack interpersonal skills leading to difficulties interacting with the opposite sex and have a higher incidence of family psychopathology, psychosocial deprivation, and school mal-adjustment and have more psychiatric illness and delinquent or criminal behavior.

Barriers to normal sexual development are often reported to occur among individuals with developmental disabilities. These barriers include no early behavioral intervention, little to no appropriate partners or privacy, limited sexual and legal knowledge along with impaired social and cognitive skills. Delayed sexual development occurs as a result of segregated and restrictive environments, unrealistic sexual expectations, vulnerability to sexual abuse by others, societal and staff attitudes, drug effects, deviant sexual preferences and distorted cognitions, and may contribute to inappropriate sexual development and expression (Broxholme & Lindsay, 2003).

Family

The role of families is apparent throughout the literature as having a positive or negative impact on illegal sexual behavior among individuals with a developmental disability. Characteristics that are significant within the parental home include a combination of factors such as multiple family pathology, severe marital disharmony, parental separation, violence, neglect, and poor control over the child's behavior (Hayes, 1991). Typically, families and care-providers have little experience or comfort with sexual education due to inappropriate or lack of

responses to the normal sexual needs of developmentally disabled persons. This can lead to inappropriate sexual behavior (Schilling & Schinke, 1989).

Abuse

Incidences of abuse within the population of people with developmental disabilities are staggering. Statistics verify many of the first sexual experiences for people with cognitive impairments involve rape or molestation from family, care-providers, and/or peers resulting in the potential for inappropriate learning based on their own history of sexual victimization. For example, one study identified that 42% (Lindsay, 2002, p.75) of the abuse of 461 cases had been perpetrated by someone who themselves had a disability (Lindsay, 2002; Schilling & Schinke, 1989). While this fact does not provide an acceptable excuse for offensive behavior, it does provide an understanding of how the abuse may have been interpreted and incorporated into ideas about sexuality (Hinsburger et al., 1999; Schilling & Schinke, 1989).

It is estimated that the experiences of being abused among individuals with developmental disabilities who are convicted of a sexual offense is high. Results from a study completed in Scotland compared 46 individuals who had been convicted of a sexual offense with 48 individuals who had bee convicted of some other offense. The results indicated that 38% of those convicted of a sexual offense and 12.7% of those who had not committed a sexual offense had experienced sexual abuse. However, 13% of those convicted of a sexual offense and 33% of those who had committed another type of offense had experienced physical abuse (Lindsay, Law, Quinn, Smart, & Smith, 2000, p. 989). Sexual

abuse appears to be significant in the history of those convicted of sexual offenses and physical abuse appears to be significant in the history of individuals who have been convicted of a different type of offense (Lindsay et al., 2000).

Mental Health Status

Mental health issues including impulsivity, depression and anxiety have been discussed as potential contributing factors for the commission of sexual offenses among individuals with developmental disabilities. Parry and Lindsay (2003) studied the role of impulsiveness among individuals who have been convicted of a sexual offense and have intellectual disabilities. Appraisal of consequences and role of reward and reinforcements were studied. The hypothesis was that highly impulsive individuals tend to underestimate negative impacts and consequences as a result of rapidly processed information. Results indicated those convicted of a sexual offense were actually less impulsive than the control group (Parry & Lindsay, 2003). Lindsay and Lees (2003) compared levels of anxiety and depression between men convicted of a sexual offense who had intellectual disabilities and those with only intellectual disabilities. This study found that those who had been convicted of a sexual offense had significantly lower levels of anxiety and depression in comparison to the control group which disputes the proposition that impaired mental health status is a major factor in sexual offending behaviour.

Assessment Considerations

Focus on assessment, treatment, and long term follow up provided by professionals with knowledge in both developmental disability and sex offending

are needed. Currently, assessment methods used in cases where an individual has been convicted of a sexual offense are applied to those with a developmental disability despite a lack of research on their suitability for this population.

Comprehensive assessments are required by professionals to ensure relevant intervention and support strategies are in place. Determinants of the needed components guide appropriate follow-up and are therefore important. Assessments should include sexual history and knowledge, level of moral development, calculating risk of re-offending, and clear recommendations for intervention and supported community living (Lindsay, 2002; Timms & Goreczny, 2002). General categories for this population should provide information on competence related to cognitive ability to participate in legal proceedings, assessment of risk for subsequent sexual behaviors that would cause them to become re-involved in the justice system, and identification of needed supports (Lindsay, 2002).

Assessment of Competence

One of the principal considerations in the legal system is determining the level of competency required to stand trial. This issue is paramount for individuals who have a developmental disability, as it is recognized throughout the literature that they have been disadvantaged by the criminal justice system. Lack of comprehension regarding the seriousness of the situation and lack of community supports, including local professionals, combined with no or insensitive representation in the early stages of the process are major barriers for these individuals. Studies have shown people with cognitive disabilities are more

susceptible to falsely confess during interrogation as a result of wanting to be liked and being easily persuaded. Further evidence has indicated people with intellectual disabilities have difficulty comprehending simplified warnings. Based on this information it is felt that only a minority of defendants with developmental disabilities have been appropriately assessed and provided with proper supports (Lindsay, 2002; Tudiver et al., 2000).

Assessment of Cognitive Ability and Functioning

Lack of standardized assessment and inconsistent inclusion criteria regarding intelligence compromise the ability to interpret studies (Barron, Hassiotis, & Banes, 2004). Instruments to determine cognitive functioning, presence and severity of various behavioral problems, adaptive behavior and mental health issues can provide this information (Barron et al., 2004; Lindsay, 2002). Semi-structured questionnaires examining demographic and other characteristics such as current circumstances, personal history, educational level, psychiatric and forensic history, in addition to previous interventions received are also noted to be beneficial (Barron et al., 2004).

Early identification of intellectual disability assists with implementation of appropriate assessments for obtaining crucial information which is often missed or not identified in the criminal justice system prior to trial. Ongoing concerns of ineffective assessment and treatment highlight the need for training of multiple professionals within the system to ensure that appropriate methods for identification of developmental disabilities and needed services including protection, diversion and habilitation occur.

Assessment of Insight

Extent of insight or self-control can be determined through examination of the following: (a) behavior before, during, and after the offense; (b) level of responsibility the person feels; (c) to whom the person attributes the offense; (d) cognitive distortions used to justify the offense; and (e) evidence of ability to use empathy. Additional considerations include the culture in which the person has been raised, potential previous abuse issues, familial relations, and additional emotional and behavioral difficulties that can be experienced as a result of disability (Timms & Goreczny, 2002).

Information on intent to abuse may be gained from various sources such as patterns of behavior, level of sexual knowledge, sexual history, self-reporting, choice of very vulnerable victims and attempts to conceal the offence. When considering that without adequate knowledge a person with a less significant disability may not intend to sexually offend, distinguishing what is a challenging behavior versus a sexual offense without an assessment is dangerous. The most notable result of mislabeling offending behavior is an increased risk to others and elimination of proper intervention (Doyle, 2004).

Assessment of Risk

Johnston (2002) provides the definition of risk as both a noun representing danger or hazard and a verb indicating the probability of danger. The purpose of a risk assessment is to determine the presence of behavior in the past or present, and the likelihood of re-occurrence. Risk management is the process of identifying hazards, determining related factors, and developing strategies to either reduce the

likelihood of an adverse event or reduce the severity in the least-oppressive and physically restrictive manner while maintaining an acceptable level of safety for others. Decision-making is dependent on the subjective experience of the person conducting the assessment and can therefore be potentially biased at any point.

Timms and Goreczny (2002) offered that a person is considered high risk and not suitable for community-based intervention if involved in repeated offenses post treatment, violence, physical force, or if there was reported use or threat of a weapon. Behaviour that would also be deemed high risk involves progression with increased force used to commit a repeated offense, use of predatory or ritualistic elements in the offense and presence of significant intellectual impairment that may limit the ability to learn from consequences. As a result, the individual would be considered ineligible for community-based intervention services.

Changes in clinical service delivery and increased research on the issue of predicting recidivism have become important as more clinicians are being asked to predict the probability of re-offense (Lindsay, Elliot, & Astell, 2004). Prediction of risk presents a problem for the assessor as errors in judgment can have a negative impact. Compromising individual rights and the financial cost of services can be massive without the use of appropriate assessments to guide intervention and support levels (Lindsay & Beail, 2004). This process involves recognizing the level of risk a person poses as a consequence of needed skill which assists with determining the least restrictive, most socially inclusive and unobtrusive approach (Johnston, 2002).

Confounding issues when determining risk include underestimation resulting in reluctance to prosecute, desire to protect the vulnerable with under-diagnosis, minimization of offences, belief that non-specific support will be successful, and overuse of structured support systems. Overestimation of risk can stem from personal prejudice and/or beliefs that intervention will not be successful. Random errors include forensic familiarity and reliance on subjective prediction (Johnston, 2002).

Since standard risk evaluations have not been used within the population of developmental disabilities, there is limited understanding of how to describe risk and associated factors. As a result, there is no agreement on what constitutes high or low risk leading to a tendency to err on the side of caution and avoid mislabeling of people as high risk. There has been little empirical evidence that can clearly state that assessments and factors among individuals who do not have a developmental disability are either irrelevant or relevant for determining risk among individuals who have a cognitive disability and have been convicted of a sexual offense (Harris & Tough, 2004; Lambrick & Glaser, 2004; Lindsay, 2002).

Risk assessments are typically formatted as a guided clinical tool with a range of empirically validated risk indicators including static, stable, and acute dynamic factors to provide an estimate. Indicators viewed as important to those who have been convicted of a sexual offense such as employment may be irrelevant to individuals with developmental disabilities, as most have had few opportunities to engage in meaningful vocational pursuits. Instead, consideration of the individual's attendance and participation in educational, prevocational, and

other programs may be substituted. Problems with relationships also need to be cautiously interpreted as individuals with developmental disabilities often have a poor history of forming appropriate relationships due to lack of opportunity or skill (Harris & Tough, 2004; Lindsay, 2002).

Issues that appear to be equally important in assessment of risk for sex offenders with cognitive impairments include cooperation with evaluation, offence and criminal history, use of violence, management of anger, willingness to discuss the offence, acceptance of responsibility, expression of remorse, displays of unusual sexual interest, victim choice, substance abuse, lack of empathy for the victim, lack of adjustment, presence of mental illness, history of abuse and motivation for change (Lindsay, 2002; Lindsay et al., 2004; Lindsay & Smith 1998; Ward et al., 2001).

Family Assessment

Family involvement is an integral piece of the assessment process, especially when management of the offender is occurring within the home. Pertinent potential risk based on ability to supervise while protecting potential victims in the home, validation of serious behavior, empathy towards the victim, concurrent dysfunction and stressors, support systems, possible knowledge of offenses prior to legal involvement, and personal unresolved abuse issues are integral pieces of information which can be provided by the family (Timms & Goreczny, 2002).

Assessment for Intervention

The most important consideration when assessing intervention needs is to first address whether the behavior was due to a lack of education or understanding leading to inappropriate sexual activity. Another potential factor is if the behavior was due to a more serious underlying problem such as severe sexual problems or anti-authoritive attitudes and beliefs (Lambrick & Glaser, 2004).

Assessment for intervention should outline the specific problem in addition to identification of targeted goals. An established baseline of sexual behavioral and thinking patterns to determine changes over time should also be established with an emphasis on exploring social skills and sexual knowledge. The Socio-sexual Skills and Knowledge and Attitudes Test (SSKAT) is one of the few tools that has been developed for people with intellectual disabilities and assists in determining what the individual knows and feels about sexuality, pinpointing whether educational emphasis should be informational or attitudinal (Hingsburger et al., 1999; Lindsay, 2002).

Sexual offending behavior is a major issue creating enormous emotional, societal, financial and personal losses. Early identification coupled with effective treatment is the best solution towards prevention and/or reduction of the negative effects of sex offending behavior (Lindsay et al., 2004; Timms & Goreczny, 2002). A thorough individual assessment to identify strengths and learning gaps is essential. Information derived from a holistic assessment directs appropriate teaching strategies and interventions to meet the goal of changing attitudes and behaviors to reduce further sex offending (Baumbach, 2002).

Intervention

Understanding the complex biological, social, psychological and environmental factors that may contribute to offending behavior is important when determining appropriate intervention approaches and strategies. Quality care and long-term follow up are critical to minimize the risk of re-offending. Expansion of community diversion programs to partner with the criminal justice system is required to address the vulnerable status of individuals with developmental disabilities. Presently, cost of services and lack of exploration of community-funded alternatives that can provide effective intervention and support to decrease re-offense rates must be explored instead of sole reliance on institutional care for public protection (Holland et al., 2002).

The current reality for continuum of care options is that services are non-existent, overly restrictive, or fragmented as indicated from responses within 81% of community agencies in the United States (Davis, 2002). Within this overview, it was reported that inadequate treatment options were due to a lack of mental health professionals and sex therapists with expertise in developmental disabilities, lack of accurate diagnosis, inadequate funding, poor collaboration between systems and lack of police understanding and intervention (Davis, 2002).

Primary goals of intervention are to minimize risk to the community, facilitate control over sexual impulses, develop appropriate social skills including sexual expression, reintegrate into the community and have a lifestyle that is as independent as possible within the limits of the intellectual disability (Hingsburger et al., 1999; Tudiver et al., 2000). Despite the lack of evidence-

based intervention options, modalities most often mentioned and utilized according to the literature included specific therapies and strategies such as environmental modifications, re-habilitation training, and criminal justice arrangements. These are discussed within the following sections.

Intervention Components

Multi-dimensional and flexible approaches when providing a combination of interventions designed for sex offenders, with modifications to address the needs and limitations of adults with developmental disabilities, are required (Baumbach, 2002; Schilling & Schinke, 1989). Adaptation of educational material is essential to foster understanding when offering life skills training, community support and follow up. Goals of intervention should be consistent with those developed for individuals convicted of sexual offenses in general, such as examining and accepting responsibility for behavior, learning how to change conduct, developing life-skills, and continuing to receive community-based intervention and support.

Holistic, flexible approaches include psychiatric consultation and appropriate medication for mental illness, anger and anxiety management when necessary. Individual psychological treatment to deal with abuse may be indicated. As well, referral and support for specific community living issues, such as employment and educational opportunities, are organized when appropriate (Boer, Dorward, Gauthier, & Watson, 1995; Lindsay et al., 2004; Ward et al., 2001).

Goals include decreasing inappropriate arousal while increasing appropriate arousal levels, improving socio-sexual skills and knowledge which

incorporates heterosexual and same sex information, and teaching self-management skills (Hingsburger et al., 1999; Wheeler & Jenkins, 2004). Longer-term follow up, life skills training, and community programming must be tailored to the unique risks and needs of individuals with disabilities, and complications that can arise. Often, it is unclear whether impulsivity, problems with judgment, aggressive behavior, among a range of other inappropriate behaviors are associated with sex offending (Ward et al., 2001; Wheeler & Jenkins, 2004). Additionally, ethical intervention should be based on supervision requirements as required by law, and take place in mandated settings such as secure, semi-secure or the community, while maintaining safety for others (Wheeler & Jenkins, 2004).

Within the community, awareness of the needs of individuals with developmental disabilities who have been convicted of a sexual offense is necessary. Otherwise, services that are designed to provide safety for people with intellectual disabilities may create environments that may make sexual abuse more accessible. Failure to provide individuals with socio-sexual education and lack of clear policies on sexuality and sexual abuse promotes a high-risk environment for other residents and staff (Wheeler & Jenkins, 2004).

Focus on sexual offending behavior itself rather than its function is especially pertinent due to the impact and perceived vulnerability of the victim. While the offender's dignity is important, protecting the community and services which are responsible for managing the risk, compete for priority. Emphasis should be placed on education in both offence-specific and offence-related areas such as problem solving, anger management, substance abuse, communication,

sexuality and legal issues. Treating sex offending as sexually inappropriate behavior within skill-building interventions such as sex education and social skills training is insufficient. Information and skill development also need to be offence-specific (Doyle, 2004).

Timms and Goreczny (2002) acknowledged progress for individuals with developmental disabilities may be slow however, it is likely authentic as they can be significantly dependent on staff which leads to greater adherence to program rules. Furthermore, it is believed that individuals with cognitive impairments may respond better to intervention as they may potentially lack a high level of sophistication and ingrained fantasies, leading to quicker changes in troublesome thinking patterns (Schilling & Schinke, 1989). Comprehensive interventions for individuals convicted of committing sexual offenses has extensively utilized educational and behavioral methods including sexual education, behavior control, social skills training, responsibility, and relapse prevention (Lindsay, 2002). Timms and Goreczny's (2002) research indicated direct skills teaching and problem solving can be effective in enhancing social competencies and are likely to benefit most individuals with developmental disabilities.

Cognitive Behavior Therapy

At present, the most favored approach to providing education is a multi-disciplinary cognitive behavior group therapy approach. Intervention is directed to address denial, motivation to change, self esteem, cognitive distortions, empathy development, intimacy/loneliness, attachment styles, sexual and non-sexual fantasies, social functioning and relapse prevention (Wheeler & Jenkins, 2004).

Cognitive distortions have been viewed as important issues relating to both committing sex offences and effectiveness of treatment. Misconceptions in cognition may justify committing future offences, therefore changing these thought patterns via cognitive restructuring is important (Lindsay, 2002). This type of therapy has been determined to be better than behavioral approaches, which do not teach or encourage self-regulation. Consequently, once the behavioral intervention is withdrawn or the environment is altered, the same contingencies no longer apply and the behavior is likely to reappear. Some authors have suggested that cognitive components of anger management have limited efficacy with individuals who have developmental disabilities due to difficulties with understanding, assimilation, and recall, while non-cognitive components such as relaxation, self-monitoring and skills training through role-play, are seen to have greater benefit. Evaluation of comprehension, re-framing and simplifying information to gain a better understanding of the individual's thoughts, attitudes and beliefs is pertinent (Guay, Ouimet, & Proulx, 2005; Wilcox, 2004).

It is premature to disregard cognitive re-structuring techniques when procedures have not been implemented or modified adequately to meet the needs of these individuals. People with intellectual disabilities do benefit from cognitive-based interventions that address poor insight and reasoning (Guay et al., 2005; Taylor, Novaco, Gillmer, & Thorne, 2002; Wilcox, 2004). As victim empathy is more difficult to address in this population, it may be beneficial to modify the approach to assist the person in recognizing personal consequences of offending rather than his victim's (Guay et al., 2005; Wilcox, 2004). Both

individual and group modalities are appropriate. However sole reliance on individual therapy does not allow the individual to practice social skills or receive positive effects of group cohesiveness coupled with the power of challenges from other participants (Tudiver et al., 2000).

Beech and Hamilton-Giachritsis (2005) maintain that intervention employing direct, confrontational approaches will likely lead to increased resistance, as opposed to change. Therefore, intervention approaches should demonstrate respect, support, confidence, emotional responsivity, self-disclosure, open-ended questioning, flexibility, positive reinforcement and the use of humor. Some strategies are more effectively utilized through group participation, such as improved perspective taking, coping skills, taking responsibility and accepting future risk and reducing denial and minimization (Bickley & Beech, 2003; Wilcox, 2004). Indeed, negative policies, attempting to punish, medicate or program away sexual impulses have not been successful (Hingsburger et al., 1999).

Environmental Modifications

External controls are essential especially when the individual does not demonstrate sufficient cognitive abilities to integrate information (Baumbach, 2002; Davis, 2002; Streissguth & Kanter, 1997). Environmental adaptations and interventions such as restrictions on community activities, reduced access to high-risk situations, single room assignments, alarms on doors and windows, motion detectors, private transportation, blocking phone calls, and removing inappropriate stimuli for masturbation while providing private time have been

employed to assist with reducing risk (Schilling & Schinke, 1989; Ward et al., 2001). Other environmental modifications such as twenty-four hour supervision, one-to-one monitoring with intense supports, low client-to-staff ratios, safety checks, and reduced access to high-risk situations are essential for ongoing individual and community safety (Baumbach, 2002; Davis, 2002; Streissguth & Kanter, 1997).

Pharmacological Intervention

Pharmacological treatment has a long history. Either direct hormonal intervention reducing the effect of sex hormones or indirectly acting on aggression, impulsivity, and psychiatric disorders which may influence sexual disinhibition can have serious side effects and cause bodily changes. Treatment approaches can include various medications. Unfortunately it has been noted that they are often the sole method of treatment for all forms of inappropriate sexual behavior (Lambrick & Glaser, 2004; Lindsay, 2002).

Setting Options

Individuals with developmental disabilities have been found to experience more difficulty in understanding principles designed to reduce denial and minimization. This may be due to conceptual difficulties and therefore, they require more time to assimilate the information. Lindsay and Smith (1998) found that a 2-3 year probation period allowed for sufficient time to comprehensively repeat and target issues of denial and minimization by challenging and changing beliefs and attitudes, in addition to a consolidation period in which more appropriate beliefs could be reinforced (Lambrick & Glaser, 2004; Lindsay &

Smith, 1998). A further recommendation of externally mandated treatment via court ordered probation versus relying on voluntary participation is advocated as the therapist and/or staff is then seen to be helping in the process of re-habilitation instead of being punitive (Lambrick & Glaser, 2004; Lindsay & Smith, 1998).

Generally, evidence for efficacy of virtually all of the proposed interventions for individuals with developmental disabilities is scarce and based on small samples. Specialist treatment for individuals with intellectual disabilities in secure settings is expensive and targets only those with the most serious offending behavior who have been caught and convicted (Hayes, 2002).

Community-Based Intervention

The probability of re-arrest for people with developmental disabilities who are in custodial care is significantly higher than for others who have been convicted of a non-sexual offense. Moreover, they are more likely to be sent to prison on first arrest while time before re-arrest is shorter than for others. Community programs as opposed to those offered in a custodial setting are better suited for people with cognitive impairments. A major advantage of community programs, according to social ecological theory that is also discussed in this chapter, is that they maximize impact by restructuring the social environment and redesigning physical and task environments.

Observations in numerous studies have indicated that a more normative environment for program delivery tends to enhance success. Findings suggested that the most important factor in predicting lower re-offending rates were a positive self-image, and regular attendance within community programs that offer

supportive therapy emphasizing positive aspects of the imposed sanction and the individual's self-image (Cockram, 2005). Reluctance to fund community-based programs is often rationalized on the basis that greater supervision and resources need to be devoted to individuals with the most serious risk. However, preventative services to address the problematic behavior for those who are in frequent contact with the law in order to maximize rehabilitation and improve the chances of maintaining a life without crime are essential (Cockram, 2005).

Despite prison being seen as a poor option for adults with developmental disabilities who sexually offend, Davis (2002) proposed that it is imperative for those individuals to be held accountable for their actions. Mandated interventions for these individuals may provide the only opportunity to learn about appropriate sexual behavior. Creative sentencing options such as diversion programs should be favored to a prison sentence as those who serve time in jail have a greater chance of re-offending since effective sexual education and related habilitative programs modified for people with intellectual disabilities are not offered through the criminal justice system. Placing people with developmental disabilities in a regular prison-based program does not offer effective treatment. The significance of this problem is compounded when considering that the majority of sex offenders with cognitive impairments fall into the mild to borderline range and are unlikely to be identified within the justice system (Boer et al., 1995).

Criminal Justice System

Overall, people with developmental disabilities within the criminal justice system face considerable adversity. They may not understand their rights, confess

quickly, have difficulty with receptive and/or expressive communication and are therefore more likely to be incarcerated, and are often considered poor candidates for parole. While in prison they are unlikely to receive treatment or rehabilitation services that address their specific needs, have greater difficulty adjusting to prison life and are likely to be exploited by other inmates (Boer et al., 1995).

Using external consequences and leverage such as criminal investigation, prosecution and court-ordered treatment may serve as effective supports for the management of sexual offending and developmental disability interventions as they can offer effective and concrete consequences particularly for those who do not accept or readily understand the connection between their behavior and involvement in the system. A priority for services should be after care, which includes the option to return to treatment, tailored for the individual at any time. Safe reintegration into the community should be gradual and closely monitored and if the level of risk increases, the individual should be directed to more intensive treatment with increased supervision (Tudiver et al., 2000).

In Canada, the option of a diversion program is provided when the Crown is satisfied that the person has a reasonable prospect of conviction and is not a risk to public safety. Discretion needs to be used if the person who offends has an extensive criminal record, prior diversion, or if weapon use or violence is noted. Minimum requirements should involve the individual's admission of guilt and willingness to participate in specific sexual offender treatment with a failure to comply resulting in prosecution (Tudiver et al., 2000).

According to Barron, Hassiotis and Banes (2002), the efficacy of therapeutic interventions for individuals with developmental disabilities in community settings or secure facilities has not been adequately studied. The practice of jail time, unless in the most serious of circumstances, should be avoided, given the potential for victimization. This risk has been made evident by the fact that although individuals with an intellectual disability had more minimum security ratings, they were transferred to protective units mostly offered within maximum settings, due to threats of physical and mental abuse. Based on this knowledge, prison should be the last resort due to ineffective treatment and the individual's limited coping ability (Cockram, 2005). If no other person is at risk, it is suggested that people with developmental disabilities be placed in community placements or the family home with appropriate supports, rather than in an institutional setting.

Family and Care-provider Implications

Families are an important aspect of intervention for many people with developmental disabilities. Recommendations forwarded by parents for their adult offspring who were convicted of an offense to the criminal justice system and professionals in the area of intellectual disabilities included increased general information on the criminal justice system, more sentencing options and a greater use of community services secondary to concerns of victimization and potential for sexual assault within the prison system against their adult child (Cockram, Jackson, & Underwood, 1998). Ongoing parental concerns regarding the particular needs that people with cognitive impairments have, as well as lack of

appropriate custodial and intervention arrangements were also addressed. Parents additionally stressed the importance of their adult child being independent. However, the lack of appropriate support services places ongoing stress upon the family system (Cockram et al., 1998).

Staff training to develop awareness of how their personal attitudes towards people who are committed of sexual offenses can negatively or positively affect treatment is advocated by Cockram et al. (1998). Effectiveness of staff training in facilitating treatment for individuals with intellectual disabilities should be evaluated, as there is a need to increase knowledge and confidence and reduce burnout. Training should include the nature of sexual offenses, theoretical and contextual issues, as well as awareness of methods for managing denial, minimization, relapse and re-offense issues (Garrett, Oliver, Wilcox, & Middleton, 2003; Jennings & Sawyer, 2003; Taylor, Eddie, & Lee, 2003; Ward et al., 2001). Education should also be extended to external staff including police, judges, attorneys, probation and parole officers as well as staff from agencies who provide services for people with intellectual disabilities (Boer et al., 1995; Cockram et al., 1998; Hayes, 2002; Lyndhurst, Scotchmen, & Bennett, 2003).

In summary, preventative strategies that provide sexual and relationship education and opportunities for sexual expression should be a high priority for parents, staff, and community agencies that work in the field (Davis, 2002). Measuring the success of intervention is determined by the person gaining greater access to the community, demonstrating and reporting use of relapse strategies when supervision is being reduced, and remaining offense-free (Hingsburger et

al., 1999). Sexual offending behavior is a community problem. Therefore an ultimate goal is comprehensive services with common philosophies and approaches in order to be responsible to participants. In order to meet this goal, expansions of options to improve upon quality of life based on evidence and best practice principles are essential.

Theoretical Perspectives

During the process of developing research questions, two theories emerged as relevant. A framework for effective intervention involves a number of strategies including family and relationship building, environmental modifications, providing individuals with direct habilitative skill training (such as sexual education, anger management, and social skills), and education for professional and external stakeholders, in addition to community outreach and follow-up. Programming that incorporates this holistic approach is supported by the social ecological approach which acknowledges the person's mental, social and physical environments. White and Klein (2002) stated that "ecological theory sensitizes practitioners and others to the multiple levels and complex interactions between various ecological units" (p. 224). They also propose that this "perspective is inherently multidisciplinary in its implications" (White & Klein, 2002, p. 224).

Barris, Kielhofner, and Watts (1988) outlined the social ecological approach and provided a summary of the perspective on people and their environments as (a) "development involves learning to be competent in a variety of settings," (b) "settings promote certain behaviors and are subject to change by

their inhabitants. Individuals learn to choose settings that are appropriate to their goals and to modify settings" and (c) "through purposeful engagement in settings, the individual develops acceptable social behavior" (Barris et al., 1988, pp. 140 & 141).

From a social ecological perspective, problematic behavior is the direct result of "a lack of experience in varied settings (which) may lead to a lack of behavioral flexibility for functioning in a wide range of environments. The individual may choose inappropriate settings for goal attainment or may not know what behaviors are required by the setting" (Barris et al., 1988, p. 141). When considering that reduced problem solving abilities are inherent within the cohort of adults with developmental disabilities, employing a variety of strategies that target both internal and external processes is warranted to ensure that continuance of daily occupations is conducted in a safe and effective manner for both the public and person. This theory is valuable in providing credence to interventions that focus on restructuring the social environment and redesigning physical and task environments with an individual who has been convicted of a sexual offense.

Within the literature on sexual offending intervention, cognitive behavior therapy is cited often. This form of treatment is rooted within cognitive theory, which addresses the link between cognitive processes and affect and behavior. Eccles and Winfield (2002) highlighted the effect that self-regulation plays in social cognitive theories as it "emphasizes the importance of self-efficacy beliefs, causal attributions, and goal setting in regulating behavior directed at accomplishing a task or activity" (Eccles & Winfield, 2002, p. 124). Once

engaged in a task, the person must "monitor their behavior, judge its outcomes, and react to those outcomes in order to regulate what they do" (Eccles & Winfield, 2002, p. 125).

Barris et al. (1988) refer to cognitive approaches and theory as including rational-emotive therapy, cognitive restructuring, coping skills and problem-solving therapies. The overall supposition is that changes in cognition will alter affect and behavior (p. 96). These therapies are directed to changing problematic thought patterns such as denial and minimization, which are viewed as salient in sexual offending. If cognitive restructuring is successful, incidences of re-offending are decreased.

A combination of these two theoretical perspectives is suited to the needs of adults with developmental disabilities who sexually offend. Together they offer a framework to outline the responsibilities of the individual, by employing cognitive behavior approaches as promoted by cognitive theories, while addressing the responsibilities of the entire environment, including a continuum of services designed for this specific population.

The literature review included developmental disability, sexual offending, community based intervention and supports. Upon reflection, it became clear that research among men who sexually offend is well developed. However, research on the issues of sexual offenders with intellectual disabilities is limited. The perspectives of individuals living with disabilities in the community who have been involved in sex offending behaviour were not well studied. Instead, research

has focused on people who have a history of institutionalization or have lived in segregated environments including educational and residential settings.

It has been reported that the majority of people with a borderline or mild cognitive disability who become involved in the criminal justice system have not been identified as having a disability. Therefore, their experiences have not been described. Recognizing and documenting their specific needs for the purposes of community-based intervention is what guides this research.

The central questions are: 1) What are the experiences of community living among individuals with developmental disabilities who have been involved in sexual offending? 2) What are their needs and challenges in the areas of relationships and living arrangements?

Based on this information and the literature, the application of a qualitative approach to this study was deemed useful to identify the needs and challenges of individuals, with reference to thinking patterns as well as overall life situations, including the social and physical components of their environment.

The following chapter describes the methodology used in this research, with specific focus on the use of content analysis to analyze the data.

CHAPTER III: METHOD

Methodological components of this study, including the researcher's background, participant profile, and recruitment strategies used, are outlined in this section. A description of qualitative research and ethical considerations are provided, followed by descriptions and process of conducting content analysis.

Researcher's Background

The author is presently a Program Manager for a social service agency that provides day services to adolescents and adults with developmental disabilities. In the last twenty years, the researcher has worked as a direct treatment staff, coordinator of services, and Occupational Therapist in this field. During this time, OFII management has provided occasional consultation to the day program to assist with providing services for individuals who were not eligible for treatment services via OFII. No affiliation or partnership with Opportunities developed in the past or present and participants had no previous direct contact with this author.

Participants

Adult clients who had a diagnosis of a developmental disability and attend sexual offender treatment offered by Opportunities for Independence Incorporated (OFII) were asked to participate in this study. A purposeful sample of participants associated with this non-profit community agency was selected, as this service specializes in community-based treatment specifically for adults with intellectual impairments.

The continuum of clinically-supervised programs offered by OFII include residential treatment centers and foster homes, community support programs,

intensive needs components, sex offender treatment, adaptive skills programs, vocational placements and monitoring, drop–in opportunities, peer based support groups, in addition to training and consultation. These services are designed to enable clients "to exercise their rights to equal and appropriate membership in society in the least restrictive setting as is possible while maintaining personal and community safety." (Opportunities for Independence Inc. Alternative Therapeutic Programming Pamphlet, nd). Opportunities, Inc. was developed by a group of professionals who identified a need to address the problems of adults with developmental disabilities who were in conflict with the law.

It was expected that 10-15 participants would take part in this study. Based on professional experience with clients of similar backgrounds, it was expected that saturation of the data would occur between 10-15 interviews. Clients who had borderline to mild developmental disabilities and who had attended the program for a minimum of six months were invited to participate. A diagnosis of a moderate, severe or profound intellectual disability excluded a person from participating due to the possible lack of requisite insight to relay specific information sought.

Ten individuals completed the interviews. Five of the ten men were between the ages of 25-29, three between 34-36 years old, and two within an age range of 48-51. Six of the men were of Aboriginal descent, three were Caucasian, and one was from an Asian background. Most of the participants had re-located to Winnipeg. One person continued to live in Eastern Manitoba, four people had moved from Northern Manitoba regions, two from Northern Saskatchewan, one

person from Asia, one from Southwestern Manitoba, and one individual has always resided in Winnipeg. The range of present residential arrangements was three individuals lived independently, two resided alone with occasional formal supports, two lived with other community agency homes and three currently lived in OFII residences. Six individuals relayed that they had been incarcerated however the extent of involvement was not discussed, one person refused to answer, while the remaining three men stated they had never been in jail.

Recruitment

Three approaches were used to enlist participants. Initially, an informal meet and greet session was conducted with potential participants where they received verbal and printed information on the study purpose, potential questions and interview details including timelines in addition to the researcher's contact information. During this time, an honorarium was offered to potential participants along with assurances that participation was completely voluntary with no negative implications on their affiliation with OFII if they chose to not partake. A request to relay information to others who were not in attendance but may be interested in participating in the study was made. An additional recruitment approach was placement of the information shared during the meet and greet session within the Opportunities for Independence Incorporated office space. Participants contacted the researcher to arrange a meeting place and time according to their preference. Only individuals who were able to provide their own legal consent responded to the request for interviews and participated in the

research. Interviews occurred in public locations and lasted between 30 to 75 minutes.

Interviewing

Participants were asked about their current situations, in terms of family and other interpersonal relationships, residential circumstances, and life in the community. They were also asked about their specific needs and challenges. Information was collected until participants' descriptions were repeated indicating that data collection was complete (Jackson, 2003). In this study, interviews were conducted until three successive interviews provided essentially the same responses. This occurred after 10 interviews.

In qualitative research, a list of core questions that vary in order or wording assist both researcher and participant to be comfortable with the process. Britten (1995) advocates questions that are open-ended, neutral, sensitive, and clear to the interviewee and based on behavior, experience, opinion, value, feeling, knowledge, and sensory experience including demographic/background details. Additionally, it is preferred to begin the interview with the easiest, most concrete questions and progress to those that are more difficult (Britten, 1995). Based on this information, sequencing of questions progressed from concrete to abstract, with content arranged according to issues identified within the literature.

Questions along with scripts for the meet and greet and introductions were prepared in advance and in a set order with supplemental questions when the participant required further clarification. Refer to Appendix A and B for an outline of questions and scripts that were approved by the Ethics Committee

before the research began. Each interview was tape recorded and transcribed immediately after the session which assisted with recall for data analysis.

Ethical Considerations

Hays, Murphy and Sinclair (2003) outline ethical considerations that should be ensured when designing research which involves adults with developmental delays who sexually offend. These authors propose that requirements to conducting ethical research with a person who has a cognitive disability include not only informed consent but also evidence of capacity to consent while interactions are free from pressure. Refer to Appendix C for the framework in which decision making status was determined.

In order to ensure confidentiality and meet the requirements of the ethics protocol for the Joint Faculty Research Ethics Board at the University of Manitoba, each individual was made aware that his participation was voluntary throughout the course of the study and that he could withdraw at any time without consequence. In addition, an independent ethics panel from Opportunities for Independence Incorporated reviewed and approved the study protocol submission. A consent form was developed to obtain informed consent and was offered verbally and in writing to aid in comprehension. Refer to Appendix D for a copy of the consent form. All participants were considered their own legal decision makers and therefore consent from another person was not required. Information was used solely for research purposes and identities were not revealed in written reports with the name being replaced with an interview number. At the conclusion of each interview, a twenty-dollar honorarium was provided.

The intent in conducting this research was to describe the experiences of community living among individuals with developmental disabilities who have been involved in sexual offending behaviour. By following the proposed research design, ethical principles of "beneficence (doing good), nonmaleficence (not causing harm), autonomy (treating people with respect and providing them with enough information to make an informed decision) and justice (weighing the costs and benefits of the research to ensure that justice is done)" as advocated by Hays et al. (2003, pp.182-183) was met.

Qualitative Research

Qualitative research places emphasis on viewing the perspective of the individual thereby allowing a more holistic method to study the person, institution, group or culture. This method relies more on words to describe the research findings while emphasizing the subjective dimensions of people's experiences (Jackson, 2003).

Creswell (1998) defines qualitative research as a "process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (Jackson, 2003, pg. 136). A cyclical approach is repeated throughout the procedure versus linear steps to assist with developing inductive theory.

Content Analysis

Content analysis defined as "any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (Holsti, 1969, p. 14) was used for the purpose of data analysis. This system is used when attempting to analyze the content of the message that is being communicated (Jackson, 2003).

This form of data analysis originated in the 1950s as a quantitative method where text was reduced to quantifiable units. The fundamental analytic principle is that core themes are produced from data through systematically reducing and analyzing text which is then coded into established categories to support the generation of ideas and to account for the results (Priest, Roberts, & Woods, 2002).

Content analysis has been found to be appropriate for many questions, and used within many disciplines. "Furthermore, the validity of the measures used may be fairly high since direct observations and classifications are being made" (Jackson, 2003, p. 205). Priest et al (2002) additionally proposed "content analysis is a particularly reliable means of analyzing qualitative data in that reliability of coding decisions can be confirmed by revisiting previously coded data periodically to check the stability over time." (p. 37) Based on these strengths, this method was chosen to analyze the data generated during this research study.

Process of Content Analysis

Creswell (2003) outlined the following steps to analyze and interpret data:

1. Organize and prepare involving transcription of interviews, optically scanning

of material, typing field notes, and arranging the data into different types. 2. Read through all material to obtain a general sense of the meaning. 3. Detail the analysis using a coding process, which involves organizing information into chunks and labeling into categories. 4. Describe the detailed information about people, places, or events within the setting. Generate codes for use with a small number of themes or categories that will assist with outlining major findings with separate headings. 5. Discuss each theme or inter-connecting themes using a narrative approach. 6. Interpret data by addressing the essence of the information, comparison of findings, history, and lessons learned throughout the experiences (Creswell, 2003).

Trustworthiness

In order to enhance the trustworthiness of the findings, qualitative research should exhibit concepts of credibility to accurately describe the experiences of participants and triangulation of data, which can involve different sources, times, places and methods. The process of member checking to verify that the content of the data is true to the participant's experience additionally provides credibility to the research findings.

Dependability refers to stability and trackability of changes in data over time and conditions reflecting the continual changing of situations due to different realities. Another determinant of trustworthiness can be accomplished via completion of an audit trail whereby the researcher documents all the raw data generated, methods and sources of data generation, in addition to analysis decisions in that another researcher could follow the procedure and arrive at the

same conclusions. Transferability refers to the ability to generalize study findings to other settings, populations, and contexts to demonstrate that the results are not context bound. Confirmability refers to objectivity of the data where other researchers would agree that meanings relate to the same concepts. Bracketing of personal biases, assumptions, and values that may have impacted the study while highlighting other conclusions and rival hypothesis are also useful methods to improve validity (Creswell, 2003).

In order to ensure that the researcher's personal biases were visible within the findings, assumptions and reactions were bracketed within a reflective journal, which can be reviewed by readers of the research conclusions. The strategy of peer debriefing with a colleague employed within the field of developmental disabilities for a prolonged time but was external and not involved with this population of people was also used. A second coder who has over twenty years experience working with people who have intellectual impairments and not involved in any other part of the research came to similar conclusions regarding coding decisions. An audit trail has been left for others to replicate the procedure in conducting the research. Direct quotes were used within the written reporting of the data collected. An attempt to member check in order to verify the findings was made through an extended invitation to all participants however none of the individuals indicated an interest or contacted the research as requested. Last, observational notes with thick description of both verbal and non-verbal information, audio-taped interview data, and documentation within a reflective journal was used by the researcher to triangulate data.

CHAPTER IV: RESULTS

Ten interviews with participants affiliated with Opportunities for Independence Incorporated (OFII) in Winnipeg, Manitoba, were completed. All research participants were male within an age range of 25 to 51 years. The individuals had re-located to Winnipeg from various Northern, Eastern, and South-Western Manitoba regions, Northern Saskatchewan areas, in addition to another continent. Six out of ten had been charged with committing an offence, one refused to answer while three were never formally charged.

While most of the men had lived in multiple residential settings, a couple of participants had resided only with their family of origin extending into adulthood prior to moving into their present living arrangement. At the time of the interviews, involvement with OFII included outreach services solely involving client driven drop-in sessions, daily program involvement and/or twenty four hour residential services. In addition, some participants reported concomitant issues involving substance abuse and/or difficulties with physical and mental health status.

Interviews were held in a local coffee shop or an alternate public location (e.g., office space at a nearby agency) as requested by the participant. Interviews were audio-taped. Upon completion of each interview, the information was transcribed into text to complete the content analysis using the procedure outlined by Creswell (2003). Prior to coding the data, transcribed interviews were repeatedly read by the researcher, searching for common experiences which were highlighted and placed directly into the transcripts. During this time, general

impressions that were recalled during the meeting or discrepancies in the information provided by the participant were noted. Initial codes were developed by analyzing word segments, phrases and sentences while developing larger themes that were relevant to each interview. These segments of text were highlighted, analyzed and arranged in common categories. A detailed list of codes, categories and rules can be referenced within Appendix F and Appendix G.

While codes and potential themes were initially developed after eight interviews, they were updated and revised upon completion of the transcription process for the remaining two. This break in time assisted in ensuring that upon further reflection, saturation of data had occurred. Over 100 codes were initially identified, however considerable overlap was noted. Each code did not apply to every interview however they did relate back to the original research question which was: what are the community experiences in social and residential settings for a person who has a developmental disability and been involved in sexually offending behaviour? Examples of these codes included:

1. Frequent moves
2. Decreased access to family
3. Isolation from friends
4. Grief secondary to loss
5. Effects of incarceration
6. Limited finances
7. Importance of work
8. Desire to be independent
9. Family conflict
10. Acceptance of self

After the data were coded, a colleague who has worked in the field of developmental disabilities for the past twenty years reviewed and evaluated the

categories that had been developed based on similar experiences and patterns of information. This procedure revealed similar and consistent coding patterns with the original process. For example, the category "productivity" included activities that participants had identified as providing structure and meaning to their day at some point. Examples were: education as a key to the future, preference for self teaching versus formal classes, a desire to learn and development of independent living skills.

To begin this procedure, all data were reviewed from an overall perspective. By reading and re-reading the information, certain patterns became evident however the final breakdown did not include all initial ideas for categories. For example, "impact of illness" did not apply to the majority of participants but could be included under the umbrella of "self care" and therefore was eliminated as a category on its own.

Personal feelings and insights were noted while reading and sorting through the transcribed data. Additionally, brief notations were made immediately after each interview and added to the interview data. Frequently mentioned experiences such as leaving their family of origin at an early age and subsequent feelings of loss due to this relocation are examples of how codes and categories became organized.

Categorization of the data was based on the participants' words and phrases in addition to ideas that emerged from reviewing the data stemming from the literature or the researcher's personal experiences. While some categories such as "safety" and "illness" were too narrowly focused, a "support systems," category

which originally included family, friends and formal supports was too broad. To better account for the data, family was separated from "support systems," into one category. Another example of this re-organization is "self-care," which became a recurring theme once statements were grouped based on taking care of oneself in regards to mental/emotional/spiritual health, safety for self and others to avoid re-offending, changes in attitudes resulting in different beliefs and behaviour and resiliency. Negative data provided by one participant which was not corroborated by any other interviewee was discarded after a thorough review of the data was completed.

After this stage, each person had approximately 15-20 preliminary categories including some of the following:

1. Independence
2. Support systems
3. Family effects
4. Effects of prejudice
5. Importance of work
6. Frequent moves
7. Barriers
8. Connections to OFII
9. Limited friends
10. Safety

In order to identify categories that could be applicable and broad in focus, all interviews were read again and re-grouped according to overarching commonalities. Seven final themes that could incorporate the data collected during the analysis were selected. The final 7 categories were:

1. Taking care of self
2. Family effects
3. Social and support systems
4. Home life

5. Assistance from Opportunities for Independence Inc.
6. Productivity
7. Societal and systemic effects

Despite each participant providing responses based on their individual

experiences, a minimum of 4 out of 7 categories were applicable to each person.

A description for each category then was developed.

1. Taking care of self
Issues related to emotional, mental and spiritual health were discussed by many participants. Safety of self including actions/behaviours that keep others in the community safe were included in this category. The impact of mental health issues was also outlined. Insight, grief and remorse related to the person's offence history, building self confidence and resiliency were also included.

2. Family effects
Positive contact as well as negative factors associated with familial relations were highlighted within this category. History of abusive relations, continued conflict and stigmatism due to family history were outlined. The impact of isolation from family members due to moving out of regions or death was also discussed. Some participants also spoke of cultural values that remained with them. Importance to maintain contact with family was indirectly mentioned by many participants.

3. Social and support systems
Individuals discussed the role of support from community resources and friends. Most participants reported limited supports from friends. A number of interviewees relayed wanting to have a girlfriend or wife in the future while some identified presently having someone significant in their life.

4. Home life
The impact of frequent moves typically away from the family including residential school, foster homes, group home settings were discussed. Feelings of loss, anger, and fear were identified as were the importance of safety, food and shelter. Many participants also highlighted the negative impact that limited financial assistance had on their ability to live independently at a comfortable level.

5. Assistance from Opportunities for Independence Inc.
Training modules such as Community Alternative Re-entry Program (CARP), anger management; social skills training offered via OFII were frequently described as beneficial. The range of services from drop in to residential services was highlighted in this section as was the value of emotional support.

6. Productivity
Many participants outlined the importance of work to increase income and life opportunities. Some participants indicated they were satisfied with attending day programs and would look for employment possibly in the future. The impact of continuing education to improve future vocational pursuits was also identified by some interviewees. Education as a child was frequently described as difficult due to their cognitive disability.

7. Societal and systemic effects
Issues related to limited finances from Employment and Income Assistance were highlighted by a few participants. Additionally noted was society's pressure to be productive and have a certain image which would be reflected by income. A number of Aboriginal participants identified racism as a significant barrier they faced on an ongoing basis. Almost all interviewees noted being 'picked on' or targeted by other students, co-participants or the general community due to cognitive disability, visual appearance, speech impediment, race, sexuality, past offence history, and/or physical health issues and accessibility.

For each theme, direct quotes compiled from the interviews were used to develop themes and are noted as follows.

Themes

Theme 1-Taking care of self

Within this theme identification and insight into the importance of keeping others including themselves safe by learning from their past was identified. These statements were typically solicited when asked why they initially became involved with OFII.

Participant #1
P. Well just to get some help. Just to be safe, not to do anything else to anybody.

P. … Well pretty much to be safe in the community and not hurt anybody else especially kids.

Participant #5
P. Cause uh….I'm uh…I get kinda to involved with little girls.

I. …like what would you say for sure sticks out in your mind?
P. Don't touch girls anymore.

Awareness of trying new strategies and behaviours to refrain from re-offending was also discussed.

Participant #4
P. I always keep my nose clean anyways so I don't bother people on this side or this side.

Participant #7
P. They still want me to do that with them but I can't because I am trying to straighten my life out, not getting too, trying to get myself into hurting another person or re-offending.

P. Well uh, that's the reason that I go to the program, this place called Opportunities getting myself involved with moving out or anything. By just going walking around. Say like if I wake up in the morning and I decide what am I gonna do today, if I decide that I am just gonna go walking around the streets and meet people that are not very good for me to hang around with then probably wouldn't. I would probably eventually run into some people that I don't want to meet and get myself going, get myself blitzed like I used to do before.

Participant #9
P. Um, yeah that made me, it told me that if I don't want to go back there, you'll try and help yourself by going to a program that teaches you to have been in some kind of offence that you could look it with a positive side. If you want to avoid this place then you'll learn.

The power of positive thinking, believing in oneself, and proving self to others in spite of being the target of negative comments coupled with an underlying resiliency were highlighted by some participants.

Participant #1

I. Why do you think it stopped?
P. Cause they saw me with like, they saw me for who I really was.

P. I showed them how I was and what I was made of.

Participant #4
P. Well, I'm still going anyways.

P. No more backing down as they say (laughing).

Participant #8
P. .. And not just that but there is also where I've made progress.

Participant #9
P. Yeah, um I think it had more to deal with self confidence and uh lots of that self building structure and uh, you need to feel good about yourself no matter what. It's like it doesn't matter what the next person thinks its more you need to feel good doing what you are doing, you know. And realize that, realize that not everyone's point is a good point, so yeah.

P. Yeah and um, one of the other things I have learned is like I want to keep holding onto those points there and um basically tell myself 'you know what, I cannot go back to where I used to be and letting other people bug me and stand up for myself and say like this is who I am and this is me now. Who you thought of me when you saw me 10 years ago 15 years ago, I'm not that person anymore you know'. But I've gained uh, I've gained alot of knowledge in life and a lot of you know, I don't let uh, I try to get my words and try to stand up for myself.

P. Um, I like to uh, I like to uh, I think a lot of it that helps me now is that I can accept who I am. I don't care what anyone says cause bottom line, I am who I am, plain and simple you know.

Future plans with a positive outlook were weighed by participants while reviewing their past and seeing a positive change for the future.

Participant #4
P. Um, they say I mostly done already and I am ready to move out of the program there.

P. Go my own way and help somebody out.

Participant #9
P. ...don't look at the bad stuff. Like don't look at the negative stuff, that will get you into trouble. But look at the stuff that you can learn off of this like what I did and what I won't go back to and you know of the offense or whatever and look at it as a learning curve. Say 'I don't want to go there I'll do better' you know, try and pick up some other types of habits of uh stuff. Get myself a job, through that it would um, increase my um overall just increase my overall capability to do better you know.

Participant #10
P. I feel like I've made a step forward. It is like I put my foot in the door when they were closing, closing it and saying no. And I put my foot in the door and said

I am going to do this no matter what even if it takes a long time for me to get what I want to get....

P. I will keep trying, I will not give up.

Grief and remorse for past history was expressed within three interviews which implies insight into accepting responsibility for their offending behaviour. Some participants identified the reason why they became involved with Opportunities specifically.

Participant #7
I. .....you feel like people are judging you a little bit?
P. Yeah, yeah. Especially what I did. Especially what I did in the past uh hurting people and bugging women and stuff like that. Emotionally.

P. And it makes me feel bad too if I get angry with anyone because that's the thing that I am working on is my anger and not to get angry because that's what got me, that's what got me into sexually assaulting people.

P. Yeah because I need lots of um, lots of encouragement and like yeah healing and not to bring myself back to who I was before. That's what that Native Elder was telling me about a couple of weeks ago. She has been talking to other people like me to talk about my past and my history. To talk about all that garbage stuff that I have been saving up and that and maybe when I start doing that, maybe things will start going a little bit better for me instead of this anger and this loneliness all the time.

Participant #8
P. And crime and the illness, I started going down hill. You know there is a lot of stuff that ruined a lot for me.

P. Yeah. I can't blame anyone but myself you know. Like I had a nice life. I guess just sometimes in life things don't work out. I made the wrong decisions.

An implied feeling of embarrassment for the past was also interpreted within one interview.

Participant #8
P. ... Sometimes it's hard to remember what I've done. Like what I've done and what was going on. But I've come along way now and I am a lot happier.

Participant #9
P. ..I haven't revealed it to all my family that knew about it and they still don't know about it so. I mean it is something that I uh don't, I kind of try to put it in the past.

Mental health and emotional issues were cited as barriers however the importance of knowing how to work within those limitations was also addressed. Participants also identified external factors such as supportive residential environments and pharmacological assistance to assist in dealing with grief and loss.

Participant #8
P. Because it'll even out my pills cause it controls my illness to be a normal person.

P. They had me drugged up and I was on the psych ward a couple of times and I had a rough time there.

P. ...But right now, last 2 years I've been really picking up. It's like I say the illness has gone lighter.

P. Yeah, a clear head and my thinking is better.

P. Yeah, but I also have problems with getting uh overwhelmed or a little bit too excited.

P. And I kind of, sometimes I feel hyper or something.

P. And that's when I start acting up or stuff like that. Not hurting anyone but sometimes when I am around people sometimes I will feel nervous.

P. Yeah, see like I can't take big crowds of people, like this is okay (referring to place where interview took place).

Participant #9
P. …I'm on medication to help me deal with some of the depression, and uh so that's pretty tough right now.

Participant #10
P. …..I don't want a nurse come knocking on my door and say you have to take your meds and that. I think I can do that on my own.

Theme 2- Family Effects

Positive feelings and memories as well as frequent contact with family either via direct contact or phone calls were described by four individuals as being important.

Participant #2
I. What helps you the most right now in your life?
P. Uh.....uh, keeping in touch with my family.
I. So even though you didn't get to see them, do you phone them or are you in touch regularly?
P. Phone them too.

Participant #3
I. So do you still see your family?
P. Yeah uh yeah.
I. Do you go home often?
P. On weekends, every second weekend.

P. Yeah, yeah, I talk on phone.
I. So do you like having that contact?
P. Yeah, yeah it's good.

Participant #4
P. A brother lives close by on (name of street).
I. Okay. Do you have contact with him?
P. Yeah everyday.

P. I take him for coffee alot.

Participant #5
P. Oh yeah. We got a family reunion at the (name of hall), this fall with a bunch of kids, uncles and aunts.

P. My brother is in this Saturday; spend time with him and then the week after I can see her.
I. Okay. So you are making sure that when your brother is in that you can spend as much time with him as possible?
P. Yeah.

Participant #6
P.....I want a lot of money to buy a new computer.

P. Big time, to contact my family.

P. I'd like that e-mail to keep in touch with my family everyday.

Participant #8
P. That's where they stay now but my dad is gone but my mom married another man.

P. …I usually sleep over. They have a spare bedroom in the senior's home.

P. And uh, yeah and uh my brother had a relationship with me too.

I. So how often do you see him?
P. Well, uh, not that terribly often. But most times I see him is when I go to my parents, he'll be there. And we go for coffee, buy some supper.

P. They couldn't have children. So they adopted me from the hospital when I was like this (small movement).

P. Yeah. They got someone to come and see me. They came along and took me home.

P. And I was 3 years old when they picked up my brother.

P. …And I was looking at my little brother and thinking I have a little brother now! It was nice it was happy.
I. What was it like growing up in that family?
P. Well it was pretty good. Uh, work was the big thing there on the farm. There was always something to do. And I helped dad and my brother too. I helped with pigs for 5 years. He was driving truck, a special truck.

Participant #10
I. And how about your sisters, do you visit them?
P. Yeah, I visit them yeah I go visit them once in awhile and that. And whenever I have time, I go see them. Give them a call and go visit them.
I. ….Who do you spend Christmas with then?
P. My sister cause all my family is far away.

Another aspect for some people was the important family traditions and values that they learned as children.

Participant #8
P. Uh, we all get together for a family gathering. We go to, first thing we go to church. It is called (name of church). And from there we go to have more family gatherings.

P. My mom and dad, they believe in keeping those holidays. So that means we go to church.

P. And my family is a lot Christian. It means they believe in the bible and that.

P…..And I had a really nice mom because she kept the house nice and clean.

Having positive family support and understanding during difficult periods or circumstances was highlighted by four participants.

Participant #1
P. My mom is supporting me. She says I hope you are going to be safe, use condoms and whatever.

Participant #8
P. Because I would sleep day and night. I felt sick; I don't know what I felt. Anyway mom was wondering about so she took me to the clinic.

P. Yeah. Like I've been living with mom and dad also on the farm when I could have gone on my own but my family still supported me through that. Now that I've been living on my own, I just go to stop in there.

P. Well uh what helps me most is uh, I still got my parents, they are still hanging in there. Like you know what I mean?

P. So that's what happened there. Yeah, like I had good parents, I really love them.

Participant #9
P. Um, I guess uh very supportive no matter what I did. Um, not really so much of as uh, the negative way but if it wasn't good for me they tell me '(participant name), this may be not a good idea right now. It might be good later on but whatever you do you know, we just wish you the best of luck with all the stuff that goes with it'.

P. Yeah, it kind of makes you uh feel wanted you know. You feel special. Kind of puts you in the centre of the spotlight (laughing).

Participant #10
P……Then there was a teacher and staff and I ran out of the school and ran to my sister's because I felt so bad and I was crying all the time and I thought what did I do. And then the cops showed up and that's when I got away from them and then I went back to my sister's…..

Negative family influences were a common theme with many participants. History of abuse within the family, substance abuse, arguments and systems' involvement were shared. The importance of being able to remove and provide distance from these situations were recalled however some individuals remained in contact with particular family members. The 3 participants who relayed a history of alcoholism in the family also discussed their own struggles with addictions at times.

Participant #1
P. Yeah. I have had people calling me down because I have uh, an alcoholic family. They can't take care of you because of the liquor.

P. Like you know what I mean- they thought I turned out to be like my parents. Just because of being alcoholic.

I. What do you think is the most difficult thing now?....
P. Um it's nothing with Opportunities or anything else like that it's that – it's like the family situation that are- that I grew up in.

P. Well, occasionally not all the time but I, like when they drink, I don't talk to them.

P….Yeah, I grew up in that family. My father used to abuse me, I know my brothers told me to give up on that, that hurted me right there.

P. And my dad did it right in front of my grandparents and if my grandparents were to do anything he'd threaten to kill them or something like that.

P. Then I was, I don't know for some reason I- something made me forgive my dad but I don't know what it was.

P. … but every time I'd see my dad I would just wanna grab a shot gun or something…..

P. But my mom said it's not worth it. If you are going to do that it's going to make it even worse, put you in jail for that.

Participant #6
P. Um, very good. My mom is doing alright, Dad's okay, (name) well not too bad. Before lots of trouble, then no trouble, but now there is trouble.

P. Yeah cause my sister don't like my dad no more and (name). Because they took (name) away, my niece and all this happened in September till now, Oh God!
I. So how does that affect you?
P. Oh, so very piss off. Yeah and scared because afraid that they take (name) away and uh through Family Service there too and the police. And no good but my sister trusts me.

P. Yeah she got 1 brother in the city so that's good. That's the main thing. My dad and (name) trouble but I don't know what to do about that but a lot of phone calls. Like he say, what she say, you know.

Participant #7
P. It is only people that are positive to me that I keep in contact with. And other members of the family members I uh, kind of avoid them eh because they are drunks or are into drugs too much or they break the law too much so I don't care to be in contact with them.

P. Well they were pretty well into alcohol at that time eh. I had it pretty hard. Along with my siblings.

P. Pretty much that was the reason for moving. I was having it rough and I was getting uh beaten up and sexually assaulted by family members and this and that and so on.

P. Yeah. I seen the things that I didn't want to see when I was young.

P. Like with family members and so on. It was getting to me physically and emotionally. That's when I left.

Participant #10
P. No, I don't see him that often no. What he does is he drinks a lot.

P. And it's uh to the point where I can't handle seeing him no more. Like he used to be abusive to my mom and I didn't like that at all.

Isolation from family members either by leaving the family during adolescence, being taken away at a young age from the birth family or effects of siblings moving away were recounted as being difficult.

Participant #2
I. Yeah, do you get to go home and see them at all?
P. Not very often, no.

P. Probably in spring maybe. When I get some money I'll be able to.
I. …When's the last time you were able to go see them?
P. Uh 2 years. It's been a while ago.

Participant #4
P. I was on my own actually at sixteen I moved out.

Participant #5
P. Well, they both have kids, they are both married, they both live far away.

I. Were you close growing up?
P. Uh…yeah kind of yeah.
I. And when you were growing up did you live with both your mom and dad and your 2 brothers?
P. Yeah, in one big house.
I. Do you have good memories of that?
P. Oh yeah.

Participant #6
P. My sister lives down there (pointing). And I've got 2 brothers, 1 in (name of town), 1 in (name of town). Mom in (name of town), dad in (name of town). I've got a huge family.

P. Sometime I phone them because it is too much money to drive down there. Once I did when my grandma passed away because it was important to me. All my family was there.

I. So how old were you when you stopped living with your parents then?
P. Oh, geeze uh... Let's see, I'm 3-4 uh….I don't know.

Participant #7
I……So do you still see your family?
P. Not very often.

P. They still are living outside of the city yeah. I've got absolutely no family contact with any family members in the city.

P. ….I still have contact with family members back home.

P. Mom, sister and elders.

Participant #9
P. I have a family. I have an uncle that lives in (name of city) too. And aunts and uncles that live in (name of province).
I. Okay, do you stay in contact with them?
P. No, actually I'm not, no. Except with the ones in (name of town), I am.

P. I have a brother that lives in (name of city). Um, and I also have a brother who lives in (name of city) here. I currently don't know where he is at right now.

Participant #10
P….. so they moved me to Winnipeg and they separated the family like, my sisters went somewhere else all over the city and that. And I was all over the place because I was the youngest….

P. You start thinking about that and my sisters are wondering where am I and what am I doing and that. And I tried to call them….it was hard it was just deep darn hard and I couldn't do anything because (agency name) didn't know how to get a hold of them. And then after (agency name) I went into uh, I moved into Opportunities.

Half of the individuals reported that illness and death of family members were significant issues with which to cope in response to what was the most difficult thing in life experiences.

Participant #2
P. Uh, right now my grandpa is ill. I mean he is having cancer in his whole body. For some years.
I. Is it tough when you are away?
P. Yeah, that's the most toughest part.

P. I don't know I don't think so it's... last time I heard his doctor checked him it's right through, the cancer.

P. Uh, one is hearing that my grandpa is still well. He gets up, walks around and in the daytime he sleeps.
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Participant #5
P. … Uh, my mom sometimes but she is sick, she's got arthritis and she's got a sore back.

P. Every week.
I. Is it tough for her to leave the house like that?
P. Yeah.

Participant #8
P. Yeah, I go there about once a month, regularly visit them out there in (name of town). Because my dad passed away.
I. Your dad passed away?
P. Yeah. What happened there is he had cancer.

P. And he had just retired a year ago before he passed away. They said it was time to retire so he took the option. He sold everything.

Participant #9
P. A little bit of, not so much of the past but um, just kind of working on uh helping to deal with some of the losses, uh the grief that I've, I've discovered this past year. The loss of my mom, so I um kind of dealing with that, kind of tough right now….

P. Actually I, she had passed away when I moved away which was last year, April 28th of this past year of 2006.

P. … we owned a house together.

P. Um, I think um, I'd probably say the loss of my mom. That was the biggest thing.
I. Okay, was she ill for a long time if you don't mind me asking?
P. No she was sick for about 1 week. And uh, it was no she passed away on April 28th of 2006. That was a very sad time that came and went.

P. ...how do you strive for your life to be happy like after you've had someone you live with your whole life and it just goes. Then one day you are happy and planning your life and then there is a shock. You know, that whole time there and uh, during the funeral I was feeling the adrenaline of what just happened there.

P. It's not easy. It's um, I don't understand. People that haven't lost a loved one who was close, they'll never know how hard it was, how much it hurts you know. And that feeling of loss is…..the first 5 months are…your mind is rewinding all those memories that you had with that person till the day you know till the day of the funeral and uh it's pretty tough.

Theme 3-Social Opportunities and Support Systems

A distinct finding for this cohort was the importance of support from friends or formal community resources. Experiences with friends were identified by some participants including support during difficult times and the importance of surrounding oneself with positive influences.

Participant #4
P. Good people I guess- take them for coffee like me and you are doing (laughing). Yeah that's what I'm doing alot, clean fun.

Participant #5
P. Fridays I go to the hospital and then I come back.
I. What do you do at the hospital?
P. I have breakfast with a couple of friends.

Participant #7
P. It is only people that are positive to me that I keep in contact with…..

Participant #9
P. Um, I have a little bit at both. I have some that are in the Winnipeg area, lot of them are from (name of town) area too.

P. Yeah, um a lot of friends that helped me you know, good job they say, don't let other people tell you that you are not the perfect person and that there is no such thing. I don't plan on being a perfect person. It's like, I really don't care about the things you've done like I've learned to live with them now and it's been 7 years since I've been out of prison so whatever.

P. It really is a mixture of people. Yeah and uh maybe the ones that are different than me maybe they are, like they are, I don't know I don't see that maybe that I grew up in a white neighborhood, I don't really see myself as Native. I just see people for who we are. I see everyone the same, you know, like human beings. I wish the world could be more like that.

Participant #10
P. ….And I got to meet some good friends and that. They were very helpful sometimes. Like whenever I had a problem they would ask me and they would open up to me to see what I was going through and that. And so I told them yeah I am going through this and going through that and they would understand that.

Conversely, negative influences from peer groups were also highlighted by many individuals. Experiences of bullying, engaging in criminal activity, alcohol use and general annoyances were discussed.

Participant #2
P. Bullied, yeah.

P. Mostly uh my attitude like with the people I uh hung out with people because of alot of my friends, they also put me down...

Participant #4
P. I don't want to hang around with those guys now (laughing). They'll get you into trouble- deep trouble and all that.
I. Who are they- like are they friends you grew up with or?
P. They used to be but they steal cars and I didn't like that so I told my friend you better leave the keys and leave. I don't want him coming back.

P. Or I'd get one of these warrant things like uh, restraint or restraining.
I. A restraining order?
P. Yeah, I could call the cops right now and they would come and take them away.

Participant #5
P. Um, my friend is abit of a pain in the ass.

P. He is always joking around and not listening and he says something stupid sometimes (smiling).

Participant #7
P. Well my friends are like alcoholics I guess. They drink every time they have a chance and uh, I don't spend time with them very much.

P.....I got friends that I don't associate with no more.

P. ....And I find that hard, I find that kind of hard for me to do that because uh, it kind of hurts my feelings to not keep in contact with them. It hurts and they know because before when I used to hang around with them they know I was like drunk with them and so on. They'd borrow things off me and so on. They still want me to do that with them but I can't because I am trying to straighten my life out, not getting too, trying to get myself into hurting another person or re-offending.

Social contacts, experiences and options were not directly discussed however an underlying issue of limited opportunities due to relocating and lack of community resources for people with developmental disabilities became evident.

Participant #2
I. ....Do you have lots of friends in Winnipeg?
P. Well a few.

P. Uh, I'm gonna go to my friends.
I. Yeah. Is it a big get together or?
P. No, no, just (friend name).

Participant #7
P. ……It would make me feel better to go out and meet different type of people that I could talk to instead of going there everyday and seeing and hearing the same thing. But it would make me feel better if I get to go out and meet different kind of people instead of wasting for the future.

P. It would be a good social opportunity.

Participant #8
P. Well, they were neighbor friends, say hi and uh, I know a lot of guys when I was they're age too. Now most of them are gone and married.

P. But they are spread around there. But every time I go to (name of place) to visit, and I see a lot of people they always say hi. They are my friends.

Participant #10
P. I didn't really get to know much of my friends at all. And uh, I was uh just being moved and that. I got to know a little bit of my friends and a little bit of what they were like and they uh thought about me and that.

P……..Um, my friends, we kind of moved in different ways and that like schools and that so they didn't give me their numbers or anything like that so….

P. So I was in there and um, the security guards were nice and that as long as you treated them nice. I got to know a few guys in there but, but uh, they asked me what I had done and I told them and then uh this and that. And they said 'oh okay' and then they got abit knowing about me and what I was about and that.

An underlying need to "fit in" to meet social expectations was highlighted within discussions that exemplified either current or future goals of relationships, marriage, and independence related to vehicle and home ownership.

Participant #4
P. I got a wife named _____.

P. I need to get her and pay rent and help her out at school.
I. Do you guys have kids together?
P. No we are engaged already so we just talked about it.
I. So she's your wife or she's your girlfriend?
P. She is my wife now so.

P. Pretty soon we're getting married. Probably next up coming January I guess.

Participant #5
P. Yeah I got a girlfriend named _____.
I. Okay. What's she like?
P. Cute, pretty, beautiful, nice.

P. (Name) makes it better.
I. Okay that's your friend.
P. No that's my girlfriend.

When asked what would make things better, some participants referred specifically to having a significant relationship and related this to obtaining a more fulfilling life.

Participant #5
P. .....be happier, being engaged.

Participant #7
P. The most important things that I have learned there is about uh how to communicate with people and how to start communicating with other people that I want them to be close to me and how to start a relationship with a woman.

Participant #9
P. I think um, if I had a girlfriend to uh, you know someone that I could talk to you know. I talked to my brother and he said that that could be the best thing for someone is to get a uh like he says you need a girlfriend that would uh kind of replace that loss and emptiness. And uh I kind of agree with him because that's

you know… After living with my mom for 25 years of my life, not being able to say hi to her you know. So but I'm opening a new chapter now…for who I am now to where I am going next is going be uh, its going to be a change. And I think that there is uh a chance of a relationship in my life so.
I. So that's important to you to have that connection with somebody?
P. Yeah, very important.

P. Um, I had it when I was younger abit of I guess a high school crush. It was uh, a short period of time but during that time I made the best of what I had you know. Um, I was on uh I was interested because I had uh for that um, for her it was like, I kind of had uh, kind of I guess I was putting all my motivation towards making her happy which was actually a lot of fun because I like making people laugh and I love making uh seeing a smile on their face because it puts a smile on my face.

Participant #10
P. ….I would probably like to uh have a nice big house where I could live and that and raise my family and have a wife and kids. But that is going to take some time to do and that so.

Some individuals additionally identified the goal of obtaining a driver's licence and other things that would indicate independence and being successful with an underlying theme of wanting to fit in socially.

Participant #10
P. …. my dream would be to uh would be to uh have my own house, have my own vehicle, get my drivers licence…..

Participant #8
P. What do I wish for? Getting a license. Get a nice Chevy truck.

P. Oh, a truck would be, you know what I think when I see a Chevy truck is the tires and the power of the motor. And that's what people in (name of place) have.

P. Yeah, that's what I see people driving around in. Then I could get there, get my license.

Other community resources were also noted as being significant supports when dealing with certain issues involving sexuality, substance abuse and convictions.

Participant #1
I. So are there any groups from the community that helped you deal with the sexuality end of it?
P. I've got that under control. There is this thing on (name of street) there. The (resource name), they like have information. And there is pamphlets you can read, and take a look at everyday pretty much every day.

P. And I've attended alot of (name of resource) meetings as well in the past and I couldn't do it anymore. I just thought alcohol is not a problem for me so – I don't drink as much as I used to in the past.

Participant #7
P. Well I have to go to school at uh, (name of resource) part time on Fridays from 10 till 12. And I go to (name of resource) every Wednesday.

Theme 4 – Home life

The continuum of residential settings from childhood to present was discussed. Negative effects associated with frequent moves as a child and difficulty maintaining relationships with people were mentioned by participants.

Participant #6
P. Yeah, well I lived at (name of place) first then I moved in with (staff name) and (staff name), moved to (street), moved to (street) up here (pointing) same thing.

P. I moved a lot of places.

P. Never stopped.

Participant #7
P. I was only born in (name of place). I was originally from (name of town), a place called (name of town).

P. They moved around eh, like they moved around from reserve to reserve.

Participant #8
P. I'm a little lost. I'm not even sure exactly. Like I moved to different places like (name of street) and then I moved to (street name) here.

P. I keep moving like to uh 4 places or so in the past.

Participant #10
P. …. And uh, Child and Family Services they said well we are going to have to find a place for you and that. They did their best and uh they tried to uh, it was like I was going through that issue and that and I didn't understand why I was doing that and that. And uh they just kept moving me because I really wasn't happy and that.

P. I was ages from 5 to uh, uh, 10.

P. Yeah, I got into (agency name). And uh they uh put me in (name of place) like Child and Family Services.

P. Uh, I lived in that kind of setting for almost 2 years. When I went there it was pretty hard and that. At first I didn't know what it was called I mean the agency and that and uh I just thought 'man what am I going to do with my life'? Then I started getting older and that.
P. I didn't really get to know much of my friends at all. And uh, I was uh just being moved and that.

Supports from staff and formal care facilities such as room and board settings or apartment living were noted.

Participant #5
P. I live alone.

I. Do people come in and help you with banking and other stuff or do you do that all on your own?
P.I have a support worker that helps me out.

P. Grocery shopping, go to the bank and have supper.

Participant #8
P. Some of these places weren't good for me like the (name of place) is kind of….. people drink.

P. And stuff like that. I didn't like it there.

P….That was not the right place.

P. It was terrible.

Participant #10
P. ….Income Assistance pays for the room and board.

P. And I only got a certain amount of money and that.
I. Did you have to make your own like meals there or were they provided or?
P. They were provided. Yeah they were provided.

Alternative residential settings such as foster care, group home settings were identified as placements for 8 out of 10 participants with varying experiences on whether these options were of benefit. Positive experiences were listed as follows.

Participant #1
I. And with your foster family- you felt safe?
P. Yes they took me in right away when they heard about the abuse about me from my dad.

P. Since I was 2 years old. They took me in when I was 2 years old.
I. So you've lived with them on and off or..?
P. For my whole life when I was a little kid. I was still with them when I was 13 when I left. I left them.

Participant #3
I. Ok, how long have you lived there with your foster parents?
P. Um it would be 2-3 months.
P. He works for uh, he said he works for (agency name).

Participant #4
P. Actually I was in at 14. I was growing up in uh, what do you call it? What is…..I can't remember the name.

P. It was like a foster parent's place and they look after you if you are going to school.

I. So how long did you live at that place?
P. Oh like 3 or 4 months around.

Struggles within the various living arrangements were noted as was loss of contact with previous care-providers. Ability to identify specific time frames related to the past seemed difficult for some individuals especially when the person had experienced frequent moves.

Participant #3
P. Sometimes, sometimes someone breaking my stuff like that, break my stuff.
I. Breaking your stuff?
P. Like I'm not sure I don't know.

Participant #6
I. How long have you lived with (agency name)?
P. Uh, geeze a long time, like 4 or 5 years something like that. I am not sure I never keep track but it's around there.

P. Yeah. I live with (name) and (name) who were foster parents a long, long time ago.
I. Okay, how old were you when that happened?
P. Oh…fourteen? I'm not sure, around then around 14.

P. Yeah but then I moved from (name) and (name) out, time to change and then I moved to this place.
I. Are you still in touch with all these people that you used to live with?
P. I used to be but not no more. (name) and (name) moved out and nobody lives there no more, well different people.

Participant #7
P. Well, half and half. Foster home and family members.

P. Well I did keep in contact with them after I left the foster homes but I lost contact with them after.

I. Did you ever feel in those foster homes like it was family or how did that feel for you?
P. Well it felt uh, I felt lots of um loneliness and I felt lots of anger.

Participant #8
P. Uh, yeah wait a minute. There was a foster home when I turned 18 but then already I was feeling the illness.

P. Yes, but also I was in a foster home for 2 months but I walked away from there. I was going through some problems there.

Participant #10
P. No the foster families, I didn't keep in touch with them.

Living within the biological family setting into adulthood was mentioned by a few participants as the primary residential placement prior to their first move into the system or living independently.

Participant #3
P. Uh, I lived with my parents before.

Participant #5
I. Always with your mom and dad?
P. Just with my mom and dad.

Independent living situations were discussed and highlighted in terms of difficulty managing money and developing the requisite skill set that is needed to successfully reside without support. Factors such as limited financial resources from Employment and Income Assistance and the inability to rely on family members directly impacted on realizing the full potential of independent living.

Participant #1
I. For how long have you been living by yourself?
P. For almost... 6-7 months now.
I. Do you like it?
P.Um, so so. Yeah – sometimes, it's kind of hard but hey.

Participant #4
P. …I was living on my own.

P. I was doing money, banking and all this.

P. Probably an apartment is better these days.

P. Well, the heat goes up pretty high, goes down but then it goes up again.

Participant #9
P. I do it all pretty much on my own yeah.
I. So no one comes in to take you shopping or help…
P. Uh just me, no.

Participant #10
P. Those settings were like an apartment where I got to live independently on my own. And I got to do things on my own and that. I enjoyed it a lot, yeah so, yeah. It was a lot fun.

P. Um, um, I would like more, uh more, abit more money because like the way Income Assistance is paying me and other people these days, it is not enough to live independently on your own. And I feel like I've been getting ripped off and I feel like man, I don't get enough money, I don't have enough clothes or enough food and that. Like I told my worker, I said, look if you want me to try, I simply told him, I want to move independently on my own where I can do my own things. But if you are giving me this amount of money, I am going to get up and leave and that would be the end of it.

Theme 5 - Assistance from Opportunities for Independence Incorporated

The range of services that OFII offers regarding intensity of contact, reason for referral, residential services, treatment programs, work experience/day program services, social opportunities and general support that the agency provides were chronicled.

Frequency of contact and extent of present OFII involvement was discussed by many participants.

Participant #1
P. Uh, not that often. I just go when I'm up for it.

P. Um, pretty much Opportunities, um is basically there when I need it.

P. If I have a problem I have workers 24/7 but they only work with me in mornings from eight to four. If I have a…There is client cell phones that I can phone and if I have an emergency, I can contact my support workers.

P. Wednesdays, it is called solve or resolve or something like that, I don't know. It is some group that you get together and you go out Wednesday and talk about our issues.

Participant #2
I.….do you still drop in there?
P. A bit. Yeah, every now and then.

P. For 6- 6 years.

Participant #3
P. ….for Opportunities for 2 years now. No, no almost 2 years.

Participant #5
I. Um, when did you start going to Opportunities?
P. Years ago, a long time.

Reason for starting involvement with OFII was expressed in relation to the question how and/or why did involvement begin with the agency and ranged from probation orders after release from prison to referrals from other community services.

Participant #1
P. So… I've been in jail for a year, then Opportunities got me out.

Participant #4
P. I think my lawyer told me to go there for 1 year anyways so.

P. He said, hey it's only 1 year anyway and then you are done so. That probation was done a long time ago.

P. No I just check in for a bit.

Participant #6
I. … Did someone tell you to contact them or?
P. Well, (name) and (name) and different people because I needed a lot of help.

Participant #7
P. Cause they told me that place would help me integrate myself back into the community.

P. …. I usually talk to somebody about it. Like maybe a staff member or maybe my sponsor, or maybe one of clients. Make a day of where can I go. Get an idea of where I can go maybe to get a job or to go hang around or talk to people.

P. Positive people.

Participant #8
P. Uh because I was uh, I had a problem with sexual aggression of women.

P. And that's why I went there because my P.O. at that time said, I can't remember her name but she is my parole officer. Yeah she suggested it.

Participant #9
P. ….. I know afterwards they had talked about that I would have to get admitted to some kind of um, program that I would see it differently I was thinking that stuff to get back on life.

P. Well that was simply after the uh, after I got out of prison and that.

P. Lot of it was uh one on one sessions with uh teachers and uh therapists.

Residential services and supports offered within the OFII treatment homes were described.

Participant #4
P. Uh, Opportunities.

P. In a group home.
I. Okay, how long have you lived there?
P. Um like I'd say like 8 years now.

P. We share the I guess the what do you call it the vacuuming and washing and like taking care of the house.

Participant #7
P. Well I live with the, the (name of street) with 2 other clients that are participating in the program.
I. Okay so it's an Opportunities group home or residence?
P. Residence, yeah.

P. Since uh, coming up to uh, pretty close to 2 years now.

Participant #8
P. Um living with a house on (street name), like a treatment house.
I. Oh okay, through Opportunities?
P. Yeah.

P. Uh, it's been 16 months or so. And like uh, when I moved in there, I am learning how to do things like cook.

P. It's clean and I like it better.

P. Like the staff are saying I am doing really well for a lot of things. Like uh, they say that who knows in a couple of months I move out to my own apartment and get a roommate or something.

Participant #10
P…….And then after (agency name) I went into uh, I moved into Opportunities.

P. Um, I was about maybe 24, 24 years old.

P. Well Opportunities was uh how the judge said you need to go and that is when Opportunities came into the picture.

P. And that's when I started with the agency and that and they said '(participant name), do you want to live at Opportunities and I said, what is Opportunities and they kind of explained. They kind of told me about and then I had to sign some papers to release and that. And so Opportunities took me in.

P. I am not sure, it would have been uh, 2004 I think that I started with them.

Assistance from OFII staff to find and secure alternate residential options was also highlighted.

Participant #10
P. Probably a different place.
I. Okay. Any ideas of where that's going to be?
P. That I don't know.
I. So who will help you with that, like to figure that out?
P. Opportunities.

P. And they put me there because they don't think that I'd be able to do that yet. But I've been, I've been trying to, I've been wanting to go back to school and that but it's hard. It's very hard for me to understand how much to get out of the bank. How much you need for such and such and whatever stuff you want. And I have to learn to budget sometimes.

P. Like I can't remember where I got to go with that, I just go spend it. And that's that, the cheque is there and I go spend it. But now they do a budget with me and they make sure I got the basics.

Benefits of treatment such as individual counseling and group programs including CARP (Community Alternative Re-entry Program) which is specifically directed to change thoughts and behaviour that perpetuates sexual offending

behaviour, anger management, and social skills training that OFII offers were weighed.

Participant #1
P. Taken groups for that. Yeah, anger management helped alot.
I. ….Do you have individual counseling for that stuff too?
P. I used to... When I first started her name was _____.

P. So I stopped going to treatment it was about two summers ago.

P. Yeah, I used to go to alot of groups. Like Mondays would be CARP, they had that every Monday night.

P. It's a group that they get together, talk about issues, problems like in the community, pretty much. And then Wednesday there is problem solving where it used to be Thursdays. Problem solving is just basically talking about problems within the group. So I used to be in that but I pretty much just said… Let's say I retired from that group.

Participant #2
P. …. mostly just talk to the groups there.

I. ….What are the most valuable things you've learnt there?
P. To learn how to keep my job.

P. Like have a good attitude.

P. To behave myself and not to lose my temper.
I. Okay. So like anger management kind of thing?
P. Yeah.

Participant #3
P. I go to Opportunities Monday to Friday.

P. Like uh, reading and writing.

I. And then do you go on work experiences or anything like that?
P. No not yet, no.

Participant #4
I. …….. Have you ever taken part in like anger management and stuff?
P. Well, no. Only on Thursdays that's about 3 or 4.

P. If there is a group in I'll probably stay at work (laughing).

Participant #6
P. I used to go to CARP I finished CARP a long time ago.

P. Where you talk about things like different things, that was a long time ago. And so I go there.

Participant #7
P. Yeah I come everyday, 5 days a week.

Participant #8
P. Opportunities is better. Oh yeah, way better. Yeah, I hope so (laughing).

P. .....But I've gone to another program there uh, let's see what's it called, about uh when people have difficulty in life. Like losing something.

P. ....not grief but where staff help people learn how to act in public, like behaviour.
I. Oh okay. Like social skills?
P. Yeah that's the one I was thinking of, yeah.
I. And did you find that helpful?
P. Oh yeah, it has, oh yeah.

Participant #10
P. Uh, sometimes Monday to Friday yeah.
I. Um, did you participate in education type classes there?
P. Yeah I would attend classes there with (name).

Participants were asked what the most important things were that they had learned at OFII. Responses included learning specific skills, having increased social opportunities, and increased safety for others and self.

Participant #3
P. Uh like sometimes like trying different activities and stuff.

P. No like someday I go for coffee, some day, movies.

P. Like sometimes we go for uh like a group, there is group too.

I. Like night time stuff you do or you just go during the day?
P. Just during the day.

Participant #8
P. That I'm safe, that I have a house, a roof over my head and food to eat and support.
You know that is worth a lot to me you know.

Participant #10
P. What helps me the most is that, um, my workers, my workers at Opportunities. They help me a lot. Uh, sometimes I try to uh, sometimes I have questions about life, about my goals and my dreams and that and they try to help me understand that '(participant name), you are going to be, you are going to be amazing someday, you're incredible. You could have all this money and that. Just keep dreaming about it and it will come true.'

Assistance offered to find and secure employment opportunities was identified as an important, valued service by five participants.

Participant #2
I. Did Opportunities help you get a job?
P. Yeah, last time my workers got me a job at (name of place).

P. To learn how to keep my job.
I. Like?
P. Like have a good attitude.

Participant #6
I. What are the most important things you think you have learned there?
P. Uh well…working jobs and make money, that's the first thing.

P. No like I can't on Friday because there is no staff to take me, only Monday to Thursday.
I. Oh okay, so you would prefer to be working five days a week?
P. Yeah, yeah. Friday is always movie day.

Participant #8
P. Yeah, I worked at this place through Opportunities. Like I've been working at (name of place) and I work for (name of place).

Half of the individuals made reference to the inherent social opportunities and leisure/recreational options that OFII fosters including activities, outings, and general social opportunities.

Participant #3
I. Where do you and your friends hang out?
P. Uh not too much, they hang out at the day program ones.

Participant #4
P. You go out for breakfast. Uh play pool or you could play pool, see a movie with all the guys.

Participant #6
P. Well I got one, I got lots of friends.
I. So are they from Opportunities these friends or other places too?
P. Oh yeah.

P. Sometime we go on outings like movies and different things. Lots of things in the summer time.

P. In the winter time we don't do that. Take the bus or drive you know.

I. .....what is your most favorite part, like what keeps you going there, what do you like the most?
P. I play pool.

P. Yeah, play tens (card game) lots.
I. It looks like it is a fun busy place to hang out.
P. Oh yeah! It's busy, big time.

Participant #7
P. Yeah, we usually go for coffees on uh Monday mornings and Thursday mornings we usually go for breakfast.

P. Yeah and between those times we usually decide if we are going to go uh some place else to go and participate in these uh other activities in the city or community.

P. Yeah my day looks like it is going to be good with a couple of card games ahead.

Participant #10
P. Yeah, I got a lot of friends like at Opportunities and uh like they are very good to me, very nice. They really like talking about the issues. Sometimes they joke around and they uh tell stories about themselves and how they want to be independent and on their own. I kind of like that they talk about those things because it makes me feel like maybe I should try that like be more responsible or.

P. It's like a group yeah. It is a good team effort there yeah.

Assistance from direct staff, therapists and management when experiencing difficulties by having a venue to communicate was noted by 6 participants. Emotional support in a non-judgmental manner was identified as important.

Participant #4
I. So who would you say are your biggest supporters like who do you turn to when you are having trouble?
P. Uh probably uh (name).

P. Yeah or (name)or somebody at the Opportunities house.

P. It is a good thing anyway.

P. It's more better to keep talking to each other about it and so and so.

Participant #5
P. Uh, well I see (name) tonight, this afternoon actually and then we might go out for coffee.

I. Okay, what helps you the most right now?
P. Um, my support worker (name), a guy from Opportunities……

Participant #6
P. Well people help me like you and a lot of people.

P. Oh yeah, like (name), (name), everybody.

P. Through different things like get a job, that's good you know. Like my allowance a long time ago.

Participant #7
P. Definitely yeah, a point person to talk to and pass on information to other members that are working and it helps me too. Like if I have a problem, now or if I have a problem in the future I can talk to someone right away and I can make the best of it so it doesn't bother me or anybody else in the future.

Participant #10
P. Well, I've learned that that they are very nice. They are supportive, uh their clients are learning things. Like I've learned a lot about life and that and I am also learning that if you have a problem that you can go there and talk about it and not

be afraid or scared or upset. And they understand how you learn and that the very nice thing about it.

P. ....but at Opportunities there if you are having a bad day they understand. They'll ask you what's going on, you know, they'll try to help you out there and that. They are not there to judge you and that and they are not there to judge anybody else either.

P. They're there to help you along in life.

P. Good support.

Theme 6 - Productivity

A larger theme of productivity including childhood school experiences, adult education, day program and employment experiences were discussed by all 10 participants. School experiences as a child and adolescent were reported to have both positive and negative consequences for individuals when asked what school was like.

Participant #1
P. Uh school? I liked it actually it was pretty good from nursery to grade 9 – I actually made it which was amazing from nursery to grade 9.
I. Why is that?
P. Because I never thought that I'd make it all.

P. Especially for like a young kid like me. When I was small I couldn't... I thought I don't think I'll be able to handle school.

P. I was an overall excellent student, I was one of the best ones.

Participant #2
P. Ughh (rolled eyes).
I. Did you enjoy it or?
P. No- sometimes I do, sometimes I don't.

Participant #3
P. I went to high school but I got kicked out of there.

P. Yeah, I like school.

Participant #4
P. Well a little bit frustrating (laughing).

P. Grade 8. I was supposed to finish my grade 9, 10, 11, 12, so.

Participant #5
P. It was kind of difficult.

P. I was in a special class.
I. So did you go all the way through or for how long were you in school?
P. Until grade five.

P. I never went back to school.
I. … How old were you when you were done school then?
P. Oh, maybe I was fifteen. Teens.

I. ….did you ever feel like people were picking on you or stuff like that?
P. Yeah, in school yeah.

P. The way I looked, the way I talked.

Participant #6
P. Oh, it was great!

P. Yeah, not too bad. I liked going to school.

P. I got alot of friends in school.
I. Good. What was your favorite topic in school?
P. Uh…recess, go outside.

Participant #7
P. It was pretty good. I kept up my grades and sometimes I would get myself into a little trouble here and there and so on. I was into sports.

P. Yeah, well I really loved it yeah, yeah. The only thing I didn't like about it was getting up early in the morning. (laughing)

Participant #8
P. Well school I wasn't very well eh. Like uh I was doing okay until grade 5. At least I finished that. I wanted to go longer to school but dad took us out of school to work.

Participant #9
P. Uh, it was tough. Uh, I would say that uh, uh, I was different from everyone, you know. While growing up I was bugged a lot you know. I was kind of the centre of teasing, you know, teased a lot when I was younger.

Participant #10
P. It was uh going easy and then after that it was going harder and then I went to that school and that and then I had a hard time. I couldn't stay in school and I was more slower than the other kids.

P. Yeah in a regular classroom. Yeah, I didn't learn that quick. Like, like it was hard from me so I just thought, I got to try my best.

P. .....some girls were bugging me at the school and they said stuff and I was getting very upset and I felt like I was getting uh, no one cared about me, no one noticed and I just about turned the knife on me.

P. Yeah, and I thought oh man. And I went down to the cafeteria that time and I brought the knife with me and the girls were there again and I made a sign that I was going to kill them and stuff and they took that as an offensive act.

Continuing education as an adult was discussed as an important aspect however at times difficult for individuals.

Participant #1
P. Yeah I get tired at the end of the day after school.

P. So I don't drink as much because school gets in the way. (Laughing)

P. If something could change? Um, well first thing – is if I uh- well schooling will probably be one thing right now.

P. Schooling. In the near future, finding a job.

Participant #7
P. Yeah, well I am working on going into a little higher grade like uh, I want to take my GED.

Participant #8
P. Now, it's uh I do a lot of writing and reading and stuff with books. Learning how to write. I've been studying a lot. Those books that are not too big words. I can pronounce all the stuff.

Participant #10
P. And uh she got me into a program like adult ed and that and uh, she said 'why don't you try out different schools and that' and I said I don't know if I could cause I dropped out at grade 11 at (name) High School because of things and that. And um, I just didn't go to school for almost 2 years and that.

P. And I didn't like, it didn't give me very much options. I had maybe 3 options, like maybe get a job or start my own business or go to school.

P. And she told me that I should go to adult ed and get registered and that. And after that the next day, or maybe a couple of days later, I uh forgot to go do the project and that at the adult ed and uh they said '(participant name) you're not doing the right things. You are not showing up on time. You're not responsible and not doing things and that'. And I said I'm sorry but I got a lot of things on my mind and I got issues and things like that. And I just decided no, I'm not going to do adult ed, I am just gonna start my business up and start working and that at maybe a job or something.

Feeling judged by others based on past offences which took place in school was also identified as a barrier to returning to school as an adult.

Participant #10
P. … Or I might be judged again and get hurt feelings by these people and that's the very scary part of that of trying to go back to school and get my grade 12. Cause also I was in the newspaper when I threatened those girls. I was in the paper and that so I don't feel confident enough to go back to school. I feel like I am going to be judged on that.

Daily activities related to day program and vocational pursuits to improve upon their financial situation and subsequent barriers were discussed when asked what occupies their time during the day.

Participant #2
P. …..to work there.

P. To do my, add to my days. Like uh, Wednesday and Thursdays that's about it to make a full week.
I. Oh okay so you'd have 2 jobs?
P. (Nodding) Just to make more extra money.

Participant #4
I. What helps you the most right now in your life you think?

P. Probably working is good. I like taking out garbage like for school, wash the floors and all that, wash the windows.
I. So it sounds like you like to keep yourself busy.
P. Yeah, um-hum.

P. I guess more work or cheques like a little bit more because we are supposed to get a Christmas bonus this week and uh... that's what I know.

Participant #5
P. During the day I go over there (pointing towards his day program) and then I go back on Tuesday I see (name) and on Thursday I see (name) and on Wednesday I see (name).

Participant #6
P. Yeah I go to work. I've got 2 jobs. At a (name of place) and with the (name of place) down that way (pointing). I do flyers on Thursdays, clean, shovel snow. And I work in the hotel, do cleaning inside and out.
I. So do you get paid for that?
P. Yes!

P. Payday this week is today. I'm happy (laughing)!

P. Yeah, I got my own bank card, my own bank. There's always money in and money out. (laughing)

I. If you could change something right now in your life, what would it be?
P. Go and get a job by myself.

Participant #7
P. The most difficult thing I face right now is getting a job.

P. Yeah, probably like uh I wouldn't mind getting a job as a janitor eh. Like at different places wherever it is possible for me to work. Like maybe a dishwasher or maybe cleaning up a general place.

Participant #8
P. Well it was pretty good. Uh, work was the big thing there on the farm. There was always something to do. And I helped dad and my brother too. I helped with pigs for 5 years. He was driving truck, a special truck.

P. And I uh, made some money there too….

P. Um huh and also get a job that will, well something I can really do well nice like cleaning and woodworking.

P. Well, part time. Cause I am on medication. I have schizophrenia illness.

P. And for me, I can't do terribly hard work like my body can't handle that.

Participant #9
P. Um, no I actually don't have a job right now. I need to find another job.

P. Um, right now I'm kind of looking because budgets are getting kind of tight.

Theme 7 - Societal and Systemic Effects

Larger effects of racism and discrimination based on experiences while living in Canada including Manitoba and Saskatchewan were reported. Racism against nationality and culture was identified by three individuals as having a major impact on their life as indicated below.

Participant #7
P. Like uh being from (name of town) and uh as I was growing up hearing and seeing these things on TV. But right now for the past 2 years, we've been through hell.

P. Yeah, I guess I would probably add something to this conversation that, you see I have been struggling with some stuff that I uh. See I lived in a residential school back in (name of town) way back eh.

P. And um, see uh that's the thing that I have ever since this meeting came through with the government about the people getting this compensation money from what they went through and what the people, what we went through in the past.

P. People getting, people sexually assaulted by these priests or whatever and the dignity that we lost. Like uh....

Participant #9
P. Um, a lot of racial stuff like color of my skin. That I wasn't uh you know the typical child you know I wasn't uh, the perfect color. It was a little depressing. You know I would come home and I thought you know, I didn't think it would ever get better so. But as I grew older I kind of grew out of that stage to more of uh I want to be uh you know the perfect looking person you know and uh.

P. Um, I would say general society that you know.... Nowadays we live in a society that we need to learn to hope and agree with like we live in a community

where there a lot of racist things that are really uh striking hard on people. I mean there are guys who commit suicide because they feel that they are, they are raised that they are not the perfect ones and feel like they need to try to get out of the world then I guess. And I feel sorry for those guys that they actually have committed suicide. It is really tough on people who have to put up with it you know.
P. ….maybe the ones that are different than me maybe they are, like they are, I don't know I don't see that maybe that I grew up in a white neighborhood, I don't really see myself as Native. I just see people for who we are. I see everyone the same, you know, like human beings. I wish the world could be more like that.

P. Yeah, I uh it hit me when I was about uh 18-19. I was ready, actually I had to start looking good so I was trying to find different ways that would make me look better so.

Participant #10
P. Yeah, there was, at times I got picked on. I was picked on because I was Native and that.

P. Um, the difficult thing is, the difficult thing is uh, going to school. Going to school is the most difficult thing. If I go to school and there is only white people and there is only 1 Native person in the school, I might think, oh I don't fit in with this crowd.

Lack of ongoing, accessible culturally relevant programs within Winnipeg was also identified in relation to dealing with racism.

Participant #7
P. ….people are coming out and talking about what we went through and it makes it hard for other people too, and it makes it pretty hard for other people to listen to. It makes it pretty hard for a person like me to find someone to talk to because I can't.

P. And like it's very uh, like emotionally it hurts and it hurts inside and so on.

I. Is there anyone at Opportunities that has a similar kind of experience?
P. Not for that. No.

P. I've briefly talked to about it to an Aboriginal Native worker but see she's usually around every second week of the month eh.

P. But it is hard for me to get a hold of her and sometimes she doesn't show because of the driving distance, eh.

P. And see the other thing too is um, plus well it's mostly lately that there is people that talk to her in the community but it makes it kind of hard for me to locate them um, especially to look for a person to drive me around.

Other examples of how participants felt disadvantaged were in regards to sexuality, cognitive disability, and physical appearance including clothing and age, in addition to physical disability. Each of these individuals indirectly relayed how they felt negatively singled out by others or the system

Participant #1
P. .... getting back to that people putting me down and everything, it had to do with pretty much about my sexuality as well because I came out of the closet when I was 14.

Participant #5
I. Why were they picking on you or why did you feel like they were picking on you?
P. The way I looked, the way I talked.

I. What is the most difficult thing happening for you right now in your life?
P. Um, I get teased.

P. He calls me old man all the time.

Participant #8
P. Well they were bugging me because I was a little bit slow. They kind of bugged me.

P. And they kind of got out of hand.
I. And this was when you were in school or when you were?
P. Like I was at school but I was going to Sunday school at church.

P. And there, again, that's where it got started where they made fun of me. That's not nice.

Participant #6
P. Oh yeah! (Name) always teasing me saying you stink or different things you know!
I. Was that as a kid or?
P. No, right now. Like I don't like that!

P. I tell staff and staff talk to him but he never listens. I don't know what to do but I try to ignore him that's all.
I. How does that make you feel?
P. Not good. Why does he say that because I never do nothing wrong. I always take a shower you know.

Participant #7
P. Sometimes it is pretty hard to find a person to take me because it's like they are very impatient with me. They can't wait. They gotta go, go, go. And that's what, and that's what gets me sometimes is when people tell me let's go, let's go, we gotta go. And I can't, I can't walk that fast.

P. So I feel really low like I can't do the things I used to do and it makes me angry and I get angry at people because people don't look at me the way they used to look at me before.

Participant #9
P. Um, I would say yeah because nowadays our society is all about you know judging on basically what your position is like in the uh community that has so much to do with it. A lot of them look down on you and judge you for who you are and what you look like and uh like if you don't have like a million or even just a job it kind of makes it that much harder for you to want to be looked at differently. It kind of sucks in that sense of the way.

P. Uh, it was tough. Uh, I would say that uh, uh, I was different from everyone, you know. While growing up I was bugged a lot you know. I was kind of the centre of teasing, you know, teased a lot when I was younger.

Participant #10
P. …They'd call me names like toothpick uh, dandy long legs and that. I used to get picked on a lot like that and I didn't like that too much.

Limited financial resources due to living independently or from reliance on Employment and Income Assistance were identified by half of the participants as significant barriers which had a negative impact on their ability to visit family and attend other activities. Current rates of EIA in Manitoba are well below the rate identified by Statistics Canada as "low income" or poverty. As well, the larger system appears to be designed for those who require more assistance with ongoing support staff due to the significance of their intellectual disability and does not

consider the implications for those who are or could be residing independently within the community.

Participant #2
P. I have to save money.

P. That's the most toughest part I have to pay my rent and all these things.

Participant #6
P. Sometime I phone them because it is too much money to drive down there.

Participant #8
I. …What do you think the most difficult thing is that you have in your life right now?
P. Uh that would be keeping up with smokes. Keeping up with uh spending money more wisely.

Participant #10
P. And I only got a certain amount of money and that.

P. ….I do think that like, I look at my sisters and that and I look at them. They get their houses, like they pay the rent and bills but I don't do that because I am a slow person. Like I don't to rush things and that……

P. Um, um, I would like more, uh more, abit more money because like the way Income Assistance is paying me and other people these days, it is not enough to live independently on your own. And I feel like I've been getting ripped off and I feel like man, I don't get enough money, I don't have enough clothes or enough food and that. Like I told my worker, I said, look if you want me to try, I simply told him, I want to move independently on my own where I can do my own things. But if you are giving me this amount of money, I am going to get up and leave and that would be the end of it.

P. So, like I told him that I need more money for things and that cause the way I am getting my cheques is just too low.

P. Yeah it is a struggle to survive and it is like not easy.

Incarceration and negative feelings associated with these experiences were mentioned by 5 out of 10 participants. Limited treatment was highlighted by a couple of individuals indicating a lack within the criminal justice system for

people who have intellectual disabilities and who sexually offend. Social ecological theory may explain this relationship between environment and personal experience as reciprocal.

Participant #7
I. …Did you ever have to spend time in jail growing up or as an adult?
P. Pretty much yeah.
I. What was that like?
P. Terrible.

P. Well I spent uh a lot of time in federal prisons see. I spent time in provincial and spent for juvenile delinquencies.

P. Since uh, the last time I went to jail was uh I got out in October the 15th of this year.

P. And ever since that time I've been going in and out of incarceration. 8 times I went in and 8 times I came back.

Participant #8
P. It wasn't good.

I. Was there any treatment in jail?
P. Not really when I went through there. The only program I went to there was for assault or something. But there was a program that some guys talked about it.

Participant #9
P. Um, you know what, it wasn't uh, like when I first got in there it was scary because I never was in jail before so the first time was the scariest and uh…..

Participant #10
I. So you were in jail for a year?
P. Yeah.
I. And what was that like?
P. It was like uh….a scary thought, a scary thought.

In summary, this chapter highlighted the seven themes that emerged during the process of content analysis. These themes were consistent across the interviews.

CHAPTER V: DISCUSSION

This study examined the experience of community life for adults with developmental disabilities who have been involved in sex offending behaviour. The goal was to explore experiences involving family, friends, residential settings, daily living and societal influences for this cohort. Participants' responses were analyzed using content analysis.

Within the following section, themes in relation to the literature are discussed. Additionally, potential limitations of the research project are outlined.

Themes and Relation to the Literature

Theme 1-Taking care of self

Throughout the literature, an essential component of personal insight in order for effective treatment to occur is identified. Moreover, individuals who are involved in sexual offending continue to be considered high risk to re-offend if this requisite skill is not evident or developed.

According to Timms and Goreczny (2002), the extent of insight or self-control can be determined through examination of: (a) behavior before, during, and after the offense; (b) level of responsibility the person feels; (c) to whom the person attributes the offense; (d) cognitive distortions used to justify the offense; and (e) if empathy is evident. Wheeler and Jenkins (2004) advocate that intervention be directed to address denial, motivation to change, self esteem, cognitive distortions, and empathy development amongst other factors.

Within this theme, insight was evident through individual statements that highlighted the importance of keeping others and themselves safe by learning

from their past experiences. These statements were offered in response to questions relating to the general impact Opportunities for Independence Inc. has on their lives. Grief, remorse and implied feelings of embarrassment for their abuse history relying on insight were also expressed by three participants.

Davis (2002) and Ward, Trigler, and Pfeiffer (2001) additionally identify that one of the contributors to sexual offending involves low self-esteem. Resiliency and the power of believing in oneself while proving yourself to others contrary to their negative opinions was discussed by some participants. These statements also highlighted how changes they have incorporated had positive effects on self perception. Awareness of maintaining a lifestyle that refrains from potential situations that may increase risk was discussed.

A positive outlook when establishing future plans was weighed by participants. Cochram (2005) reports that a positive self-image is most important in predicting lower re-offending rates along with community programs who offer supportive therapy emphasizing positive aspects of the imposed sanction and the individual's self-image.

Within the literature, mental health issues including anxiety and depression are considered to be potential contributors to sex offending among individuals with developmental disabilities (Parry & Lindsay, 2003). Mental health and emotional issues were cited as barriers for some participants however the importance of knowing how to work within those limitations was also addressed.

Theme 2- Family Effects

Effects of family contact were highlighted within this theme. Hayes (1991) reports the role of families is apparent throughout the literature as having a positive or negative impact on illegal sexual behavior among individuals with intellectual disabilities. Characteristics that are significant within the parental home include a combination of factors such as multiple family pathology, severe marital disharmony, parental separation, violence, neglect, and poor control over the child's behavior (Hayes, 1991). Within this study both positive and negative aspects were highlighted.

Positive feelings and memories as well as frequent contact with family including extended members such as grandparents, cousins, aunts and uncles were described as being important either through direct contact or phone calls. Family traditions and values were also recounted by one individual as being important. Having family support during difficult periods was additionally highlighted by some individuals as being of value in their lives.

Lindsay (2002) and Schilling and Schinke (1989) propose that many of the first sexual experiences for people with cognitive impairments involve rape or molestation from family, care-providers, and/or peers resulting in the potentiality of inappropriate learning based on their own history of sexual victimization.

In support of the literature, negative contact with family was a common theme for many participants. The ability to remove and provide distance from these situations was discussed as an important strategy to keep themselves safe. However, ongoing contact with some family members was maintained.

Incidentally, the 3 participants who relayed family history of alcohol abuse also reported personal struggles they each had at some point with substance abuse.

Davis (2002) and Ward et al. (2001) highlight that another potential contributor to committing sex offenses may be a reduced ability to develop and practice appropriate relationships. Isolation from family members either due to leaving the family home during adolescence, being removed from the birth family or, natural effects of siblings moving away was mentioned as being difficult for seven of the participants. Despite this separation or removal from the family system at formative ages, individuals managed to maintain contact with some of the family members and deemed this relationship important. Illness and death of family members were mentioned as significant hurdles for half of the individuals when relating to what was presently the most difficult thing for them to cope with overall.

Theme 3-Social Opportunities and Support Systems

Social skills have been highlighted within the literature as an area that requires development for people with cognitive disabilities who sexually offend. Tudiver et al. (2000) and Hayes (1991) found that individuals who have a developmental disability are different from others convicted of a sexual offense in that they display significant amounts of social skill deficits, are sexually naïve, and lack interpersonal skills leading to difficulties interacting with the opposite sex. The limited social support is consistent with the literature which highlights the link between a lack of social skills and secure attachment during childhood

due to difficulties within the family and cognitive disabilities (Hinsburger et al., 1999).

Within this theme positive and negative influences and lack of social contacts were discussed. Positive experiences with friends were identified by some of the participants. Conversely, negative influences from peer groups were also highlighted by many individuals. An underlying issue of limited opportunities to develop friendship and social relationships due to frequent relocations and a general lack of community resources for people with developmental disabilities became evident however was not directly addressed. Community resources that were noted as being significant for certain issues involving sexuality, substance abuse and convictions were addressed.

Tudiver et al. (2000) and Hayes (1991) report that lack of interpersonal skills can lead to difficulty interacting with the opposite sex which was highlighted by the research participants within their responses of either planning on or identifying themselves as currently having a significant relationship. Hinsburger et al. (1999) suggest that generally people with cognitive impairments have limited or inappropriate partner selection when trying to form a sexual relationship of any kind, inappropriate courtships when attempting to demonstrate sexual interest in another person, and lack of sexual education and information.

These findings are relevant to this research as when asked what would make life better, some participants referred specifically to having a significant relationship underscoring a desire to have what other people in society experience.

Other examples of perceived independence and being successful according to the standards of general society were identified.

Theme 4 – Home life

Hinsburger et al. (1999) proposed that many individuals with disabilities have resided in and continue to live in non-normative settings. Contributing factors are inappropriate social behaviors learned within the residence. Hinsburger et al. (1999) advanced the term 'counterfeit deviance' which proposes sexual offenses occur as a result of the structural environment in which the person lives.

As addressed within the literature, reduced opportunity to develop and practice appropriate relationships within the family or other social circumstances, and limited independence and autonomy due to reduced privacy in group homes or institutional settings must be considered when developing treatment goals (Davis, 2002; Ward, Trigler, & Pfeiffer, 2001).

Frequent moves as a child and some of the negative effects associated with difficulty in maintaining relationships with people were mentioned by participants. According to Broxholme and Lindsay (2003), multi-user residences can have a negative effect on residents due to little or no appropriate partners or privacy. These authors further suggest that segregated and restrictive environments may contribute to inappropriate sexual development and expression.

Alternative residential settings such as foster care and group home settings were identified as residential placements for 8 out of 10 participants with varying opinions of whether these options were beneficial based on experiences. Supports from staff and formal care situations such as room and board facilities or

apartment living were also discussed. Difficulties within various living arrangements were also noted as was loss of contact with care-providers.

Cockram et al. (1998) found that ongoing parental concerns regarding the particular needs that people with cognitive impairments have, coupled with lack of appropriate custodial and intervention arrangements were addressed as issues. Parents additionally stressed the importance of their adult child being independent however, limited appropriate support services tended to place ongoing stress upon the family system. Potential evidence of this difficult decision making process was exemplified when participants spoke of residing only with their family members prior to their initial move into the system or living independently.

Independent living situations were discussed which additionally addressed some of the perceived pre-requisite skill sets and barriers when residing without formal or familial support. The literature did not specifically refer to issues of independent living.

Theme 5 - Assistance from Opportunities for Independence Inc.

OFII's mission is to provide safe and appropriate re-integration into the community. Hingsburger et al. (1999) suggest that the measure of successful intervention is determined by a person gaining greater access to the community, demonstrating and reporting use of relapse strategies while supervision is being reduced, and remaining offense-free. In addition, Tudiver et al. (2000) offer that priority for services should be after care, which includes the option to return to individually tailored treatment at any time. The range of services that OFII offers regarding amount of contact, reason for referral, residential options, treatment

sessions, work experience, day program services, social opportunities and general support that the agency provides were chronicled. Frequency of contact and extent of present OFII involvement was discussed by many participants.

Residential services and supports offered by OFII were discussed by some participants including assistance with finding alternate residential options. These specialized treatment homes offer environmental adaptations and interventions such as restrictions on community activities and reduced access to high-risk situations, as recommended within the literature by Schilling and Schinke (1989) and Ward et al. (2001). Additionally, Baumbach (2002), Davis (2002), and Streissguth and Kanter (1997) support environmental modifications and advocate that twenty-four hour supervision, one-to-one monitoring with intense supports, low client-to-staff ratios, safety checks, and reduced access to high-risk situations are essential for ongoing individual and community safety.

Multi-dimensional and flexible approaches when providing a combination of interventions designed for sex offenders, with modifications to address the needs and limitations of adults with developmental disabilities are required (Baumbach, 2002; Schilling & Schinke, 1989). Within the literature, goals of intervention have been outlined as needing to be consistent with those developed for individuals convicted of sexual offenses in general, such as examining and accepting responsibility for behavior, learning how to change conduct, developing life-skills, and continuing to receive community-based intervention and support.

Benefits of OFII treatment programs involving individual counseling, CARP (Community Alternative Re-entry Program) which is specifically designed

to change offending behaviour, through anger management and social skills training were discussed by the participants. Participants reported that learning specific skills, having increased social opportunities, safety for others and self, and programs based on their individual strengths, needs, and perceptions were among the most important experiences they had through OFII. Doyle (2004) is consistent with this finding as he emphasizes that education in both offence-specific and offence-related areas such as problem solving, anger management, substance abuse, communication, sexuality and legal issues be offered. Ward et al. (2001) and Wheeler and Jenkins (2004) propose that it is often unclear whether impulsivity, problems with judgment, aggressive behavior, among a range of inappropriate behaviors are associated with sex offending.

Throughout the literature, it is advocated that longer-term follow up, life skills training, and community programming tailored for the unique risks and needs of individuals with disabilities be included in treatment programs (Lambrick & Glaser, 2004; Lindsay & Smith, 1998). Assistance offered by OFII staff to find and secure employment opportunities was identified as a valued service. Half of the individuals made reference to the informal social opportunities, leisure and recreational options that are inherently fostered within the OFII environment. This component is paramount when considering that the literature highlights limited social opportunities overall.

In conclusion, Hingsburger et al. (1999) and Tudiver et al. (2000) outline that the primary goals of intervention are to minimize risk to the community, facilitate control over sexual impulses, develop appropriate social skills including

sexual expression, reintegrate into the community and have a lifestyle that is as independent as possible within the limits of the intellectual disability. Additionally, within the literature Bickley and Beech (2003) and Wilcox (2004) advocate that intervention approaches should demonstrate respect, support, confidence, emotional responsivity, self-disclosure, open-ended questioning, flexibility, positive reinforcement and the use of humor. Some strategies are reportedly more effectively utilized through group participation, such as improved perspective taking, coping skills, accepting responsibility and identifying future risk and reducing denial and minimization.

Assistance from OFII staff when experiencing difficulties by having a venue to communicate was noted by over half of the participants. This finding provides credence to the power that emotional support in a non-judgmental manner has on individuals.

Theme 6 - Productivity

An overarching theme of productivity which included childhood academic experiences, adult education, day program and employment opportunities were discussed by all 10 participants. School experiences during childhood and adolescence were reported to have both positive and negative effects on individuals.

Tudiver et al. (2000) and Hayes (1991) found that individuals with developmental disabilities are different than regular sexual offenders as they have greater chances of experiencing school maladjustment. Consistent with this

research, this study found that difficulties in school were identified by 6 of 10 participants.

Boer, Dorward, Gauthier and Watson (1995), Lindsay et al. (2004) and Ward et al. (2001) suggest that ongoing support for educational and employment opportunities are integral to holistic treatment for persons who sexually offend. Continuing education as an adult was discussed as being important for some individuals however at times difficult. Feeling judged by others during childhood school experiences based on past offences and race was also identified as a barrier to returning to an educational setting as an adult.

Daily activities and barriers related to day programs and employment to improve upon their financial situation were discussed in response to being asked how they spend time during the day.

Theme 7 - Societal and Systemic Effects

Within the literature, underlying factors which perpetuate sexual offending behaviour are related to societal prejudice for people with cognitive impairments are identified (Davis, 2002; Ward et al., 2001). Holland et al. (2002) suggest that a global understanding of the complex biological, social, psychological and environmental factors that may contribute to offending behavior is important when determining appropriate intervention approaches and strategies.

The findings within this research support the literature as significant effects of racism based on life experiences in three interviews were discussed. Discrimination against nationality and culture was identified by these individuals

as having a lasting impact on their life. Lack of culturally relevant programs was also identified in relation to racism.

Timms and Goreczny (2002) highlight that emotional and behavioural difficulties experienced as a result of disability could relate to sexual offending. Broxholme and Lindsay (2003) proposed that inappropriate sexual development and experiences are a result of societal attitudes towards disability. Examples of how participants felt disadvantaged were discussed in regards to sexuality, cognitive disability, general appearance including clothing, age, and physical disability. In addition, issues related to limited financial resources due to living independently or from systemic practices such as from Employment and Income Assistance were identified by half of the participants. Financial issues were not discussed directly within the literature.

Davis (2002) proposes that it is absolutely imperative for people who are involved in sexual offending to be held accountable for their actions as these mandated interventions for individuals may provide the only opportunity to learn about appropriate sexual behavior. Throughout the literature, creative sentencing options such as diversion programs are favored to a prison sentence as those who serve time in jail have a greater chance of re-offending due to a lack of effective sexual education and related habilitative programs modified for people with intellectual disabilities.

Boer et al. (1995) highlight the need for alternative treatment to address specific issues that persons with developmental disabilities experience due to greater difficulty adjusting and being exploited within the prison system. In

support of the literature, 5 out of 10 people interviewed spoke of their experiences within the criminal justice system. Individuals expressed generally negative feelings associated with incarceration while lack of treatment was highlighted by a couple of individuals.

While this chapter merged the literature and results from this research project, there were some inconsistencies highlighting potential gaps within the literature.

Highlighted Differences

Within the literature, individuals with an intellectual disability who are convicted of sexual offenses were reported to be typically older than others who are convicted of sexual offenses (Lindsay et al., 2004). Most participants within this project were in their mid to late 20s and 30s and had been involved with OFII for a minimum of 2 years which is therefore inconsistent with the literature. Another major proposition put forward by the literature was people with developmental disabilities typically have resided with ageing parents or have lived in institutions which was not found to be the norm for this research cohort.

These discrepancies could be due to research focusing on the effects of institutional care as the norm. Therefore the shift towards community care within the last three decades has not been accounted for. As a result, this younger cohort who has always lived in the community has not been investigated or examined in depth.

Information on living independently was vaguely presented as a viable option within the literature. Instead, environmental controls and external supports

were proposed at length. Within this group, the data collected showed that living independently was presently or previously had been a reality for half of the participants. The discrepancy between the participants in this study and previous data may be again related to a lack of research that highlights issues of community care and people who have primarily resided within group home, foster care, and/or parental settings.

The inclusion criteria of individuals with a borderline to mild developmental disability may have exemplified the strengths and skills that these individuals possess instead of people with more significant impairments. Additionally, programs that are developed specifically for this target group should be assessed for their effectiveness in providing relevant education and treatment which enables people to return to the community not only as safely but also as independently as possible.

A major finding within this scope of research was the significant impact that families continue to have on individuals in both negative and positive aspects. While the literature does address families in a cursory manner mostly directed towards providing negative explanations for deviant behaviour, positive aspects that family members can and do bring to an individual living with a developmental disability has not been suitably considered. Again, the history of institutional care as the norm may be a reason why the research is not congruent with the actual phenomena.

The considerable impact of racism and discrimination were found to be major barriers for some individuals within this project but not discussed at length

within the literature. People of Aboriginal descent are able to speak to the lasting impact of racism and have not been directly addressed within the literature. Discrimination towards cognitive disability even amongst segregated groups has not been researched extensively. The effects of bullying and harassment are long lasting and may be a contributing factor to sex offending and warrants further investigation.

Finally, while independence is provided as an option within the literature in terms of discussions involving assessment of risk, competence and intervention strategies, information on formal adult education, employment and financial implications were not mentioned. Within this research, participants acknowledged the impact and importance that these three components have on the ability to live as independently as possible within the community. Moreover, individuals who reported positive childhood educational experiences seemed to view continuing education as an adult as a viable and plausible goal to pursue to assist with becoming more productive and independent.

Findings and Ecological Model

The human ecological model provided a framework to filter through the multiple layers that comprise each individual's life. White and Klein (2002) propose that "ecological theory sensitizes practitioners and others to the multiple levels and complex interactions between various ecological units" (p. 224).

Within this research, the micro-level supports which included the primary systems allowed for information on the person's immediate surroundings to be discussed. The meso-level system provided an opportunity to understand the

interactions and significant relationships that the individual has had in his life. External networks within the exo-system which encompassed educational, employment and effective intervention strategies such as environmental modifications and providing individuals with direct habilitative skill training was also examined. Questions relating to macro-level supports offered an opportunity to understand the complex social experiences including economic conditions, discrimination, and barriers that this cohort had experienced. Barris et al. (1988) further explained that a social ecological perspective allows for a person to develop appropriate social behavior by engaging in a purposeful manner within his settings.

The second frame of reference that was useful in guiding this study was cognitive theory which is the basis for cognitive behaviour therapy. Eccles and Winfield (2002) highlighted that promotion of self-regulation allows for emphasis to be placed on the importance of developing self-efficacy beliefs and attitudes which regulates and changes problematic behavior inherent to sexual offending.

Findings from this study exemplify the complex, intertwined effects of the individual and environment. Despite the commonality of being men with borderline to mild developmentally disabilities attending programs at OFII and residing in the community, the data demonstrated that each person had different life experiences which, to varying degrees, impacts on the ability to cope, succeed or maintain their present lifestyle. The combination of these two theoretical perspectives offered a foundation to explore the attitudes of the individual via cognitive behavior approaches while acknowledging the internal and external

environmental responsibilities including family, social, cultural and societal influences.

The following chapter offers a summary of this research project and concludes with research, assessment, intervention, and practice implications.

CHAPTER VI: SUMMARY AND CONCLUSIONS

The purpose of this research was to examine community life for people with developmental disabilities who have been involved in sexual offences. Participants were asked to respond to questions relating to personal demographics, past and present residential settings, support from family and friends, formal educational experiences, services received from Opportunities for Independence Incorporated and experiences with the criminal justice system. Societal influence in relation to discrimination based on disability, income, offense history and current barriers and needs were also discussed.

Individuals spoke of changing their lives in terms of acknowledging past behaviour which had led to sex offences and identifying important strategies relating to emotional and mental health to refrain from re-offending while coping with grief and remorse. Participants additionally highlighted the role of family and friends in both negative and positive aspects, and importance of these support systems. Strategies to deal with loss of contact either through circumstance or personal choice or how to disengage from people who negatively influence them were discussed. The range of residential services that individuals had experienced as either beneficial or as having a detrimental effect on people were also highlighted.

OFII's supports which include residential, day service, employment opportunities, individual and group treatment to re-habilitate offending behaviour and specific skill building related to anger management and social skills were

discussed. The importance of having emotional support at any given time was viewed as a major benefit of continued association with the agency.

Productivity in terms of childhood and adult education, day programs and work opportunities were reported in terms of developing or maintaining independence in the community. Finally, societal and systemic effects of racial discrimination, prejudice against disability and limited finances due to systemic issues were discussed at length and identified as having a significant impact on individuals.

In order for the researcher to gain a holistic perspective on the participants' lives, a social ecological approach was used to frame the interviews. This theory proved useful as all aspects that have an impact on a person could be considered. Totality of the environment and factors that mold personal experience were analyzed by reviewing the micro, meso, exo-system and macro-levels. Cognitive theory was also considered as it is consistent with the intervention strategies targeted towards the individual. The combination of these two models can be applied to identify strategies that are inclusive of internal vs. external locus of control.

Implications

Through discussions with the individuals and data collected from this research project, there are research, assessment, intervention and practice implications.

Research Implications

In general there was a great deal of consistency between the results of the study and the literature. After reviewing the data collected in combination with the literature, there are some notable discrepancies between the bodies of information.

Within this research project, family including extended members was highlighted as being highly significant for individuals with developmental disabilities. The influence of family was not addressed in depth within the literature. Instead, focus on people who were typically raised within institutions or non-normative settings was the standard. Future research should include the role of the family in terms of upbringing, culture, abuse history, and ongoing support as this deserves attention based on responses of the research participants.

To account for the change within the larger system of de-institutionalization and more integrative community environments, research will need to focus on this younger cohort. The vast difference in general life experiences for younger individuals as compared to those who resided within institutions or attended segregated school systems need to be considered in upcoming research.

Additionally, the large impact that education has on people with cognitive disabilities was not addressed. Data collected showed negative school experiences whether in a segregated or integrated environment can yield negative effects on self- esteem as seen within reports of feeling "picked on" or "singled out" as a child. The goal of continuing education as an adult to increase employment

opportunities and finances to improve upon quality of life when residing independently in the community must also be addressed in future research.

The significant role of employment was not discussed within the literature review. However, employment should be considered in future research, based on the overwhelming responses of how important paid work and productivity was for these participants. Last, cultural considerations especially for Aboriginal service users deserves further recognition especially when considering that in Canada this group of people are reported to be convicted of crimes at a higher rate than the general public.

Assessment Implications

As addressed within the literature review, assessments specifically designed for adults with developmental disabilities who sexually offend are limited and have not been extensively researched to ensure validity or reliability. Transferability of assessment procedures that are employed with mainstream sex offenders has not been established.

Within this research, the value of tracking program, work and educational program attendance would appear to be a valid indicator of commitment to treatment. Dynamic predictors for risk of re-offending such as aggression, alcohol use, and anxiety were highlighted as issues that some individuals struggle with presently or in the past. These findings should be considered for future research when developing assessments specifically designed for this population.

Intervention Implications

Intervention specific to the individuals who participated in this research for the most part are encompassed within the Opportunities for Independence Inc. treatment programs. Areas where additional community programs are accessed include substance abuse treatment, same-sex informational resources, formal adult education training, and Aboriginal teachings and counseling.

While it can be argued that assimilation in the larger community and broadening social opportunities for all people should be considered, alternate resources that are not designed for the needs of an adult with a developmental disability may not be as effective. Multiple intelligence strategies as suggested within the literature that OFII uses to ensure comprehension of intervention materials, should also be extended to other treatment resources within the community.

Practice Implications

Programs that acknowledge differences and similarities between cultures, consider effects of second languages, and the significance of racism especially for First Nations people are required.

Second, the lasting impact of bullying or feeling singled out was highlighted within the research. These childhood experiences may extend to adulthood within community programs and residences. Policies that effectively deal with bullying and harassment are required at every level especially with integration as the guiding principle. Within educational programs this is especially

important as there appears to be a correlation between positive childhood school experiences and furthering adult education.

Third, further to the inclusion principle, sexual education within schools will need to be extended to and adapted for those living with a cognitive disability. Based on the notion of counterfeit deviance, social skill development coupled with sex education is the key to ensure that sex offending behaviour is prevented.

Fourth, as noted throughout the research, social and recreational opportunities are limited for people with intellectual disabilities within the community. Funding to support structured programs to meet this underlying need for social contact is required to provide opportunities that could support people in developing and practicing skills in a natural environment.

Fifth, employment is a goal for many participants as it relates to increased finances and consequently more independence. In order to maintain safety for the general community while offering employment opportunities, individual specific work sites must be developed and supported by agencies and employers. Specialized services that offer supported employment such as job coaches and developers may be warranted to meet the wants and needs of individuals with developmental disabilities who sexually offend.

Sixth, systemic issues such as limited financial resources provided by Employment and Income Assistance should be reviewed with respect to costs of independent or supported living. Current standards that limit an individual's ability to earn more than a minimum amount of money without being penalized

also needs to be reconsidered to support the goals of individuals who want and are able to work but may not be able to manage full time employment.

A final recommendation with a potentially significant outcome would be to involve family within treatment plans especially if contact is regarded as positive even if the individual is not residing in the family home. Counseling to re-unify or deal with underlying negative influences of the family should be weighed especially since the research participants relayed the lasting impact that these experiences have had on their emotional well-being.

Conclusion

Within this research, a better understanding of the life experiences of men with a developmental disability who sexually offend was gained. The perspective of considering a continuum of life experiences from child to adulthood was of great value.

Lindsay (2002), Lindsay et al. (2004), Lindsay and Smith (1998), and Ward et al. (2001) highlight the underlying need to treat and ensure decreased risk for everyone while assessing risk for sex offenders with cognitive impairments. These authors identify that offence and criminal history, management of anger, willingness to discuss the offence, acceptance of responsibility, expression of remorse, substance abuse, mental illness, history of abuse and motivation for change need to be addressed. The findings of this study are consistent with these suggestions.

This project has additionally provided support for the significant influence that family, care-providers, friends, community resources and relationships with

others have on emotional, mental and spiritual health. Independence within a balance of safety for self, others, and the general community is the underlying desire for individuals. Education, employment and finances were found to be important for persons with developmental disabilities. In conclusion, this cohort is entitled to culturally and cognitively relevant supports to overcome barriers and assist those who are committed to not sexually offend while maintaining the same human rights and dignity that is afforded to people living without a cognitive disability.

Limitations

Limitations to this research included sampling, timing of interviews, place where meetings were held, limited interview experience of the researcher and potential language barriers.

Ten participants were interviewed for this project. Data became saturated after seven interviews, possibly due to the sample population which were men presently involved with OFII. The adult male participants were of varied ages, from various regions including Manitoba and Saskatchewan, and received ongoing support from OFII for a minimum of two years. Results may have been different if people with developmental disabilities who were no longer involved with OFII or had never been associated with this agency had been interviewed.

Individual meetings were held around the Christmas season therefore emphasis on the family and support systems may have been more readily discussed or deemed important as family and friends are often associated with this time of year. Interviews were also held in public places such as restaurants and

coffee shops therefore willingness to discuss life events in depth may have been impeded by the potential perceived loss of privacy or confidentiality. In addition, participants did not know the interviewer before this process and may have been reluctant to share extensive personal information with a relative stranger.

The researcher became more relaxed and willing to probe deeper as more interviews were completed. Based on this, opportunities to yield more information may have been missed during the initial meetings. In addition, participants appeared to feel more comfortable discussing their lives after the first 2 interviews were completed. The reason for this change may have been due to individuals who had completed the interviews informally dispersing information on the positive experience of being involved in the research.

Finally, English was one participant's second language therefore responses required more clarification which made the interview process arduous. Language barriers should be considered in future research involving people with developmental disabilities.

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APPENDIX A

INTERVIEW QUESTIONS

1. DEMOGRAPHICS:
   - How old are you?
   - Where were you born?
   - How long have you lived in Winnipeg?
   - Where in Winnipeg have you lived?

2. MICRO-LEVEL STRESSORS/SUPPORTS:
   - Who do you live with, how long?
   - Where do you live now?
   - Do you work, go to school, go to program?
   - Who is in your family, do you see them?
   - What are your friends like?

3. MESO-LEVEL STRESSORS/SUPPORTS:
   - Where did you grow up?
   - What were your family and friends like?
   - Did you live in foster care or a group home as a kid, as an adult?

4. EXO-SYSTEM STRESSORS/SUPPORTS:
   - What was school like for you as a kid?
   - Did you ever spend time in jail? What was that like?
   - When did you start coming to Opportunities for Independence Inc?
   - Why did you start coming to Opportunities?
   - What are the most important things you have learned here?

5. MACRO-LEVEL STRESSORS/SUPPORTS:
   - Did you ever feel disadvantaged because of your offenses, or disability?
   - Did you ever feel disadvantaged because of your gender or race or income?
   - What helps you the most right now?
   - What is the most difficult thing you face right now?
   - What would make things better?

APPENDIX B

2B (i) Script for Meet and Greet Session

Hello everyone and thank you for coming. My name is Charmayne Dubé. I am completing research for my thesis on people who have a developmental disability and been involved in sexual offending. I am interested in sharing with you this evening what would be involved if you choose to participate. I will talk about the research questions that would be asked and then please feel free to ask questions.

I am interested in setting up individual meeting times with people to discuss their life experiences such as where they were raised, relationships with friends and families, school and work experiences and what has helped them in life.

The interviews will be held in a nearby location that we can decide on together and will be about 30 to 60 minutes long. After the interviews, I will record the information to make a large report. Your names will not be used and if you want, we can discuss your part of the report before I share it with others to make sure it is okay with you. You do not have to agree to meet with me and no one from local agencies will know whether you were interviewed or not. There are no negative consequences to participating or not-participating.

I am hoping that this research will give you a chance to share your views with others who can make a difference in programs. I will also be offering a gift of $20.00 after the interview to show my appreciation for your time. You can let me know tonight if you are interested or you can call me at 470-2376 within the next week.

2B (ii) I would appreciate that if you know anyone else who has experiences in sexual offending and who may be interested in meeting with me, please give them my name and telephone number.

2B (iii) Script for Other Recruitments

Hello. My name is Charmayne Dubé. I want to share some more information with you about why I am interested in meeting with you.
(I will then share the same information as above in (i) with exception of the recruitment piece.)

2B (iv) Introductory Format for Interview

Hello _____. How are you doing? Did you find the place okay. Thank you for taking time with meet with me. I want to read out some information that I will give you a written copy of so that you are aware of what is involved and what we are going to do in the next hour or so. I want to make sure that you know your information is confidential and that you should not feel forced to talk to me. I also want you to feel relaxed when we are discussing general questions about your life. Do you have any questions or concerns?

Let's get started then. **OR** We don't need to go on. Thank you for your time. Take care (if choosing to not participate).

APPENDIX C

Adults with Developmental Disabilities who Sexually Offend: A Qualitative Examination

By: Charmayne Dubé

Procedure for Ensuring Capacity to Consent

1. For those individuals who were tried in court for a previous offence, competency was established therefore will be considered competent to voluntarily participate in the research.

2. For those individuals who have a Substitute Decision Maker (SDM) for Personal Care, consultation with the SDM or Public Trustee (PT) will occur to determine if it is appropriate to proceed. If it is decided that the individual could potentially participate, the screening tool used at Opportunities for Independence Inc. to determine capacity to consent will be administered. If the person is considered competent to give informed consent and permission is granted from the SDM/PT, the individual will be asked to participate in the study.

3. Before proceeding with the interview, each individual will be read the informed consent agreement to ensure understanding and given a copy of the signed document.

4. If the individual chooses to participate and provides consent, the interview will proceed.

APPENDIX D

Adults with Developmental Disabilities who Sexually Offend: A Qualitative Examination

By: Charmayne Dubé

Procedure on Disclosing Information

1. Prior to the interview, the researcher will clearly explain that the law requires that reporting of information discussed regarding abuse against children or vulnerable adults by the individual or disclosing incidences of abuse committed against the individual will be upheld during the interview time spent together. This statement will be additionally written within the consent form. The individual's right to not disclose will be clearly stated.

2. Should a participant disclose information on abuse against others, the researcher will inform the authorities and appropriate protection authority immediately and document the details (victim identity, characteristics, address, age, name, date of alleged offense, specific nature of the offence). The researcher will encourage the individual to disclose the information to the Opportunities for Independence, Inc. Coordinator.

3. Should a participant disclose information on abuse that was against the individual, the researcher will inform the authorities and appropriate protection authority immediately and document the details (victim identity, characteristics, address, age, name, date of alleged offense, specific nature of the offence). The researcher will encourage the individual to disclose the information to the Opportunities for Independence, Inc. Coordinator.

APPENDIX E

UNIVERSITY OF MANITOBA

Faculty of Human Ecology
Family Social Sciences

Winnipeg, Manitoba
Canada R3T 2N2
Phone: (204) 474-7386
Fax: (204) 474-7592
jason_brown@umanitoba.ca

Consent Form

You are invited to participate in a study about men with developmental disabilities who have been involved in sexual offending.

I would like to talk to you about your experiences and ideas and provide you with an opportunity to share your ideas.

After talking with people like you, I will put all of the ideas together to make one big report. This information will be included in my thesis. I will use what I learn to make suggestions to community groups, policy-makers, and service-providers, so that people might work together to enhance the quality of programs and living situations.

None of your rights are affected by participating or not participating. Your relationship to Opportunities for Independence or any other agency you are involved with will not be affected by your participation.

If you agree, I will talk with you for about 30 to 60 minutes. Your ideas will be put together with other peoples' ideas so that no one will recognize you.

You may choose to participate or not. It is up to you. If you choose to talk with me you can change your mind at any time. You can refuse to answer any question or you can end your participation at any time. Your decision about participating will not affect you or any services you receive in any way.

If you would like more information about anything, please feel free to ask me before we start or during our talk.

If you agree, I will tape record our discussion so that I can remember what we talked about.

At the end of the discussion, I will give you twenty dollars. This gift is my way of thanking you for the time you have spent with me.

When the project is over, you can get a copy of what I learned and my suggestions if you like. If you give me your address, I will mail you a copy of the results.

This project is being done by myself, Charmayne Dubé with assistance from Dr. Jason Brown who is a professor at the University of Manitoba. If you need to contact me, you can reach me at 470-2376 or Dr. Jason Brown at 474-7386.

The University has reviewed what will be done in this study to be sure that no one will be harmed. The University has approved this study. If you have questions you may call the Human Ethics Secretariat at 474-7122.

Please note that we are required by law to report information about abuse against children or vulnerable people.

I hope that you will agree to help us by sharing your ideas with us.

Do you understand what I am asking you? _____

Do you agree to speak with me about your ideas? _____

If you are a client of Opportunities for Independence Incorporated, do I have your permission to check your decision making status against agency records? _____

Do you understand that you can ask for more information at any time? _____

Do you understand that you can refuse to answer any questions or end your participation whenever you wish? _____

Do you give permission for me to tape record our discussion? _____

Are you interested in meeting again to read and discuss this interview had before I write the report? ____

Do you have your copy of this form? _____

Is there anything that you would like to ask me before we get started?

_____ _____

Participant Signature Date

_____ _____

Researcher's Signature Date

APPENDIX F

CODES: Round 1

1) Safety for others
2) Safety for self
3) Safety of residential settings
4) Impact of mental health issues for self
5) Impact of physical health issues for self
6) Impact of family illness
7) Positive contact with family (parents, siblings, grandparents)
8) Negative contact with family (parents, siblings, grandparents)
9) Positive aspects of friends
10) Negative aspects of friends
11) Isolation from family
12) Isolation from friends
13) Impact of frequent moves
14) Love of family
15) Decrease access to family
16) Impact of moving away from family/friends (into city)
17) Family traditions/norms (+ & -)
18) Relationships with women (current and plans for future)
19) Foster care/group home living
20) Culture shock
21) Justice/parole influences
22) Food & shelter (Room and Board)
23) Social skills
24) Anger management
25) Grief secondary to loss
26) Grief/remorse for past history (illness, offences)
27) Wanting to fit in (cars, marriage)
28) Limited finances impact living independently
29) Positive school/educational experiences
30) Negative school/educational experiences
31) Family history of alcohol/physical/sexual/emotional abuse
32) Own history of alcohol abuse
33) OFI workers positive support system
34) Prejudice (sexuality, race, income, family history, developmental delay, speech impediment, dress, past abuse history)
35) Support/community resources (residential agencies, AA, Aboriginal Groups, Rainbow Resource, John Howard)
36) Effects of incarceration (scary, need for change)
37) Independent living skills
38) Finances
39) Sharing feelings with others, importance of communicating

40) Language barriers
41) Resided with family only
42) No incarceration
43) Importance of work for financial gain
44) Work for social opportunities
45) Having a plan for the day
46) Difficult childhood
47) Impact of residential school
48) Resiliency
49) Rehabilitation effects: Community alternative re-entry program
50) Accessibility to workers (physical barriers, remote locales)
51) Family conflict
52) Trust in family
53) Recognized need for help (OFI)
54) Social opportunities at OFI (pool, cards, outings)
55) Picked on by co-participants, kids in school
56) Importance of phone, e-mail, visits to family
57) Desire to be independent/on own
58) Dealing with grief/loss of mother (struggling with how to deal, intensity of loss)
59) Positive support and good advice from friends
60) Wants girlfriend to share feelings and cope with loss/emptiness
61) Medication to help with mental health issues
62) Support makes you feel special
63) Bugged due to being different from everyone else in school
64) Centre of teasing
65) Racism (not the perfect color)
66) Despair: didn't think it would get better (grew out of it)
67) Change in external and internal presentation
68) Importance of self esteem/confidence
69) Need to feel good no matter what
70) Doesn't matter what others think (stand up for self)
71) Decision to move ahead/make changes (cannot go back, in the past)
72) Embarrassment of jail (not shared with everyone)
73) Change in thinking patterns to avoid re-incarceration
74) Need to try and help self
75) Try to see the positive side, don't look at only the bad, look at what you can learn, learning curve,
76) Learn other types of behaviour to avoid trouble
77) Work to increase my own capabilities to do better
78) Judged on position by general society (no job, what you look like)
79) Effects of racism (strikes hard on people, commit suicide, feel like they are not the perfect ones, need to get out of this world, really tough on people who have to put up with it)
80) See all people the same, wish for society to be the same
81) Acceptance of self (learned to live with the things I've done)

82) Looking forward to future (new chapter, chance of a relationship)
83) Wants to make others happy
84) Trying to upgrade but difficult
85) Not many options in life
86) Early removal from family
87) Prefers to not contact father due to ETOH and physical abuse
88) Kept moving as a child, lack of continued contact with people
89) Positive effects of hearing/sharing stories with other OFI clients' re: experiences and successes (helps to keep motivated to be independent)
90) OFI = part of team
91) Worry for future, what am I going to do with my life
92) Group home living difficult (not happy)
93) Negative effects of knowing that you are slower than others (didn't learn as quick)
94) Didn't think anyone cared
95) Went to family members when in trouble despite lack of ties growing up
96) OFI does not judge, supportive, listen and help work towards goals
97) Need to stand up for self
98) Income assistance does not allow for independent living, need for more
99) Determination for goals with awareness that things will take time

APPENDIX G

CODES: Round 2

1. Safety:
   - For self; plan for the day, avoid negative influences (family, friends, alcohol, situations), learn new behaviours to stay out of jail (scary place)
   - For others; keep my nose clean, stay away from girls
   - Housing; move due to feeling "unsafe" residence

2. Illness:
   - self physical health
   - self mental health
   - mom health issues
   - grandfather health issues

3. Family Effects:
- Grief of mother's death
- limited contact
- missing family
- lack of access (moving into the city)
- history of abuse
- history of alcoholism
- conflict
- frequent contact with parents
- live with family only
- love of family
- trust/reliance on participant
- family traditions
- cultural effects
- removal of family into foster care
- difficult childhood, may moves
- Importance of contact via phone, e-mail, visits
- Want to be married (fitting in)
- Reliance on even with limited contact (advice, protection)

4. Socializing/Supports/Accessibility:
- Importance of communication with workers
- decreased contact with family & friends due to negative influences
- isolation from family& friends due to move into city
- wanting girlfriend/marriage
- social skills training at OFI
- wanting to fit in (truck, marriage)
- AA meetings for assist with alcoholism
- Rainbow Resource for sexuality

- John Howard for offences
- Positive of support from workers, therapist at OFI
- Drop in abilities at OFI and emergency contact
- CARP (Community Alternative Re-entry Program) at OFI
- Accessibility to workers
- Importance of pool, outings, cards
- Needed help = went to OFI
- Accessibility to other resources with physical disability
- Learning from other clients at OFI (team effort)

5. Residential Settings:
- frequent moves
- moved into the city in mid-late teens
- with family
- with foster homes
- within Residential School
- Boarding Homes
- OFI treatment homes
- External agencies
- Feelings of loss, anger with moves
- Importance of safety, food, shelter
- Support from supports for independent living
- Independent living skill building for future
- Independent living and difficulty with managing money
- Afraid with unsafe living situations
- Other resources/agency involvement
- Accessibility to/communication with workers
- Lack of financial support from EIA to support independent living

6. Negative Impacts (Prejudice/ Disadvantaged/Grief/Remorse):
- due to cognitive disability
- due to family history of ETOH/abuse
- due to sexuality
- due to speech impediment
- due to looks
- past history of abuse against others
- physical health issues
- racism +++++
- picked on by co-participants
- picked on at Sunday school and reg. school
- general society looks down when not working and appearance
- limited finances when living independent
- remorse for offence history
- remorse for past life
- anger towards family members (abuse)

- frustration with illness
- embarrassment of family
- frequent incarcerations
- language barrier
- culture shock
- societal prejudice effects resulting in suicide

7. Productivity: (day program, work experience, paid employment, volunteer)
   - Importance of work
   - Importance of work for social opportunity
   - Work to increase finances
   - Day program only
   - Parole ordered treatment at OFI
   - enjoyed school as a child (recess, sports, excelled at school)
   - school was a negative experience as a child due to disability
   - picked on due to racism
   - Views education as a key to future for employment
   - views education as difficult with limited options
   - prefers social opportunities
   - preference for self teaching
   - Importance of anger management, social skills training, CARP
   - Work experience
   - needing to balance work with ill effects on mental health
   - balancing finances for independent living, smokes, cell phones, access to family
   - wanting continued involvement with OFI
   - "No going back"
   - having a "plan for the day" to avoid re-offending
   - need to develop independent living skills
   - society frowns on not working

Round 3: Overarching Themes

1. Theme for **taking care of self** (physically, emotionally, mentally, spiritually) includes: safety of self/others, changing thoughts/behaviours to avoid re-incarceration, illness (physical/mental), dealing with grief/remorse and resiliency.

2. Theme for **impact of familial relationships** includes: family positives/ negatives, isolation, illness, lack of contact, impact of moving away.

3. Theme for **social and support systems** includes: lack of social opportunities, friends positive and negative influences, paid support, OFI, wanting to fit in with marriage/girlfriends, other agencies, community resources.

4. Theme for **home life and residential issues** includes: paid supports, family, foster, alternate placements, independent living issues.

5. Theme for **importance of productivity** includes: paid/unpaid work, education (positive/negative), day programs, training, school experiences.

6. Theme for **societal & systemic effects** includes: racism, prejudice towards disability, culture, looks (clothing), Employment and Income Assistance (financial issues), effects of school integration, lack of culturally relevant programs.

DESCRIPTIONS

1. Taking care of self
Issues related to physical, emotional, mental and spiritual health were discussed by many participants. Safety of self including actions/behaviours that keep others in the community safe are included in this category. The impact of physical and/or mental health issues are also outlined. Grief and remorse related to the person's offence history, building self confidence and resiliency are also included.

2. Family effects
Positive contact with family members as well as negative factors associated with familial relations are shared within this category. History of abusive relations, continued conflict and stigmatism due to family history are outlined. The impact of isolation from family members due to moving out of regions or death are also discussed. Some participants also spoke of different cultural norms and values that remained with them. The importance to maintain contact with family is mentioned by some participants.

3. Social and support systems
Participants discussed the importance of OFI assistance and other community resources. Most participants reported having limited supports from friends. A number of interviewees relayed wanting to have a girlfriend or wife in the future while some reported presently having a significant partner in their life.

4. Residential settings
The impact of frequent moves typically away from the family including residential schools, foster homes, group home settings were discussed. Feelings of loss, anger, fear were identified as were the importance of food and shelter. Many participants also highlighted the negative impact that limited financial assistance has on their ability to live independently at a comfortable level.

5. Productivity
Many participants outlined the importance of work to increase income and social opportunities. Some participants indicated that they were satisfied with attending day programs and would look for employment possibly in the future if feasible. Training modules such as CARP, anger management, social skills training offered via OFI were frequently described as beneficial. The importance of continuing

education to improve future employment was also identified by some interviewees. Education as a child was frequently identified as difficult due to their cognitive disability.

6. Societal and systemic effects

Issues related to limited finances from Employment and Income Assistance were highlighted by a few participants. Additionally noted was society's pressure to be productive, have a certain image which would be reflected by income. An overwhelming amount of Aboriginal participants identified racism as a significant barrier they faced on an ongoing basis. Almost all interviewees noted being picked on or targeted by other students, co-participants or the general community due to cognitive disability, looks, speech impediment, race, sexuality, past offence history, physical health issues.

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