Evaluation of a Treatment Program for Individuals with an Intellectual Disability who Have High Risk Behaviours

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ABSTRACT

In the past two decades numerous programs have emerged to treat individuals with developmental disabilities who have sexual offending behaviours. There has, however been very few studies that systematically examine the effectiveness of long term treatment with this population. The present research examines the therapeutic outcomes of a multi-modal behaviour approach with six individuals with intellectual disabilities previously charged with sexual assault. The participants also exhibited severe behavioural challenges that included verbal aggression, physical aggression, destruction and self-injury. These six participants (5 males, 1 female) were admitted to a Long Term Residential Treatment Program (LTRTP), due to the severity of their behaviours and due to their lack of treatment success in other programs. Individualized treatment plans focused on the reduction of maladaptive behaviours and the enhancing of skills such as positive coping strategies, socio-sexual knowledge, life skills, recreation and leisure skills. The treatment program also included psychiatric, psychological, medical, behavioural and educational interventions. The participants remained in the Long Term Residential Treatment Program (LTRTP) program from 181 to 932 days (average of 1.5 years). Pre and post treatment evaluations were conducted using the following tools: frequency of target behaviours, Psychopathology Inventory for Mentally Retarded Adults (PIMRA), Emotional Problems Scale (EPS), Socio-Sexual Knowledge and Attitudes Assessment Tool (SSKAAT-R) and Quality of Life Questionnaire (QOL-Q). Recidivism rates and the need for re-hospitalization were also noted for each participant. By offering high levels of individualized interventions, all six participants showed a 37% rate of reduction in maladaptive behaviours with zero to low rates of inappropriate sexual
behaviour, there were no psychiatric hospitalizations, and there was no recidivism for 5 of 6 participants. In addition, medication was reduced. Mental health scores on the PIMRA were reduced across all participants by 25% and scores on the Quality of Life Questionnaire increased for all participants by an average of 72%. These findings add to and build upon the existing literature on long term treatment benefits for individuals with a intellectual disability who sexually offend. By utilizing an individualized and multi-modal treatment approach to reduce severe behavioural challenges, not only can the maladaptive behaviours be reduced, but adaptive behaviours can be increased, mental health concerns can be managed, and overall quality of life can be improved.
Acknowledgements

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In addition to this I would like to thank Bethesda Homes Incorporated for allowing me to evaluate their newly developed treatment program. Without this support I would not have been able to complete this very valuable study. I would also like to thank the individuals and their families, who agreed to participate in study. I am privileged to have been a part of theirs lives and even more importantly, to be able to improve their quality of life. The staff of the Bethesda program, were also dedicated in supporting this research and I appreciate all of their team work.

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CHAPTER ONE:

THE PROBLEM

Individuals with intellectual disabilities who offend sexually present significant challenges for caregivers and community service providers. In recent years, specialized intervention services for this population have emerged. Many of these services operate with limited or no empirically validated evidence of treatment effectiveness. A new program, the specialized Long Term Residential Treatment Program (LTRTP) at Bethesda Services Inc. in Vineland, Ontario, began in 2002 to provide long-term residential and therapeutic intervention for eight individuals with intellectual disabilities who have been identified as being sexual offenders. The objective of this LTRTP program is to provide assessment and intervention to ameliorate the offending behaviours, while teaching appropriate behaviours; the long-term goal is to return each individual to a less restrictive community setting.

The main focus of the present research was to examine the effectiveness of an individualized multi-modal behavioural approach for individuals with developmental disabilities who sexually offend. Participant improvements were noted in the following manner: reduction in maladaptive behaviours, reduction in mental health indicators as noted in the Psychopathology Inventory for Mentally Retarded Adults (PIMRA) and Emotional Problems Scales (EPS), improvements in socio-sexual knowledge as evaluated by The Socio-Sexual Knowledge and Attitude Assessment Tool (SSKAAT-R) and improvement in quality of life as evaluated by the Quality of Life Questionnaire (QOL-Q).

Very few studies have reported long term follow up on the longevity of treatment effects for individuals with a intellectual disability who sexually offend. Although many
studies, such as in the study completed by Murphy, Coleman, & Hayes (1983), reported that a reduction in inappropriate sexual behaviour was noted with their participants, most of the data were based on self-reports or reduction in rates of recidivism. In addition to this, most studies focused on the reduction of single behaviours using a single treatment approach. Many times the treatment only focused on reducing maladaptive behaviours versus increasing adaptive behaviours (Cook, H. Altman, K. Shaw, J. & Blaylock, M., 1978; Murphy, W. D., Coleman, E. & Hayes, M., 1983; Nolley, D. Muccigrosse & Zigman, E., 1996).

Many other articles published on the treatment of individuals with a intellectual disability who sexual offend, merely described community-based treatment programs that assist in the reduction of inappropriate behaviour. These articles also made recommendations about how treatment programs for sexual offenders should be offered and suggested potential components to assist in the reduction of sexual acting out behaviour such as social skills programs, socio-sexual education, cognitive restructuring, self-monitoring and supervision (Griffiths, Quinsey & Hingsburger, 1989; Haaven, J. Little, R., & Petre-Miller, D., 1990, Ward, K., Heffren, S., Wilcox, McElwee, D., Dowrisk, P., Brown, T., Jones, M. & Johnson, C., 1992).

The present research expands the previous literature in several ways. Pre and post behavioural treatment data were collected on the maladaptive behaviours for each participant of the LTRTP including frequency data, mental health concerns (using PIMRA and EPS scales) and quality of life (using QOL-Q). In addition psychosexual knowledge was assessed using the SSKAAT-R before and after socio-sexual education was provided. Behavioural assessment was completed for each participant who was admitted to the LTRTP in order to determine the function of each participant’s behaviour.
Once the function of the behaviour was determined, individualized multi-modal behaviour programs were established for each person. A multi-disciplinary team including a physician, psychiatrist, psychologist, clinical support coordinator, behaviour therapist, front line staff members and family members, monitored the progress of each person in the LTRTP. In addition to this, the long term effects of the multi-modal approach was monitored because participants remained in the program from 181 to 932 days.

The present study further provides an historical basis for understanding the sexuality of people who have intellectual disabilities and, in particular, those who present with sexual offending behaviours. Specific treatment programs that have been developed to address behavioural challenges such as sexual offending behaviour will be reviewed and critiqued. Lastly, the paper will describe the Bethesda Services Inc. treatment program, and how this program has been designed to represent best practice in the field.

*Definition of Intellectual Disability*

The American Association on Mental Retardation (AAMR) (American Psychological Association, 2002) identifies a person who has an intellectual disability as presenting substantial limitations both in intellectual functioning as well as in adaptive behaviour in the areas of conceptual, social and practical adaptive skills prior to age 18. They identify significantly below average intellectual functioning that is expressed concurrently with related disabilities in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work.
CHAPTER TWO:
LITERATURE REVIEW

Historical Context of the Sexuality of Persons who have an Intellectual Disability

Historically, the sexuality of individuals who have an intellectual disability has been ignored, repressed and even punished (Griffiths, Watson, Lewis & Stoner, 2003). Recent years have witnessed greater awareness of the sexuality of persons with intellectual disabilities. The approach towards responding to sexual issues has also changed, however practitioners attitudes around the issue of sexuality with people who have an intellectual disability have changed very little (Anderson, 2000).

In the 18th century, most individuals who had intellectual disabilities were institutionalized with other persons who had differing disabilities or mental health needs. However, during the revolutionary period in Europe and America, a trend towards caring for individuals who presented with disabilities began (Kempton and Kahn, 1991). Special schools were developed to house and educate persons with intellectual disabilities. Nevertheless, even during this time of progress, negative attitudes remained towards the sexuality of persons with intellectual disabilities (Kempton and Kahn, 1991).

The Eugenics Movement of 1880 – 1940, was largely prompted by a Sheerenburger (1983) that linked intellectual disability, criminality and sexual promiscuity. During the Eugenics era, it was commonly believed that persons with intellectual disabilities would reproduce faster and produce children who would become a burden on society (Kempton and Kahn, 1991). As a result, involuntary mass castration and ovariectomies were preformed on thousands of persons with intellectual disabilities worldwide (Scheereburger, 1983).
During the 1940s and 1950s, there was very little progress in the areas of treatment or education in the area of the sexuality of persons with intellectual disabilities. The sexuality of this population continued to be overlooked and misinterpreted. Many individuals remained housed in institutions where sexual behaviour was treated with harsh consequences (Kempton and Kahn, 1991). Heterosexual interactions were severely punished by solitary confinement or shaving the heads of heterosexual couples. In contrast, there was toleration of sexually inappropriate behaviours such as inappropriate touching, public disrobing and public masturbation (Kempton and Kahn, 1991).

With the civil rights movement of the 1960s and the advent of a philosophy of normalization in the field of intellectual disability, the policy of deinstitutionalization was introduced (Kempton and Kahn, 1991). The bases of the normalization philosophy included the need for daily work and leisure, the ability to make choices, the opportunity to live, work and love people of both sexes and the dignity of risk (Kempton and Kahn, 1991). Proponents of the normalization philosophy also recognized that people with intellectual disabilities are sexual beings and have the need for socio-sexual education.

The 1970s and 1980s ushered in a sexual revolution during which sexual rights of persons with intellectual disabilities became recognized. During this period there was an increased emphasis on the development of sex education, birth control, and family planning for this population. Goals, guidelines and curricula for socio-sexual education were developed. Parents, staff and other professionals were trained to teach the curricula and policies around sexuality for persons with intellectual disabilities. However, the focus of the curricula was primarily on protection from unwanted sexual consequences, rather than on a more proactive and positive approach to sexuality (Griffiths & Lunksy, 2000).
A further shift occurred in the 1990s. The focus of the curricula changed to include sexual abuse, inappropriate sexual behaviour, HIV/AIDS and sexual health (Griffiths & Lunsky, 2000). As a result, society became aware of the increased rate of sexual abuse of persons with intellectual disabilities. Sobsey (1993) reported that persons with disabilities are 150% more likely to be sexually abused than the general population. This awareness prompted the demand for training in self-protection against sexual molestation and abuse for this population.

In recent years, there has also been a general increase in the acceptance of and understanding of the sexuality of people with an intellectual disability by care-givers and family members (Griffiths & Lunsky, 2000). However, even with these changes and improvement in services, attitudes and education of people who have intellectual disabilities, there remains several prevailing attitudes of care givers and the general public towards sexuality for the disabled and these include the following:

One of the common myths is that persons with intellectual disabilities are neither sexual beings, nor experience sexual thoughts, feelings or desires (Anderson, 2000). In fact, people with an intellectual disability go through the same stages of psychosexual development from childhood to adolescence to adulthood as other people. While progressing through these stages, people with a disability experience the same body changes, emotions, desires and dreams. Viewing people with disabilities as nonsexual and as repressing their sexual expression is not only unrealistic, but also violates their rights to sexual expression.

A second myth is that persons with intellectual disabilities are perpetual children. The cognitive limitations of adults who have intellectual disabilities may cause families and care-givers to view them as children and, in our society; children are not viewed as sexual
beings (Anderson, 2000). As such, sexuality is not deemed to be an important aspect of the life of a person with a disability. Anderson (2000) argues that children are just as much sexual beings and their sexual interests and feelings change as their bodies change (Anderson, 2000). However, the eternal child myth is further reinforced by the concept of mental age. Persons with intellectual disabilities are often described in terms of a mental age equivalence of a child; however an adult male with a life time of learning as an adult male cannot be misunderstood to be identical to a child. This type of reductionist approach, Griffiths (2003) argues, tends to minimize the experiences of the adult with a disability to nothing more than a number on a test of intelligence.

Another myth is that people with intellectual disabilities are dangerous, promiscuous, deviant and over-sexed (Griffiths, 2003). There is no reason to believe that persons with intellectual disabilities will present with any more dangerous, promiscuous, deviant or sexually inappropriate behaviour than the general population if they are afforded appropriate and normative learning experiences (Edgerton, 1973). However, the sexual development of persons with intellectual disabilities are often influenced by over protection, a lack of socio-sexual education, a lack of access to appropriate peer groups, poor adaptive skills, denial of privacy, lack of appropriate supports systems, abuse and even the influence of medical conditions. Although persons with intellectual disabilities are over represented in the criminal justice system for sexual offences, the over representation may be less related to a higher incidence than to the fact that they are more likely to get caught, confess and have higher conviction rates (Griffiths, Taillon-Wassmund & Smith, 2002). Moreover, the sexual offences that are committed by people with intellectual disabilities tend to be less serious than those committed by non-disabled
individuals; their sexual offences are more typically public masturbation, inappropriate touching or public disrobing.

A fourth myth revolves around socio-sexual education for persons with intellectual disabilities. It is believed that individuals with intellectual disabilities should not attend socio-sexual education classes because it will encourage inappropriate sexual behaviour (Griffiths, 2003). However, educating persons with intellectual disabilities will assist them in understanding the changes that occur within their bodies as they mature and the emotions that go along with these changes. Education will also provide them with the guidance and knowledge to be responsible about their sexual needs as well as to prevent possible sexual abuse (Griffiths, 2003). Further, socio-sexual education will teach individuals to distinguish the difference between inappropriate and appropriate sexual behaviour.

A final prevailing belief involves the myth that people with an intellectual disability cannot benefit from counselling or treatment for sexual issues. However, there is growing body of literature that suggests that people with intellectual disabilities can benefit from interventions directed at sexual abuse counselling and education of appropriate sexual behaviour (Griffiths, 2003). In some cases, it has been shown that education alone as a treatment for certain inappropriate sexual behaviours were effective interventions in decreasing these inappropriate sexual behaviours with individuals who have an intellectual disability (Griffiths, 2003).

The continued presence of these myths, has largely influenced how the sexuality of persons with intellectual disabilities has been perceived and treated by society in regards to their sexual interests and education. These myths, and the attitudes they inspire, have a direct bearing, in many cases, on how the sexuality of people with intellectual disabilities
may be influenced in an inappropriate manner. This issue will be described more fully later in this thesis.

**Sexual Offending Behaviour**

Among charged offenders it is reported that 15%–33% have an intellectual disability (Griffiths et al., 2002). Griffiths et al. (2002) noted that the disparity in reported rates may be due to the manner of data collection. However, these rates appear to over-represent persons with intellectual disabilities within the offender population. Most data are gathered from arrest rates that may not accurately depict offence rates in this population. Over representation may occur with the disabled population because they tend to have higher arrest rates, confessions and convictions (Griffiths et al, 2002). Clinical data that indicate a higher rate of persons who have cognitive impairment among sex offenders often fail to differentiate the referral bias that may be related to a higher than expected rate of referral to certain clinical settings staffed by clinicians with an expressed interest in the research and treatment of persons with intellectual disabilities. As such these data may be pooled from a skewed sample (Griffiths, Personal communication, June 19, 2005). Others have argued that the population samples may be under-estimates of the real statistics, suggesting that persons with intellectual disabilities are often not charged for offences due to diversion to residential facilities or because people may be deemed unfit to stand trial (Day, 1994). Further investigation is required in this area in order to obtain accurate data on this subject.

**Definition of Sexual Offending Behaviour**
Sexual offending behaviour involves sexual contact with another person without consent and any sexualized adult contact with children. There are several categories of sexual offending behaviours; they may have a direct impact on another person, an indirect impact on another person, or not involve another person at all (Griffiths, 2003). For the purpose of this paper, they will be simplified into behaviours that are considered sexually deviant, and those behaviours that are inappropriate (behaviours which may appear deviant but lack the recurring urges and fantasies associated with deviance) (Griffiths, 2003). These distinctions will be elaborated below.

Sexually deviant behaviours may involve some of the following: sexual masochism, sexual sadism, pedophilia, exhibitionism, frotteurism, fetishism, scatologia, coprophilia, klismophilia, urophilia and voyeurism (APA, 1994). Sexual aggression can reveal itself as sexual sadism or pedophilia. Sexual sadism involves sexual arousal to images in which the victim is being physically or psychologically harmed (Griffiths, 2003). The DSM IV defines pedophilia as a sexual disorder that is considered to be an offence as it involves fantasies, sexual urges or behaviours involving sexual activity with a child 13 years or younger (American Psychological Association, 1994). Typically, most sexual deviant behaviours committed by individuals with an intellectual disability are among the less serious offences such as exhibitionism (exposing their genitals), frotteurism (touching or rubbing against a non-consenting person), voyeurism (observing unsuspecting people disrobe) or fetishism (exclusive interest in a certain object or certain textures) (Griffiths, 2003).

Inappropriate sexual behaviour is defined as any sexual behaviour that violates ordinary standards of social norms and typically indicates the need for social or sexual education, but in which there is no intent to harm (Tudiver, Broekstra and Barbaree,
1993). Generally, sexually inappropriate behaviour results from lack of a support system, poorly developed social skills, lack of information about appropriate sexual expression or segregation (Tudiver et al., 1993). The term counterfeit deviance was coined by Hingsburger, Griffiths and Quinsey (1991) to describe sexual behaviour that topographically is deviant, but upon further analysis is a result of some other unravelled factor. Behaviours such as public exposure and inappropriate touching may not indicate deviant sexual behaviour, but may be a result of other factors. Hingsburger et al. (1991) describe eleven hypotheses that should be investigated prior to diagnosing an individual as sexually deviant. Some of these hypothesis include structural/environmental issues such as lack of privacy in their homes, modelling the actions of others such as staff or actors on TV shows, behavioural challenges (i.e., engaging in masturbation to avoid doing chores), and lack of opportunity to interact with appropriate partners (Hingsburger et al., 1991). Other hypotheses to be considered include lack of socio-sexual knowledge, medical concerns such as rubbing vaginal area due to a yeast infection, or medications that can cause sexual side-effects, such as erectile dysfunction (Hingsburger, Griffiths and Quinsey, 1991). Inappropriate sexual behaviour, may also result from environmental restrictions, lack of limit setting, poorly developed social skills, or lack of information about appropriate sexual expression. Mulhern (1975) stated that 84 % of persons with intellectual disabilities who were labelled as having sexually inappropriate behaviour exhibited masturbation. In his study, the majority of sexually inappropriate behaviours exhibited in this sample did not involve a victim. Without a complete assessment, it is often difficult to distinguish whether the behaviour of a person with an intellectual disability is sexually inappropriate behaviour or sexually deviant. The impact on the
victim may be identical regardless of the intent; differentiation however is vital to appropriate intervention (Griffiths, 2003).

A Review of the Research on Treatment Programs for Sexually Offending Behaviour

A review of the literature on treatment for sexual offenders who have an intellectual disability produced thirteen treatment related research papers and four treatment program reviews (See Table 1). Each study was examined in terms of participant characteristics, treatment duration, results of the intervention and long term follow up of the treatment. The participants in the research studies consisted primarily of males with mild intellectual disabilities. The sample sizes of the studies were generally small and consisted of 10 or fewer subjects (Cook et al., 1978; Nolley et al., 1996; Lindsay, Marshall & Neilson, 1998). However, two studies had larger samples. Xenitidis, Henry, Russell, and Ward (1999) described a sample of 64 participants of both male (46) and female (18) gender from an inpatient treatment model for adults with mild intellectual disabilities who had challenging behaviours. In most instances, the research design of the studies reviewed consisted of single case studies (Lund, 1992; Day, 1994; Foxx, 2003). A few studies had pre/post test designs (Bose & Ward, no date; Lindsay & Smith, 1998) in which change in attitudes or knowledge was assessed before and after the implementation of educational programs. Standardized tools were not used to examine quality of life of the individuals after their treatment period. Quality of life was measured on the basis of the participant being transferred to a less restrictive living environment, change in level of independent functioning level, and change in level of supervision required. Most studies did not have any follow up data, however a few did have follow up of 3 – 5 years such as Lund (1992) and Nolley, Muccigrosse & Zigman (1996).
Lindsay, Olley, Baillie & Smith (1999) completed a case study on four male adolescent sex offenders with mild intellectual disabilities. A group treatment approach based on cognitive behaviour therapy was used and assessment of attitudes related to committing sexual offences was assessed. After 3 – 4 years had elapsed, there was no recurrence of an offence. Another study, of the long term effects of anger management training with individuals who have intellectual disability and were convicted of assault related charges, examined rates of recidivism for up to 19 years after treatment. A single case study design with repeated measures for six men was employed. The anger management training consisted of cognitive restructuring and arousal reduction. Five of the men did not re-offend and one re-offended after 6 months, but has not offended in the last four years prior to publication (Lindsay et al., 2003).

Therapeutic intervention for sex offenders is a difficult task. Then when you add cognitive limitations of the offender into the treatment process, the issues become even more complicated (Murphy, Coleman & Haynes, 1983). Historically, treatment was either denied or consisted of institutionally-based behavioural interventions of an aversive nature. Treatment to reduce deviant sexual behaviour for people who have an intellectual disability included electrical aversion therapy, satiation and covert sensitization. The major procedure for increasing appropriate arousal was masturbatory conditioning.

A review of the literature revealed several early studies that demonstrated how sexually inappropriate behaviour was managed in the 1970s and 1980s. Cook, Altman, Shaw and Blaylock (1978) describe the use of lemon juice as a punisher for public masturbation in a seven year old intellectually disabled boy. Public masturbation was defined as when the boy placed his hands inside his pants and on his penis anywhere in
public and was considered to have ended when he removed his hands from his pants. This behaviour was deemed acceptable when it occurred in his bedroom. The behaviour occurred at home as well as at school. Initially, both the parents and teachers were instructed to slap the child’s hand whenever masturbation occurred, however this procedure increased masturbation at home. As a result, a punishment procedure was implemented at school that consisted of squirting 5 - 10 cc of lemon juice into the boy’s mouth whenever he attempted to masturbate in public. After thirteen days of treatment at school, the family implemented the procedure at home. The result indicated that after 16 days of treatment at school and 13 days of treatment at home, public masturbation was reduce to zero (Cook et al., 1978).

Murphy, Coleman and Haynes (1983) describe a case of a 38 year old man who was mildly intellectually disabled. He had a long history of attraction to children that resulted in his incarceration at age 30. While in prison this man was treated using electrical aversion that he stated was helpful. Upon release to the community, this individual requested continued use of electrical aversion, which his family also agreed to. The patient received 16 treatments over 3 months in order to curb his fantasies and behaviour towards children. In addition to this, the patient received masturbatory reconditioning that involved masturbating to pictures of adult women 2 -3 times per week. The patient and his family reported no incidence of deviant sexual behaviour over a five year period after the treatment (Murphy et al., 1983).

Clare and Murphy (1993) completed a study that evaluated the effectiveness of service delivery by M.I.E.T.S. (Mental Impairment Evaluation and Treatment Service). They completed a follow up on six intellectually disabled individuals (1 female, 5 males) who had been discharged from the M.I.E.T.S program. These participants have remained in
the program on average for 9 months and follow up occurred approximates one year after discharge. A variety of standardized measures were used to compare the change in level of challenging behaviour, examine the change in life skills and social skills as well as to evaluate quality of care and quality of life improvements. Although, this study did not define the severity of behavioural challenges or describe the treatment method that promoted the behaviour change, the results upon discharge were significant. All six individuals made gains in their skill levels and social functioning (Clare and Murphy, 1993). Five out of six participants also had a reduction in their challenging behaviours. In addition to this, all six intellectually disabled persons showed improvements in their quality of care as well as increases in their quality of life (Clare and Murphy, 1993).

In summary, past research methods primarily used a simple approach to a complex problem that consisted of treatment to decrease the negative behaviours, such as masturbation, or to increase skills, such as victim empathy. The treatments in these studies tended to be short term, approximately 2-6 months. Case studies were typically used, therefore the research was not data based and evidence of positive outcomes was not conclusive. Limited measures were used, such as recidivism rates, and standardized assessment tools were typically not used. Baseline data of the maladaptive target behaviours, as well as the use of pre and post treatment measures would validate the effectiveness of the interventions. Pre and post measures of the adaptive skills being taught would further validate these studies. Also, there is a need for additional longitudinal studies in order to determine the long term effectiveness of small group treatment with this population. Several factors must be considered when evaluating the above mentioned studies. Formal behavioural analysis of the function of the behaviour was not completed which may have lead to less intrusive treatment being employed.
null
Further, although these studies demonstrate that treatment was successful in reducing the inappropriate sexual behaviour, limited empirical data were presented. The conclusions most of the studies were based on self-reports of a reduction in the maladaptive behaviour by family members or support staff. Long term follow up on the longevity of the treatment effects would also add to the validity of the research. A comparison of baseline frequency of behaviour pre and post treatment would have validated the research more effectively. Finally, with the exception of one study completed by Clare and Murphy (1993), these studies focused on the modification of a single behavioural challenge using a single treatment methodology.
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<tr>
<th>Study</th>
<th>Article</th>
<th>Sample Number</th>
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<th>Outcome Measure</th>
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<td>Community based support services for women who exhibit high risk sexual behaviour</td>
<td>26 women, DD</td>
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<td>Knowledge obtained from educational groups, staff observation, recidivism rates</td>
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<td>Case study</td>
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<td>Case study</td>
<td>Self report of frequency behaviour</td>
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<td>Long-term treatment of sexual behaviour problems in adolescent and adult developmentally disabled persons</td>
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<td>Response to treatment for sex offenders with intellectual disability: a comparison of men with 1 and 2 year probation sentences</td>
<td>14 males</td>
<td>Pre/post test</td>
<td>Assessed attitudes towards offending</td>
<td>1 &amp; 2 years (depending on probation)</td>
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<td>Lindsay, W.R., Baillie, O.S. &amp; Smith, A.H. (1999)</td>
<td>Treatment of adolescent sex offenders with intellectual disabilities</td>
<td>4 males</td>
<td>Case study</td>
<td>Assessment of attitudes related to offence</td>
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<td>Author(s)</td>
<td>Title</td>
<td>Offenders with intellectual disability: the size of the problem and therapeutic outcomes</td>
<td>Data review of literature</td>
<td>Recidivism review</td>
<td>None</td>
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<tr>
<td>Linhorst, D., Bennet, L., &amp; McCutchen, T. (2002)</td>
<td>Development and implementation of a program for offenders with intellectual disability</td>
<td>600</td>
<td>Program overview</td>
<td>Recommendations for developing and implementing similar programs</td>
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<td>Lindsay, W.R., Allan, R. MacLeod, F., Smart, N., &amp; Smith, A. (2003)</td>
<td>Long term treatment and management of violent tendencies of men with intellectual disabilities convicted of assault</td>
<td>6 males</td>
<td>Single case design with repeated measures</td>
<td>Recidivism rates, anger inventory results, anger self reports</td>
<td>4, 5 &amp; 10 years</td>
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<td>Fox, R. (2003)</td>
<td>The treatment of dangerous behaviours</td>
<td>3 males, severe ID</td>
<td>Case study</td>
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**SUMMARY OF TREATMENT PROGRAMS**

<table>
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<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Program overview with case examples</th>
<th>Recidivism rates</th>
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<td>Griffiths, Quinsey &amp; Hingsburger (1989)</td>
<td>Community treatment program for inappropriate sexual behaviour: supporting individuals with developmental disabilities in the community</td>
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<td>Clare, I.C.H. and Murphy, G.H. (1993)</td>
<td>M.I.E.T.S. : A service option for people with mild mental handicaps and challenging behaviour and/or psychiatric problems.</td>
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<td>Adaptive Behavior Scale, Part II, Vineland Social Maturity Scale, Quality of Life Questionnaire, Personal Independence and Education, Occupation and Leisure Schedules</td>
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Nature of Treatment Programs for Sexual Offenders

More recently, treatment programmes for individuals with an intellectual disability who exhibit sexually inappropriate behaviour have changed from suppression and punishment to endorsing a multi-treatment design that includes teaching adaptive, alternative coping skills and prosocial-sexual behaviours. Linhorst, Bennett & McCutchen (2003) described service provision by an agency that had provided direct-care services to six hundred offenders with intellectual disabilities. Recommendations for the development and implementation of similar services for individuals with mild intellectual disabilities who had offending behaviours were offered.

The recommendations that were offered for the development of similar services for intellectually disabled offenders included addressing assessment needs, funding issues, developing a comprehensive board of directors, developing a program philosophy, developing program services, staff, developing a referral process and creating a program evaluation. The first programme developed in Canada for the treatment of persons with intellectual disabilities who sexually offend was York Behaviour Management Services (Griffiths, Quinsey, & Hingsburger, 1989). Their sexuality intervention involved six treatment components: social competency skills, sex education, relationship training, responsibility training, coping skills training and altering deviant behaviour (Griffiths et al., 1989).

Social competency training takes place in the form of instruction, modeling, practice and role plays. A social skills game titled, the Social Learning of Independence through Functional Experience game (Social L.I.F.E.), developed by the York Behaviour Management Services in 1985 is also used to teach, practice and learn social skills in a fun manner (Griffiths et al., 1989).
Sex education is another key educational element of the York Behaviour Management Services approach. These sessions include education about body parts, social behaviour, sexual intimacy, reproduction, health care and self-protection. By focusing on sex education, persons with intellectual disabilities who display inappropriate sexual behaviour can be provided with the information and training necessary to become sexually responsible (Griffiths et al., 1989).

Relationship training can further build on social skills training and sex education through enabling persons with intellectual disabilities to be able to discriminate between sexual and nonsexual relationships, identify appropriate and inappropriate partners, approach and respond appropriately in various relationships and acknowledge the value of various relationships (Griffiths et al., 1989). Responsibility training builds on teaching skills such as personal responsibility, interactive responsibility, social responsibility and moral responsibility.

Griffiths et al. (1989) also focus on teaching coping skills to sex offenders with intellectual disabilities to instruct them on positive methods for managing anger and frustration. These techniques can include but are not limited to relaxation training, cognitive restructuring, assertion training, and problem solving skills.

The final element of the treatment program developed by the York Behaviour Management program involves altering sexual arousal patterns. This treatment component is only considered if the individual has inappropriate interests such as interest in children or violent sex acts. Treatment may centre on refocusing sexual arousal to appropriate sexual stimuli. In most cases, York Behaviour Management Services uses covert sensitization in which the objective is to teach the intellectually disabled person to stop the thoughts and fantasies that stimulate the inappropriate sexual behaviour and to
replace them with thoughts and images that are more sexually appropriate (Griffiths et al., 1989).

York Behaviour Management Services reviewed the nature of their program and provided clinical examples of community application (Griffiths et al., 1989). In each case an individualized treatment plan was developed depending on the person’s needs and based on the six components of treatment described above. In each case success was noted through an increase in appropriate skills and a decrease in inappropriate behaviour. However, no empirical data were provided.

Another early programme was Oregon State Hospital’s Social Skills Program (SSP). It was designed for adults who were intellectually disabled who displayed sexually offending behaviour. The SSP provided a secure 31 bed hospital treatment approach for persons with intellectual disabilities with limited adaptive skills and who required intensive treatment in a controlled, safe setting (Haaven, Little & Petre-Miller, 1990). In this program, three to four participants shared a unit. The participants had access to day programs, a dining room, cooking facilities, a music room, chapel, recreational activities, and a fenced in yard. Treatment techniques included behavioural contracting, journaling, life skills training, cognitive restructuring, recreational skills, educational groups (anger management, sex education), counselling, developing daily schedules, responsibility training, medical/psychiatric assessment, relationship development, and sexual deviancy treatment. Each person was assessed and then a treatment plan was developed to meet the needs of that participant. Goals were set and reviewed on a regular basis. Once the individual’s needs were met, a transition plan was developed to assist the intellectual disabled person to reintegrate back into the community (Haaven et al., 1990). Several case studies illustrated how the SSP treatment progress was documented through the
acquisition of skills, decrease in maladaptive behaviours and reintroduction into a less structured and supervised setting.

The Alaska Specialized Education and Training Services Program (ASETS) was based on the above two programmes. It was similarly designed for people with intellectual disabilities who have inappropriate sexual behaviours living in a community setting (Ward et al., 1992). This program was developed in order to provide community-based services that had five components including assessment, treatment, supervision and monitoring, socio-sexual training and an Advisory Team. Assessment included a review of case records, interviews, and assessment of risk. The treatment component involved weekly group therapy sessions that focused on changing behaviour using cognitive restructuring, self-monitoring and self-management skills. Each case consultation and group was supervised by a licensed psychologist. Supervision and monitoring of individuals in the ASETS programs was provided by external controls, supervision and staff supports depending on the persons needs. The ASETS staff members also work closely with other agencies, family members, correction services, psychologists, psychiatrists, and behaviour therapists. In addition to group treatment, socio-sexual training/treatment was another component of the ASETS program. Participants in this program were educated on the social, biological and legal consequences of sexual decision making, social skills and anger management techniques. Training in these areas was completed using a variety of formats such as guest speakers, life skill games, videos, skills repetition and role playing. The final element of the ASETS program was the function of the Advisory Team. This team functioned to plan, implement and monitor individual treatment and support plans. The Advisory Team was comprised of treatment, training and residential representatives, the Executive Director and other community
experts. The team meets weekly to address ongoing issues of treatment effectiveness, changing consumer needs and individual growth (Ward et al., 1992).

The ASETS program was designed for two individuals with intellectual disabilities who exhibited inappropriate sexual behaviour in the form of engaging in inappropriate contact with children. Both persons were assessed for intellectual functioning, sexual knowledge, and risk factors. The treatment plan for both individuals was similar and consisted of relapse prevention, teaching positive coping strategies, supervision, socio-sexual education and appropriate day supports (Ward et al., 1992). It was noted that each individual was progressing well, however specific outcome measures were not described in order to determine what their actual progress was. No follow up data were illustrated.

As noted from the programs described above, there are few treatment programs available to address the complex needs of individuals with an intellectual disability who have inappropriate sexual behaviours. Early studies were largely single case studies and typically employed punishment to repress the sexual offending behaviour. Studies within the past twenty years provide lessons learned from a larger number of individuals and are based on multi-modal treatment approaches that focus on habilitation rather than rehabilitation. Newer programmes emphasize education, and increasing client skills development while altering deviant behaviour. Individual treatment needs are also examined and addressed in newer treatment programs. However, limited information about baseline rates of behaviour has been provided and follow up data on individual behaviour change after treatment is not evident.

Elements that differ among the various intervention programs mentioned above include community versus facility treatment, single treatment design versus multi-treatment design, and repressive approach versus a holistic, habilitative approach. Community-
based treatment programs have the advantage of programming in the natural environment thereby enhancing generalization, however not all interventions can be carried out easily in the community and consistency in following programs can also be difficult. Facility-based intervention programs can be difficult to generalize into the community, however they have the advantage of greater consistency, higher supervision if required, access to a variety of resources (such as educational groups, employment services, life skills training, etc), access to a wider variety of professionals (such as physicians, psychiatrists, psychologists, social workers, counsellors, behaviour therapists, speech and language pathologists, etc). An inpatient treatment environment may be required when the current setting is no longer able to manage the acting out person or if the criminal justice system determines that the risk to the community is too great. Advantages of an inpatient program can include specialized staffing, access to group intervention such as anger management training/socio-sexual education, consistent programming, a consistent method to monitor the progress of the individual, etc. One drawback to a specialized treatment program is generalization back to the community. Methods for increasing generalization of treatment effects in the natural environment must be addressed as part of community based intervention programs.

Multi-treatment designs represent best practice because patterns can be seen in a larger group of participants over time, and it is easier to determine which interventions work the best and under what conditions. In addition to this, a positive and individualized approach to increase skills deficits while altering deviant behaviours is the most effective means of changing behaviour. Whenever behaviour change is necessary, assessment of individual need is important in order to determine skills that need to taught to the individual as well as maladaptive behaviour that needs to be reduced. This
assessment will also assist with determining the most effective treatment modality that will have positive, long term positive effects.

The literature identifies several considerations that should be made prior to treatment and evaluation (Murphy et al., 1983). First and foremost is the cognitive ability of the person with intellectual disability. Each individual may differ in cognitive functioning, social functioning, social knowledge, learning style and insight into their behavioural challenge. In addition to this, the person may have compounding factors such as psychiatric issues, genetic abnormalities, medical conditions or physical conditions that may impact upon them (Murphy et al., 1983).

Second, the individual with an intellectual disability who is presenting with sexual problems may also have other behavioural challenges. These behavioural challenges may include difficulties with impulse control, physical aggression, destruction, social skill deficits and self-injurious behaviour to name a few (Murphy et al., 1983). It may be necessary to consider the use of ongoing and multi-model treatment methods in order to address these complex issues.

Third, as stated previously, there are many myths, stereotypes and misunderstandings among caregivers and family members who support individuals who have an intellectual disability. Special efforts may be required to dispel the beliefs that caregivers may hold, so that treatment and education around sexual issues can be provided for the disabled person. Educating caregivers/families that appropriate sexual expression by the disabled person is a normal part of their growth and development and should be encouraged is an important part of the intervention process.

Fourth, the literature suggests that the treatment environment for persons with sexual offending behaviour could occur in a variety of different settings (Murphy et al., 1983).
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The treatment environment should consider the individual needs of the person as well as the risk that the person may present. For example, an outpatient setting may be considered if the frequency and intensity of the acting out behaviour does not place the individual or others at risk and if the referred individual agrees to cooperate with the treatment team. The treatment team and the family/residential setting must work together closely in order to ensure consistent and effective programming (Murphy et al., 1983).

Fifth, the qualifications of treatment facilitators are also critical to treatment; they should have training in both intellectual disability and knowledge of sex offender assessment and treatments. Members of professions that may be included as part of a treatment team can include, but are not limited to, a psychologist, psychiatrist, physician, behaviour therapist, area supervisor, and specialized support staff (Murphy et al., 1983).

Sixth, Tudiver et al. (1993) noted the importance of examining risk and safety issues with this group of individuals, for the sake of both for the individual and others in the environment. Individuals, who have been involved with the criminal justice system due the severity of their behavioural challenge, should be viewed as high risk individuals to the community, especially if they have had multiple charges against them. In these cases safety of the community needs to be a priority. Safety measures can be addressed by ensuring appropriate supervision of the individual, ensuring the safety of all children, clear communication of risk with the treatment team to facilitate support of staff/family members, conducting relapse prevention programs and ensuring that the victim is safe. Additionally, the integration of individuals with an intellectual disability, with non-intellectually disabled sex offenders may place the intellectually disabled offender at great risk of victimization. It is important to put in place safeguards to ensure the safety of the intellectually disabled offenders. If labelled a “sex offender” inappropriately, the
intellectually challenged person may be stigmatized, will have difficulties eradicating this label, have unnecessary restrictions placed on them, and they may even start to believe that they are in fact sex offenders. Thorough assessment and historical information must be gathered prior to any label being placed on any individual (Tudiver et al. 1993).

Seventh, all individuals with an intellectual disability must be given the legal opportunity to exercise their right to make voluntary and informed decisions about treatment options. If an individual, due to cognitive limitations, is unable to make the decision, family members and/or an advocate may be required to assist with this process (Tudiver et al. 1993).

Eight, a comprehensive assessment should be conducted by trained professionals who have experience and knowledge working with individuals who have an intellectual disability. The assessment should be geared to the cognitive abilities of the individual, and involve information provided by the individual as well as all support staff involved with the person, a history of the person and his/her offences, and consideration of all contextual factors. The results of a thorough assessment of this nature should be used to assist with the development of an individualized treatment plan (Tudiver et al. 1993).

Lastly, treatment methods for intellectually disabled offenders are based on those for non-intellectually delayed offenders. The generalized use of treatment not specific to intellectually disabled offenders does not reflect the unique needs of this population. Treatment should focus on the reduction of maladaptive behaviours as well as the development of appropriate social skills, sexual expression, community safety, etc. The progress or lack of progress, of the individual, as a result of the treatment, should be continuously monitored. Progress will be noted by a reduction of inappropriate behaviour, taking responsibility for their actions as well as an improvement in pro-social
behaviours (Tudiver et al. 1993). Once the individual has completed the treatment program, ongoing monitoring should continue in order to ensure generalization in the discharge setting. The individual should have the option to return to the program if additional treatment is required.

*Understanding Challenging Behaviours and People with Intellectual Disabilities*

People who have intellectual disabilities exhibit more disruptive behaviours than their non-disabled peers. Reiss (1994) estimates that between 12% and 15% of all people with intellectual disabilities display severe behavioural challenges such as physical aggression towards others, property destruction and self-injury. Gardner (2002) states that there are various influences that may produce behavioural challenges among individuals with an intellectual disability including medical, psychiatric, psychological or environmental conditions which may act as instigating conditions, vulnerabilities/risks and maintaining conditions. This biopsychosocial model has been applied to persons with intellectual disabilities who offend sexually (Griffiths, 2003).

The Biopsychosocial Model of Behavioural Intervention is a multi-modal behavioural approach that involves applied behavioural analysis techniques, cognitive behaviour therapy, social/sexual education/therapy and organized daily activities. This approach provides a template from which to develop and implement behavioural strategies with individuals who exhibit challenging behaviours (Griffiths, Gardner & Nugent, 1999).

Challenging behaviours, on most occasions, represent functional social behaviours that have been shaped and strengthened over time (Gardner, 2002). The functions of these behaviours may include establishing/maintaining social interaction with others, avoiding/escaping disliked tasks or activities, or obtaining a desired item/activity,
expressing emotions and/or communicating wants and needs. Based on observation, historical information and analysis of data, a multi-modal behavioural approach can assist with the identification of the function of the behaviour, which will lead to appropriate treatment/interventions.

Conception of the Long Term Residential Treatment Program (LTRTP) at Bethesda

Bethesda is a non-profit Christian organization that supports individuals with intellectual disabilities in the Niagara Region. It was founded in 1937 and is owned and operated by the Ontario Conference of Mennonite Brethren Churches. Bethesda’s emphasis is based on a holistic, individualized approach that considers a person’s social, emotional, intellectual, physical, medical, psychiatric and spiritual needs. Bethesda provides a wide range of supports and services to individuals with an intellectual disability who reside in the Niagara Region and who are over the age of 18 years.

In 1998, Bethesda Services noticed that there was an increase in referrals for individuals with severe behavioural challenges, not only to their Outreach Programs for behavioural services, but also to their Short Term Behaviour Program. Many of these behavioural challenges included severe aggression towards others, property destruction and inappropriate sexual behaviour that could not be managed in the traditional community setting and was resulting in involvement with the criminal justice system. As a result, these individuals were being referred to placements away from their families, living in hotels with minimal supervision and treatment, or being incarcerated. As a result, Bethesda submitted a proposal to the Ministry of Community and Social Services to develop a program that would meet the needs of this population and would allow them
to have a safer and improved quality of life. The success of this application resulted in the development of the Long Term Residential Treatment Program (LTRTP).

Offenders with intellectual disability have complex needs that may pose an increased risk to themselves as well as to the public (Barron, Hassiotis & Banes, 2002). The Long Term Residential Treatment Program (LTRTP) at Bethesda was designed to create a safe, secure and positive setting in which this population can receive assessment and appropriate individualized treatment. Positive aspects of the treatment setting involve a stable, safe and secure placement within their local region. The environment was set up to replicate an apartment like setting in which the person has her/his own bedroom, bathroom, and a shared sitting room. In order to enhance life skills, a kitchen, a dining room and laundry facilities are also present.

To further ensure the safety of the individual as well as the public, specialized one-to-one staffing is available for each participant. Staff members have a variety of training in area such as Applied Behaviour Analysis, Relationship Management, and Crisis Intervention. The enhanced staffing also allows the individuals to participate in a variety of educational, vocational and recreational activities that will enhance their self-esteem, improve their quality of life and allow for generalization of treatment strategies into the community. The staff members are part of a multi-modal treatment team that involves professionals such as a Clinical Support Coordinator, a Behaviour Therapist, a Psychologist, Medical Professionals, a Psychiatrist, Support Worker, etc. All team members work together in order to best meet the needs of each individual.

Another positive aspect of the LTRTP is the ability to complete a comprehensive assessment by trained professionals. As stated earlier by Tudiver et al. (1993), these assessments are geared towards the cognitive abilities of the person, and involve
examination of all past information, assessments, offences, and treatments that the person referred has incurred. A functional assessment of the behaviour is also completed. In order to have a holistic understanding of the individual and follow the Gardner’s Multi-modal Biopsychosocial Approach as described for this population by Griffiths (2003), a medical and psychiatric assessment is also pursued. This thorough assessment process not only allows the treatment team to obtain a better understanding of the person’s patterns of behaviours, but also provides insight into the person, their past experiences, psychiatric considerations and the function of the participants’ behaviour. By examining the person holistically, an individualized treatment program can be developed in order to maximize the person’s potential while reducing their maladaptive behaviours.

Once the assessment phase has been completed, an individualized Behavioural Intervention Program (BIP), based on the assessments, is developed in order to meet the specific needs of each individual. Treatment not only focuses on the reduction of maladaptive behaviours, but also on the development of appropriate social skills, sexual expression, community safety, anger control, etc. (Tudiver et al., 1993). The BIP includes components such as positive programming, socio-sexual education, training in social competence, positive anger control, and relapse prevention.

In addition to the individualized treatment, the length of the treatment is significant. The average treatment stay for the LTRTP is 18 to 36 months. Many studies have indicated that there is a positive correlation between the length of treatment over two years and a positive outcome (Day, 1994). In a study completed by Lindsay & Smith (1998), they found that treatment that lasted for less than one year had a greater likelihood of reconviction and imprisonment. Therefore, it is recommended that treatment for individuals with intellectual disabilities who have offending behaviours
remain in a program that is over one year in length in order to maximize treatment and reduce recidivism.

Another asset of the LTRTP consists of not only providing pharmacological and behavioural programming, but also training in life skills such as meal preparation, grocery shopping, laundry, cleaning, and budgeting which will assist with the transition into a community setting (Griffiths et al., 1989; Ward et al., 1992; Nolley et al., 1996). The acquisition of these skills will also improve the person's independence, self-esteem and quality of life. To further enhance community living and life skills, each person has a daily activity schedule developed that meets their personal needs and interests. This can include involvement in job skills, volunteering, sports, academic classes and other recreation and leisure activities.

By enhancing the social and physical environment of the participants in the LTRTP, resiliency can be improved by providing a sense of meaning and physiological/psychological well-being, providing a sense of belonging for the person with an intellectual disability within the community and with others, and, finally, by developing a sense of engagement and growth in their everyday life. A positive social environment is a key element to social habilitation for individuals with an intellectual disability who sexually offend. Long-term, stable relationships promote opportunities for the development of friendships, trust and, where possible, intimate relationships. The ultimate outcome is to enhance the individuals' experiences in order to enhance social interactions and build on life skills so that they will gain increased self-esteem and self-control (Griffiths & Fedoroff, in press).

Once the participants met their treatment goals and are ready to be discharged from the program, the treatment team develops a discharge plan. The discharge process
consists of developing a Discharge Report that includes recommendations to the receiving agency about how to best meet the needs of each individual once they return to the community. Staff members from Bethesda assist with training the new support staff and supporting the staff through the transition process. Depending on the participant and how they manage change, visits to the new community placement with their new staff members begin to occur approximately one month prior to their move. Once the individual moves into their placement, Bethesda continues to support the individual and the receiving agency for several months afterwards to ensure that the placement is successful.

The LTRTP has many benefits such as its location on 75 acres of land in a rural country setting that is very quiet and peaceful. However, it does have drawbacks. It does not promote independence in public transportation. Although 1-1 staffing eliminates the transportation barrier in a rural setting, the participants may become dependent on the enhanced staffing and many agencies are not able to continue to provide such high staffing ratios. To overcome this issue, as the participants gain more personal control over their sexual challenges and their adaptive skills increase, the staffing ratio is slowly reduced over time whenever possible.

Generalization of the treatment effects into a community setting is a key component of the LTRTP. For example, if a seclusion time out procedure is initially required as a crisis procedure for an individual in order to keep them safe as well as their peers safe, the long term goal would be to teach the person anger management strategies such as problem solving, relaxation techniques and self-calming in a more natural setting such as their bedroom. Generalization of the strategies learned across settings, individuals and time must be achieved if treatment outcomes are to have social validity. However when
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there is a high staffing ratio there is consistency across all treatment settings. Another drawback of the 1-1 staffing ratio is the high cost of the program. The base budget for the LTRTP is funded by the MCSS, however the agency involved with the individual must secure funding for the 1-1 staffing; this funding may not be available in all areas. On the other hand, more agencies are working together in an attempt to provide funding for the individual that they support. Although the LTRTP is an expensive program, studies on the effectiveness of such inpatient treatment programs state that the long term benefits is cost reduction to the community agencies, the criminal system and improved quality of life for the individual (Xenditidis, Henry, Russell, Ward & Murphy, 1999).
CHAPTER THREE

METHODOLOGY

Bethesda Services provides Behavioural Supports, Dual Diagnosis Services (a psychiatric nurse and, behaviour therapist provide consultation and support for individuals with a intellectual disability as well as psychiatric issues), Speech and Language Services, Psychometric Assessments, Residential Treatment Programs, Residential Housing, Respite Services and Employment/Day Program Services, among others. Specialized programs are also offered to adults who have an intellectual disability and live outside the Niagara Region. For further information about Bethesda Services, refer to Appendix A.

Over the last ten to fifteen years, Bethesda has conscientiously pursued expertise in the area of applied behaviour analysis and, as a result, has developed a reputation throughout Ontario for effectively supporting people with severe behavioural challenges who have intellectual disabilities. With support from the Ministry of Community and Social Services (MCSS), Bethesda created a specialized Long Term Residential Treatment Program (LTRTP) in 2002. The long-term residential treatment program is designed to provide the required structure and expertise to effectively support eight individuals with severe behavioural challenges including physical aggression, destruction, and inappropriate sexual behaviour that have caused the police to become involved.

The Bethesda LTRTP is a new initiative; therefore the current researchers had the luxury of documenting reliable baseline data in both adaptive as well as maladaptive behaviours. Interventions attempted for each subject were noted using a single case study design for each subject, including interventions that were successful as well as those that
null
were not effective. Comparison data on adaptive as well as maladaptive behaviours were examined in order to determine whether interventions were effective and generalized to a community setting.

In order to house the LTRTP program, renovations were made to the second floor of the main building at Bethesda. The treatment program consists of two units that provide support for four individuals; eight individuals in total. The program is separated into two smaller units in an attempt to make the setting more home-like, as well as to simulate an apartment like setting. Each unit has four bedrooms in which each person has his own bedroom with a bed, a desk, a walk in closet and a bathroom with a shower. Two people share a small sitting room with a television, a VCR, a couch, and a chair. Each unit has a kitchen where the individuals can learn to prepare their own meals. Each side also has its own dining room. A laundry facility is available on each unit to further independent living skills for the participants. On each unit there is also a family visiting room as a quiet place to meet with friends/family or just play cards. A staff office is present on each side that contains participant information, a locked medication cabinet and a video monitoring system for each side. The LTRTP also has a computer room that the participants can access to do academics or play computer games. There is a large joint recreation room that all participants can use to watch TV, play games, do crafts, etc. A meeting room is on the unit for staff meetings, conferences as well as to hold group sessions such as anger management classes, socio-sexual education classes, or job skills classes. The entire program is designed to be wheelchair accessible.

Due to the nature of the behavioural challenges of the people who live in this program, all outside doors have magnetic locks that can only be opened with a key and release automatically if there is a fire, all windows are lexon, the kitchens are locked and can
only be accessed with a key. There are calming rooms on each unit if participants require a safe place to calm. All calming rooms, as well as the sitting room and the recreation room are video monitored for client safety.

All individuals are supervised during community outings. All participants are involved in appropriate day activities as well as recreational activities. Recreational activities can be accessed on the Bethesda property including a gym, pool, chapel, and a sensory room. Recreational facilities are also available in the community. Bethesda also offers music therapy that benefits many of these individuals. In addition to this, Bethesda Services offers Outreach Services that include Psychological Assessment, Behaviour Management Services, and Speech and Language Services.

To ensure the safety of both staff and clients a one-to-one ratio is in effect during waking hours. All staff members are trained in Safe Management Crisis Intervention Techniques and First Aid. Staff members are trained in Applied Behaviour Analysis, including observation and recording behaviours, data collection, interpreting data, graphing, relationship management, implementation of behaviour programs, professional interactions, sexuality (normal vs. deviant), abuse, anger management, “eyes on” supervision and other training as required. Staff training is provided by the Behaviour Therapist, Clinical Support Coordinator, Consulting Psychologist and other professionals as requested. The Behaviour Therapist and the Clinical Support Coordinator provide all supervision and support to staff. Bi-weekly staff meetings occur along with pre and post crisis supports and a 24-hour on call back up system. In addition to adequate staffing, safe storage of all sharp objects, tools and any potential weapon takes place. Each staff member carries 2-way radios and a cell phone for emergency situations within the programs as well as in the community.
A Clinical Support Coordinator is responsible for the overall coordination and supervision of the program. The duties of the coordinator include staff scheduling, managing staffing needs, overseeing home maintenance, assisting with staff training and acting as a liaison with the community and other agencies.

A Behaviour Therapist (BT) is responsible for behavioural assessment and programming for these programs. The BT’s role is to conduct behavioural assessments for all individuals admitted to the program, develop individualized behaviour programs, provide staff training and ongoing monitoring, conduct individual behaviour therapy sessions, complete risk assessments on each person, provide group therapy and monitor the overall program. Clinical supervision takes place four hours per week by a certified psychologist.

The focus of the treatment programs is based on the Biopsychosocial Model of Behavioural Interventions (Griffiths & Gardner, 2002). This model is based on the premise that behavioural and emotional challenges faced by people with intellectual disabilities, reflect the influence of biomedical, including psychiatric and neuropsychiatric, psychological and social environmental factors. Each factor may play an individual role, however, each factor may also influence or interact with another factor or factors. It is this understanding of the interplay among factors that brings the field of behaviour modification to a new understanding on the complexity of the behavioural challenges of people with intellectual disabilities (Griffiths & Gardner, 2002). Some areas of assessment for the Biopsychosocial Model include: Bio (medical) – medical, psychiatric, medication, syndromes, neurological state; Psycho (logical) – current psychological features and skill deficits and Social – environment, interpersonal programmatic, physical, etc.
There are various influences that can affect the medical, psychiatric, psychological or environmental conditions such as instigating conditions, vulnerabilities/risk influences and maintaining conditions. Instigating conditions are stimulus events that trigger the occurrence of the challenging behaviour and can exist in many forms such as the physical environment (i.e., noise, lights, crowds, etc.), social environment (i.e., certain people, change, etc.), programme environment (i.e., routines, transition times, unpredictability, etc.), psychological conditions such as fears, boredom, etc., medical conditions (i.e., causing pain, irritability, etc.) and psychiatric/neurological conditions (i.e., those that produce cognitive, perception, motor, etc.) (Griffiths & Gardner, 2002).

The program follows the Biopsychosocial Model of Behavioural Intervention and involves applied behavioural analysis techniques, cognitive behaviour therapy, social/sexual education/therapy and organized daily activities. The Biopsychosocial approach acknowledges and integrates biomedical, psychological, social and environmental influences on challenging behaviour (Griffiths, Gardner & Nugent, 1999). This approach provides a template from which to develop and implement behavioural strategies with these challenging individuals.

Individual treatment involves feedback regarding progress in areas of anger management, confronting thinking styles related to sexual behavioural problems, assistance with problem solving and behavioural interventions to reduce maladaptive behaviour. Behavioural Interventions used in the treatment program include token economy, positive reinforcement, and behavioural contracting. Independent living skills are taught and maladaptive behaviours are reduced through token economy interventions that encouraged the use of skills taught in anger management, social skills training, problem solving and self-regulation.
The LTRTP provides a safe, secure and positive environment that includes developing positive relationships with staff, peers, family and the community. Personal strengths such as drawing, gardening, athletics and creativity are encouraged and these skills improved upon which in turn enhances self-esteem.

In following the resilience models, the quality of life model (QOL) proposes similar philosophies including improving the life domains of the individual as well as the individual values of the person. The emphasis is on building an improved quality of life by shifting the focus from hopelessness and lack of control to a future of hope and resiliency (Griffiths & Fedoroff, in press). The enhancement of social supports, a positive and reinforcing environment along with skills development promotes positive self-esteem and well-being.

The quality of life philosophy, along with the holistic model describes the similar approach of the Biopsychosocial model used in the LTRTP. At the very least, altering the level of a particular asset or risk in an individual’s life or in a population such as improving parenting/caregiver responses, promoting self-perception in individuals and reducing poverty will ultimately benefit everyone regardless of the situation. Individuals who are intellectually disabled will certainly benefit from this form of assistance.

Using the Biopsychosocial Model, a Behavioural Assessment Report (BAR) was completed for each participant prior to admission or shortly after admission to the program. The format of the behavioural assessment included examining the characteristic of the problem behaviour, clarifying the contextual factors related to the behaviour, assessing the impact of the problem behaviour, determining the factors that are maintaining the behaviour, accessing the contribution of developmental and maturational factors, assessing the contributions of sociological and coexisting
behavioural/emotional factors, assessing the individual’s functional social skills and relationships, assessing administrative support for sexual behaviour and finally determining available resources (Demetral, 1993). The BAR was completed by reviewing reports on the individual’s social history, family history, medical history, psychiatric history, and behavioural history. Individuals who were familiar with the person were interviewed. Self-report information was obtained from the individual and observations were conducted of the person in his/her living situations.

Based on the BAR, a Behavioural Intervention Plan (BIP) was developed for each individual prior to or shortly after admission. The plan addresses the bio-psycho-social factors that influence the person’s behaviour, as well as the instigating, vulnerabilities and reinforcing conditions that impact upon the person’s behaviour. With this information at hand, an individualized plan was developed to assist the person to decrease maladaptive behaviour and increase pro-social behaviours.

The current study is unique because we used a mixed sample consisting of 6 subjects with 5 males and 1 female in contrast to previous research that focused primarily on women (Bose & Ward, 2003) or primarily on men (Lindsay & Smith 1998.) The treatment program involves a holistic individualized approach to the problems presented that involves both decreasing maladaptive behaviours as well as increasing adaptive behaviours. The treatment program varies in content depending on individual need, but is 18 – 36 months in length for all participants. A wide range of data are collected including the frequency of the positive and negative behaviours to be changed, and pre and post test measures using standardized tools to assess gains made after exposure to the educational groups. Quality of life was also measured using a standardized assessment
tool. In order to measure gains in the status of mental health concerns, standardized assessment tools are also used.

Additional differences between the present study and other research completed in the past (Cook, Altman, Shaw and Blaylock, 1978) consists of recognizing the individuals’ vulnerabilities and either decreasing their vulnerability, such as decreasing over sedation from medication, or increasing a vulnerability such as teaching positive coping skills. A multi-focused, Biopsychosocial Model (Griffiths & Gardner, 2002) was used to assess and determine appropriate individualized treatment plans for each participant in the program. These treatments focused on reducing inappropriate behaviours, while increasing appropriate behaviours

At the time of this study, the LTRTP did not have any participants graduate from the program, however it is the intention of Bethesda to monitor the long term effects of this program once the individuals have moved into the community.

Hypotheses

The effectiveness of Bethesda Services specialized treatment program will be evaluated by testing the following hypotheses:

1. Following a multi-modal behavioural interventions approach, there will be a reduction in targeted maladaptive behaviours and an improvement in adaptive replacement skills compared to pre-intervention baseline.

2. Following socio-sexual education training, the scores on the SSKAAT-R and, thus, knowledge of socio-sexual issues will be greater than at pre-training baseline. Following anger management training, the frequency of aggression in the form of self-injury, verbal aggression, physical aggression and
destruction will be less than at pre-training baseline and following anger management training, the frequency of positive coping skills in the form of self-calming, problem solving and completing Hassle Logs will be greater than at pre-training baseline.

3. Following a multi-modal behavioural intervention approach, the scores on the Quality of Life Questionnaire will be greater than at pre-intervention baseline.

**Purpose of the Study**

The purpose of this research is two fold. Firstly, it will allow evaluation of the effectiveness of a multi-component treatment program for individuals with intellectual disabilities who have high-risk behaviours. Secondly, information obtained from this thesis will provide valuable feedback to the agency on the effectiveness of the LTRTP program and how program success may be maintained. Information about effective treatment for this population will assist with reduction of maladaptive behaviour. The researcher will also learn, the importance of teaching adaptive skills that will improve the individuals’ quality of life. This study is different from any other study because it focuses on a multi-modal approach versus a single study design. In addition to this, baseline data on target behaviours were collected on each participant in the study. Data were collected on negative target behaviours as well as replacement skills.

**Participants**

The individuals who are identified as high-risk by the Ministry of Community and Social Services and selected for Bethesda’s Long Term Residential Treatment Program met the following criterion:

- Are 18 years of age or older
- Live in Niagara, Hamilton-Wentworth or Brant Region
- Have a diagnosis (through psychological assessment) of intellectual disability as defined by the American Association for Mental Retardation (AAMR, 1992)
- Have consented to participate in this voluntary treatment program
- Alternative treatment programs have been attempted unsuccessfully and additional treatment in a structured, secure setting is still required
| TABLE 2 - Participant Demographics (NOTE: These are NOT the participants’ real names). |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                 | Wally           | Rodney          | Jack            | Paul            | Jasmin          | Doug            |
| Age                             | 20              | 22              | 19              | 18              | 19              | 25              |
| Gender                          | M               | M               | M               | M               | F               | M               |
| Length of Stay (days)           | 932             | 782             | 250             | 210             | 195             | 181             |
| IQ                              | Mild MR         | Mild MR         | Mild MR         | Mild MR         | Mild MR         | Mild MR         |
| Psychiatric Diagnosis           | Conduct Disorder, ADHD, YYY, Pedophilia, History of Abuse | Bipolar Disorder, ADHD, History of Abuse, Pedophilia | Prader-Willi, Bipolar Disorder | PTSD, Pedophilia, History of Abuse | BPD, Conduct Anxiety and Attachment Disorders, History of Abuse | FAS, ADHD, Pedophilia, History of Abuse |
| Behaviour Assessment             | Anxiety, Communication Problem Escape | Communication Problem Attention | Genetic Syndrome Obtain Item Escape | Trauma Resp Attention Stress Response | Attention Communication Problem Escape | Attention Escape Stress Response Gain Control |
| Nature of Offence                | Physical Assault, Sexual Assault, Property Destruction | Sexual Assault, Physical Assault | Sexual and, Physical Assault, Theft | Sexual Assault | Physical Assault | Sexual and Physical Assault, Property Destruction |
| Placement History               | CAS since age 5, 6 residential, 7 school, 2 hospitals, 5 jails, multiple treatment placements | CAS since infancy, 7 residential, 6 school, 6 jail, multiple treatment placements | Specialized placement at early age, 2 jail terms, 1 hospital term | Multiple placements since early age, 2 jail terms | Placement at early age due to behaviour, multiple placements (12+), 3 jail terms | History of behaviour disorder, multiple jail terms since age 18 (12+) and failed placements |
| Placement Prior to Admission    | Jail            | Jail            | Hospital        | Special Community Placement | Jail            | Jail            |
Measures and Programs

Several standardized assessment tools were used throughout the study. The tools that were used included the Psychopathology Inventory of Mentally Retarded Adults (PIMRA) (Matson, 1988), the Emotional Problems Scale (EPS) (Prout & Strohmer, 1991), the Socio-Sexual Knowledge and Attitudes Assessment Tool (SSKAAT-R) (Griffiths & Lunsky, 2003), and the Quality of Life Questionnaire (QOL.Q) (Schalock & Keith, 1993).

Anger Management and Socio-sexual Education Classes were conducted using a standard curriculum for individuals who have an intellectual disability. The BeCool Program (Stanfield, 1992) was used to teach Anger Management skills and the LifeFacts program (Stanfield & Cowardin, 1992) was used to teach socio-sexual skills to teach participant.

Psychopathology Inventory for Mentally Retarded Adults (PIMRA): The PIMRA is a checklist of psychopathological behaviours that was developed for use with individuals who have a dual diagnosis (intellectual disability and a mental illness). The PIMRA consists of two structured interviews one of which is completed by a caregiver or work supervisor who knows the individual well. The other interview is conducted with the adolescent or adult with an intellectual disability. The items on the PIMRA are based on the major categories from the Diagnostic and Statistical Manual III (DSM-III) (Matson, 1988). The purpose of the PIMRA is to assist clinicians to identify specific psychopathological behaviours that require treatment, to help evaluate the effects of
mental health treatments, and to assist with the diagnosis of psychopathological conditions (Matson, 1988).

An analysis of variance was done on the PIMRA checklist and the results indicated that individuals diagnosed with psychopathology based on institutional records had elevated PIMRA total scores when compared to individuals' with no psychiatric diagnosis. These data provide some evidence for the validity of the PIMRA total score as a measure of the presence or lack of a psychiatric disorder (Matson, 1988). Staff members who were the most familiar with the client completed the full PIMRA upon admission to the Long Term Residential Treatment Program. If elevations were found, then revised versions of the elevations found on the PIMRA were completed by the same staff every two weeks.

*Emotional Problems Scales (EPS):* The EPS is comprised of two instruments including the Behaviour Rating Scale (BRS) and the Self Report Inventory (SRI). The EPS is designed for use with individuals 14 years of age or older who fall in the mild intellectually disabled through borderline range of intelligence. The purpose of the EPS is to evaluate the presence or severity of psychopathology and emotional difficulties in individuals who have intellectual disabilities. Normative data for the EPS were collected on 841 adolescent and adults who have an intellectual disability. The subjects lived in various cities in Canada and the United States (Prout & Strohmer, 1991).

The BRS has 135 items on which raters state, on a scale of 0 to 3, how often the individual demonstrates a variety of behaviours. The items scores combine to produce 12 clinical scales including: Thought/Behaviour Disorder, Verbal Aggression, Physical
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Aggression, Sexual Maladjustment, Non-compliance, Distractibility, Hyperactivity, Somatic Concerns, Anxiety, Depression, Withdrawal and Low Self-esteem. The reliability for the BRS is as follows: for internal consistency with a sample of 673 was .96 and the inter-rater reliability with a sample of 42 was .88 (Prout & Strohmer, 1991).

The SRI has 147 items and is written at a grade four reading level or less. The items are read to the individuals and their answers of “Yes” or “No” are marked in the test booklet. The SRI produces one validity scale (Positive Impression) and five clinical scales (Thought/Behaviour Disorder, Impulse Control, Anxiety, Depression and Low Self-esteem). The reliability for the BRS and SRI normative data were obtained from 673 and 704 individuals, respectively, who had a mild to borderline intelligence and were over 14 years of age. Internal consistency reliability coefficients for BRS and SRI scales ranged from .90 - .97 and from .77 - .96 (Prout & Strohmer, 1991). Staff most familiar with the participant completed the EPS each month.

The Socio-Sexual Knowledge and Attitude Assessment Tool (SSKAAT-R): The SSKAAT-R (Griffiths, & Lunsky, 2003) was developed in order to determine the knowledge and attitudes of people with intellectual disabilities with regards to socio-sexual information. This tool serves as a baseline and as an educational aid when developing person-centred socio-sexual curricula, provides a means of evaluating socio-sexual training effectiveness, and serves as one aspect of a comprehensive assessment for individuals who may be experiencing socio-sexual challenges (Griffiths, & Lunsky, 2003). This tool can be used for individuals who have limited verbal skills or for those whose speech is difficult to understand.
The SSKAAT-R includes questions designed to assess the participant’s knowledge and attitudes about sexuality. These categories are scored separately. Most of the questions on the tool are presented along with a picture and often the assessor can ask the individual to point to the correct answer. The topics on the SSKAAT-R include anatomy, terminology, birth control, menstruation, dating, marriage, intimacy, intercourse, pregnancy/childrearing, birth control, masturbation, homosexuality, community risks, HIV/AIDS, sexual health, and appropriate/inappropriate touch. 276 adolescents and adults with developmental disabilities were asked to take part in the evaluation study of the SSKAAT-R from Canada (46 %) and the United States (54 %). 60 % of the sample were men and 40 % of the sample were women with a range of IQ levels. Internal consistency reliability coefficients for SSKAAT-R ranged from .81 - .92 (Griffiths, & Lunsky, 2003).

The SSKAAT-R was completed by a Bethesda psychometrist who had been trained to administer the SSKAAT-R by the test authors. The same psychometrist completed the pre and post test measures for all participants of the LTRTP program.

Quality of Life Questionnaire (QOL.Q): The Quality of Life Questionnaire (QOL.Q) (Schalock & Keith, 1993) is a 40 item rating scale designed to measure the overall quality of life of an individual who has an intellectual disability. For individuals with adequate language skills, this tool can be administered in an interview format. For individuals who lack the necessary language skills, the instrument can be completed by two raters who know the person well and are familiar with the person’s present living environment and activities. The uses of the QOL.Q can include: as an assessment of the service need for
the individual, as a consumer outcome measure, as a program evaluation measure and as a research tool (Schalock & Keith, 1993).

The QOL.Q was based on a sample of 552 individuals with an intellectual disability being served by an agency in Nebraska and Colorado. The focus of these programs includes community living, employment and integration (Schalock & Keith, 1993). The internal reliability determines the maximum possible validity coefficient and for the QOL.Q the total score is .90 that indicates a high degree of internal reliability (Schalock & Keith, 1993). The questions on the QOL.Q were based on a number of published sources on well-being for individuals with intellectual disabilities and therefore the items on this scale have high face validity as measures of quality of life (Schalock & Keith, 1993). The QOL-Q was completed by the Bethesda staff, along with the agency staff member who was the most familiar with the client prior to admission to Bethesda. This same Bethesda staff member completed the QOL-Q six months after admission to the LTRTP program.

The BeCool Program: The BeCool Program, developed by James Stanfield (1992), is a set of videotapes that depicts appropriate and inappropriate coping responses to dealing with difficult situations that evoke an anger response. This program is designed to teach individuals how to cope with difficult people or with difficult situations by watching videos of how others cope in social situations. BeCool uses video modelling to dramatize successful and unsuccessful ways of relating with others. Individuals can see how interacting with others in a positive manner affects others as well as see what the
consequences can be if you interact with others in an inappropriate manner (Stanfield, 1992).

Passive/Cold Responses, Aggressive/Hot Responses and Assertive Responses are discussed, modelled and reinforced through the use of the videos tapes as well as worksheets.

**The LifeFacts Program:** The Life Facts program is a course designed to teach individuals with intellectual disabilities topics relevant to living life fully, safely and healthfully (Stanfield & Cowardin, 1992). The Life Facts (Stanfield & Cowardin, 1992) program consists of 10 weeks of group work that involves education/discussion about sexual identity, feelings and social growth, friendship and dating, anatomy, reproduction and birth, sexually transmitted diseases and sexual touching, love and sexual decision making, choosing a lifestyle and preventing abuse.

The curriculum from the Life Facts program (Stanfield & Cowardin, 1992) consists of lessons plans for each topic, worksheets, and a collection of large laminated pictures that come in two sets (non-explicit or more explicit pictures) or 35 MM slice for larger groups. The Life Facts program has a pretest/posttest assessment; however this researcher used the SSKAAT-R as a pretest/posttest assessment tool.
Data Collection and Recording

Multi-modal Behavioural Intervention Approach

The frequency of the participants’ inappropriate target behaviours was assessed using the Behavioural Assessment Report and through the assessment of appropriate skill building behaviours. All daily data regarding observations of maladaptive behaviours and adaptive behaviours were entered on a Microsoft Excel Master Data Spreadsheet in order to determine if the BIP was effective in decreasing the inappropriate behaviour as well as increasing replacement behaviours such as social skills, anger management strategies, activity participation, compliance to tasks, etc.

Data were collected by the support staff trained in data collection techniques by the Behaviour Therapist. Several data sheets were completed on a daily basis on each participant including a Maladaptive Daily Data Sheet (which also includes interventions used), Positive Daily Data Sheet, Reward Chart, Sleep Chart, Graphic Daily Chart (which charts day to day activities, appointments, physical health, etc.). Every two weeks the support staff members completed a revised version of the PIMRA and these scores were also entered into the Master Data Spread Sheet. Once per month, support staff members completed the EPS on each participant and they assist the participants in completing the self-report EPS. The Behaviour Therapist monitored the support staff completing the data sheets by spending 2 – 3 hours per day, at different times of the day, observing the staff completing the data sheets. The Behaviour Therapist also reviewed the data sheets 2 -3 times per week which also includes ensuring that the support staff members have correctly entered the data into the Master Data Spread Sheets.
Due to the various methods employed for collecting data, several different forms of data analysis were used. When comparing the participants’ behaviour change scores, a pre/post research design was used. In order to determine treatment effectiveness the post-training measure of each treatment component must be significantly greater that the pre-training measure by comparing the pre and post test scores and calculating the percent change on these scores (Graziano & Raulin, 1989).

**Socio-sexual Education**

The SSKAAT-R was administered to each participant in the LTRTP in order to assess their knowledge and attitudes about sexual issues as well as to determine if any sexual deviances were present. This tool was also used to assess the knowledge of each individual who took part in the Socio-sexual education classes by comparing the pre and post SSKAAT-R scores. In order to determine the effectiveness of the socio-sexual education training, a simple single group pre-test/post-test research design was used.

The SSKAAT-R was administered to each participant prior to the start of the Socio-sexual Education Group. Then each individual took part in 12 weeks of Socio-sexual Education using the *Life Facts* Curriculum. After completion of the training, the researcher re-administered the SSKAAT-R to each person. In order to conclude that the Socio-sexual Education Training does increase knowledge about sexual issues, it must be determined that the post-training measure of sexual knowledge is significantly greater that the pre-training measure by comparing the pre and post test scores (Graziano & Raulin, 1989). Percent change between the pre and post measures were also calculated for these measures.

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^53
Quality Of Life Questionnaire (QOL-Q)

Prior to admission the LTRTP each participant completed the QOL.Q questionnaire. After six months to one year in treatment, this scale was completed with each individual in order to determine if the quality of life for that individual had improved as compared to their baseline QOL-Q score. In order to determine if a multi-modal behavioural intervention approach improves the quality of life for individuals with an intellectual disability who exhibit high risk behaviours, a simple single group pretest-posttest research design was used by examining the scores on the QOL.Q (Graziano & Raulin, 1989). Percent change between the pre and post measures were also calculated for these measures.

Emotional Problems Scale (EPS)

Each month the support staff completed the Behaviour Rating Scale portion of the EPS on each participant and assisted each participant in completing the Self-Report Inventory portion of the EPS. As mentioned previously, the EPS measures the mental wellness of individuals with intellectual disabilities. Many of the individuals supported by the LTRTP have had traumatic histories including abuse, family dysfunction, multiple intervention attempts, incarcerations and have resided in multiple settings/placements. These factors impact on their mental health. One of the goals of the LTRTP is to provide consistency, stability and treatment in order to address past trauma. In order to determine that the post-intervention measure of mental wellness is significantly greater then the pre-intervention measure, pre and post treatment scores of the EPS scores were compared.
(Graziano & Raulin, 1989). Percent change between the pre and post measures was
calculated for these measures.

**PIMRA**

Initially the full PIMRA was completed on each participant in the LTRTP. Elevated
PIMRA scores were placed on a revised PIMRA data sheet (see example attached). This
Revised PIMRA data sheet was completed on each participant every two weeks and the
scores were entered on the Master Excel Spreadsheet for easy review of mental health
status. These scores are used to evaluate the mental wellness of the individual. Again,
in order to determine that the post-intervention measure of mental wellness is
significantly greater than the pre-intervention measure, pre and post PIMRA scores were
compared (Graziano & Raulin, 1989). Percent change between the pre and post measures
was calculated for these measures.
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CHAPTER FOUR
DATA ANALYSIS

Pre-treatment was randomly determined as three months after the client entering the Long Term Treatment Program. Baseline data in the areas of mental health scores (PIMRA), behaviour scores (EPS and frequency of target behaviours), socio-sexual knowledge (SSKAAT-R) and overall improvement in quality of life (QOL-Q) was recorded. Post treatment was also determined as the last three months that the client took part in the study. The post treatment scores that were recorded were the same as the pre-treatment scores. Treatment consisted of the time between the pre and post treatment phases. In order to show the effectiveness of the LTRTP, percent change of the pre and post measures of the behavioural data SSKAAT-R, EPS, QOL-Q and PIMRA will be reviewed.

Behavioural Data Analysis

Problem behaviour of concern was identified for each person and frequency of these behaviours was recorded daily on a data sheet. These target behaviour consisted of verbal aggression (VAB), destruction (destruct), physical aggression (PAB), self-injury (SIB), and inappropriate sexual behaviour (ISB). Verbal aggression was defined as any time the person swore, shouted at others, threatened to harm others or made derogatory comments about others. Destruction was defined as any time the person attempted to or did break an item such as furniture, windows, doors, tear up clothing, etc. Physical aggression was defined as any time the person attempted to or did harm others by biting, hitting, kicking, punching, head butting, etc. Self-injury was defined as any time the
person attempted to or did harm them self by biting, punching, banging their head on hard objects, picking at their skin until it bled, cutting them selves, etc. Inappropriate sexual behaviour was defined as any time the person physically touched another person in a sexual manner such as on the chest, upper thigh or genital area without the person consent. Any physical contact, other than hand shakes, with children was also considered as sexually inappropriate.

Pre treatment phases consisted of three months after the person had entered the program, post treatment consisted of the last three months of the study and treatment was in time between pre and post treatment. Percent change was calculated for each target behaviour of verbal aggression, physical aggression, destruction, self-injury and inappropriate sexual behaviour. Percent change was calculated by for each target behaviour by subtracting the current behaviour frequency from the baseline frequency of behaviour and then dividing it by the baseline behaviour frequency. Percent change was not calculated for those target behaviours with a daily average that was less than 0.1 due to the low frequency of these behaviours which result in low reliability results.

Overall, the percent change across all target behaviours across all clients who participated in this study showed a 37 % improvement in these maladaptive target behaviours (See Table 4). Five out of the six participants showed positive improvements across all target behaviours. One client had such low rates of pre and post frequency of behaviours that the results were less reliable and therefore it was more difficult to show the treatment effects by using percent change. The range of percent change across these target behaviours was 23 % (VAB) to 54 % (SIB). The percent change for the target
behaviour of inappropriate sexual behaviour (ISB) showed the second highest behaviour change at 52%, although the frequency rates of these behaviours was very low.

In addition to the reduction in challenging behaviours, none of the participants required emergency psychiatric treatment or placement while in the LTRTP. Further, there was an overall reduction in the rate of recidivism across all participants, however one participant did require police involvement for severe destruction and physical aggression towards staff early in the treatment program. The first participant to enter the LTRTP was large in stature and in weight. He was also very physically aggressive towards himself, staff and the environment. On one occasion he became aggressive to the point that staff were at severe risk of injury, therefore the police were called to assist with managing his aggression. The police assisted with calming the participant and then they left. After this behavioural outburst occurred, a team meeting was held and a new behaviour intervention was developed along with changes to his environment and a high level of staffing was incorporated into his daily care (See Client Profile 1).

SSKAAT-R Data Analysis

The SSKAAT-R was administered as a pre/post test for the Socio-sexual Education Group. All six participants of the LTRTP at Bethesda took part in the group and agreed to have the SSKAAT-R administered to them. There are seven components to the SSKAAT-R that is reviewed with each person and they include Anatomy, Women's Body (only completed by women), Men's Body (only completed by men), Intimacy, Pregnancy, Birth Control and Healthy Boundaries.
The pre test scores on the SS KAAT-R for the participants in this study were indicated that their knowledge of sexuality health and healthy boundaries was relatively good. However, after socio-sexual education, the scores for all of the participants increased slightly with the overall percent change being 9% (See Table 4 for SS KAAT-R data summary and Appendix G, Table 7 for individual total and subscale changes). Figure 11 in Appendix G illustrates the changes across participants. The participant knowledge base increased from a range of 5% to 12%.

**EPS Data Analysis**

The EPS has two components that include the Self Report Inventory (SRI) and the Behaviour Rating Scale (BRS). The EPS is designed for use with adults who fall in the mild intellectually disabled through borderline range of intelligence. The purpose using the EPS for the LTRTP was to screen for behavioural and emotional difficulties for the individuals who participated in the treatment program. The EPS was also used to monitor on going progress made through behavioural programming. Both scales were completed for each client in the LTRTP on a monthly basis (Figure 13 in Appendix I illustrates the total average EPS score at pre and post). The scores were then entered into the EPS computer scoring system and the percentage scores on the SRI and BRS were examined. If scores on the SRI or the BRS were between 75 – 89 % they were determined to be in the high range psychopathology and if the SRI or the BRS scores were 90 % or higher then they were said to be in the very high range psychopathology. The percent scores for the first month prior to treatment were then averaged and labelled
as pre-treatment and the average percent scores for the last month were labelled as post-treatment.

The EPS scales were effective in identifying the participants' target behaviours on both the staff report scale as well as the client self report scale. The EPS was also helping in showing the severity of the participant behaviours because most of the average behavioural t-scores were rated by the staff and the client to be in the severe behavioural range (See Table 4). However, the EPS was not effective in identifying the positive changes in negative client target behaviours. These scales may not have been sensitive enough to measure the change in behaviour.

Quality Of Life (QOL-Q) Data Analysis

The Quality of Life Questionnaire was administered prior to the participants entering the Bethesda LTRTP, after they had resided at Bethesda for 6 months to 1 year and, for two participants, at a follow up stage in treatment. There are four sections on the QOL-Q that include Satisfaction, Competence/Productivity Scale, Empowerment/Independence and Social Belonging/Community Integration. Staff and participants review the questions and rate each question on a scale of 1 to 3 with 3 being the best score. The highest score that can be obtained on each scale is 30 points. Possible answers are scored in the following manner: "Lots" (3), "Some" (2) or "Not much" (1). A total score is then generated for each category.

The Satisfaction Scale asks questions related to overall life happiness. An example of a question from this scale is, "How much fun and enjoyment do you get out of life?"
Questions on the Competence/Productivity Scale are related to education and employment. If an individual does not have a job, then the last eight questions are scored with a 1. An example of a question under this section is, “How well did your educational or training program prepare you for what you are doing now?”

The Empowerment/Independence Scale examines life skills. Many of the questions on this scale were rated low due to limitation from their probation order or due to limitations of living in the treatment program. For example, “May you have a pet if you want it?” Some participants are not allowed to be around pets due to a history of harming animals and because the participants are in a treatment program versus a place of residence, pets are not allowed. However, through day programs at Bethesda, the participants did have access to learn about animals, care for animals, and take dogs for walks with staff supervision.

The last scale is Social Belonging/Community Integration which reviews options to be involved in community activities. An example question from this section is, “How many civic or community clubs or organizations (including church or other religious activities) do you belong to?”

Table 8 in Appendix H shows the pre, post and follow-up measures for each participant. A summary of the participants’ quality of life rating can be found on Table 4 and illustrated in Figure 12 in Appendix H. The results indicated that all six participants reported an increase in their level of satisfaction, productivity, independence and community integration after treatment occurred. Prior to entering the LTRTP, the QOL-Q was implemented with these participants and their total scores ranged from 46 to 58. The participants indicated that they were not satisfied with their current living situation
(most were in jail), they had limited family involvement, did not have employment, were not able to join clubs and had limited choices in their life. After treatment in the LTRTP, their QOL-Q scores increased to 74 to 100 for a mean overall percent change of 72 %.

The range of percent change across all participants was 42 – 117 %.
<table>
<thead>
<tr>
<th>Client</th>
<th>Target Behaviour</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>PreTreatmet</th>
<th>PostTreament</th>
<th>Percent Change</th>
<th>Target Behaviours</th>
<th>Standardized Tests</th>
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<td>VAB</td>
<td>Destruct</td>
<td>PAB</td>
<td>SIB</td>
<td>ISB</td>
<td>Mean %</td>
<td>SSKAAT-R</td>
<td>EPS</td>
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<td>0.49(9.6)</td>
<td>0.26(6.4)</td>
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<td>0.14(42)</td>
<td>0.15(47)</td>
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<td>89.1</td>
<td>88.6</td>
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<td>9%</td>
<td>7%</td>
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</table>

1Mean Elevated PIMRA Scales
2Percent change was not calculated for TB with daily averages < 0.1 due to low reliability.
The PIMRA was used as a screening tool in order to identify possible dual diagnosis in the individuals who participated in the Bethesda LTRTP. It was also used as an ongoing tool to monitor the mental health status of the clients. Staff completed the full PIMRA on each client upon admittance to the LTRTP. The scores of the PIMRA were then entered into the PIMRA computer analysis program in order to determine if elevations were present. If elevations were found on the PIMRA, then a revised version of the PIMRA was developed using the items related to the elevated areas (scores above 4). Each month, staff would complete the revised PIMRA on each client. The revised PIMRA was completed on a monthly basis in order to monitor the effects of medication changes as well as the effects of behavioural programming.

Four out of the six participants had elevated scores on the pre test scores of the PIMRA. All four of the participants showed a reduction in PIMRA scores for a mean overall decrease of 25 % after treatment (See Table 4). The mean range in the reduction of PIMRA scores across participants was 16 % to 44 %.
Table 5  Mean Pre-Tx and Post-Tx T-Scores for PIMRA Subscale

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<th>ADJ</th>
<th>ANX</th>
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Schizophrenia  Affective  Psychossexual  Adjustment  Anxiety  Somatoform  Personality  Inappropriate
Disorder     Disorder     Disorder     Disorder     Disorder     Disorder     Disorder     Adjustment
CHAPTER FIVE

DISCUSSION

In the present study, an individualized, multi-modal behaviour intervention plan was designed to meet the needs of each participant of the program, while offering a highly structured and supervised long-term program. Individualized treatment plans focused on the reduction of maladaptive behaviours, while enhancing skills such as positive coping strategies, socio-sexual knowledge, life skills, recreation and leisure skills, etc. The treatment program also included psychiatric, psychological, medical, behavioural and educational interventions. Competent staff members are essential in order to following as well as to provide a high level of supervision. Due to the requirements, the program is costly. The costs however to maintain corrections or psychiatric facility would be significantly higher.

Throughout the treatment process was stressed and high levels of individualized interventions, all six participants reduction in maladaptive behaviours with zero to low rates of inappropriate sexual behaviour, zero psychiatric hospitalizations, recidivism for 5 of 6 participants was zero, and medication was reduced. In addition to this, mental health scores on the PIMRA were reduced across all participants by an average of 25% and QOL-Q scores increased across participants by an average of 72%.

This research has advanced previous literature in several manners. Many studies completed in the past (Foxx et al., 1986 and Barron et al., 2002) noted the need for better baseline assessment of behavioural data and skill levels in order to determine objective behavioural change. In the present study, pre-treatment assessment data were collected
on maladaptive target behaviours, mental health concerns (PIMRA, EPS), quality of life (QOL-Q) and socio-sexual knowledge (SSKAAT-R).

In addition to the collection of pre and post treatment data, a comprehensive and diverse range of data was gathered. Many studies such as Lund (1992), Lindsay et al.(1999) and Lindsay et al., (2003) reviewed singular data sources including case studies, rates recidivism, levels of independence achieved, etc. The present research included a broader and holistic approach to examining the behaviour change of each participant. Extensive data were collected on maladaptive behaviour, quality of life, emotional well being, recidivism rates, rates of hospitalization, reduction of medication and improvement in socio-sexual knowledge.

Treatment began as each participant was admitted to the Long Term Treatment Program, therefore treatment time varied across participants. With the exception of one participant, the longer the individual remained in the treatment program, the more progress the person showed. For example, Wally resided in the treatment program for 932 days and he showed a reduction of 51% across all target behaviours. In addition to this, Wally also showed a reduction in mental health concerns, as noted on the PIMRA, of 44%. Jasmin was the second last person admitted (197 days) to the LTRTP and the overall improvement in her target behaviours was 19%, with an improvement of 16% in her PIMRA scores. The exception to this observation was Doug who was the last person to be admitted to the LTRTP (181 days). He showed a 48% reduction in target behaviours. Doug did not exhibit any elevations on the PIMRA scores. In general, the longer the person participated in the LTRTP, the greater the reduction in target behaviours as well as a reduction in PIMRA scores.
The low rates of inappropriate sexual behaviour are particularly interesting and may be due to several factors. The main factor may be due to counterfeit deviance which resulted in the mislabel of pedophilia for many of these individuals (Hingsburger et al., 1991). The history and nature of the sexual offending behaviour for each participant was carefully examined. It became apparent that four of the six individuals had been labelled as having pedophilia, when in fact none of the incidents used to determine this label met the DSM-IV criteria of pedophilia. For example, three of the four participants who were label as pedophiles, were severely abused by family members at a very young age until they were removed from their homes. Many of the sexual incidents on file reported these children as acting out sexually towards other children of the same age. The forth participant who was labelled a pedophile, had a report on file in which he "flashed" another child when he was young. This participant was not abused as a child, however he did have significant behavioural challenges that presented as difficult for the community agency to manage and, as a result, he spent most of his days between the ages of 18 – 22 years in jail where he was physically and sexually abused by the other inmates.

The remaining male participant who was charged with sexual assault presented with Prader-Willi syndrome. The agency which was to provide services for him also lacked the necessary safe, structured setting with highly skilled staff members who were trained in providing specialized care to meet his particular needs. This resulted in Jack physically attacking staff members in order to get food. Jack would also steal food from neighbouring homes, garbage cans and stores. On one occasion when staff members were physically intervening to prevent him from ingesting a harmful substance, Jack
grabbed the buttocks of a female staff. This incident was used to secure the proper treatment he required (Foxx et al., 1986).

The female participant also had an abuse history. Her case also appears to a situation of counterfeit deviance. Through investigation of her history, it appears that a lack of structure, support systems, lack of limits and a lack of education resulted in her acting out sexually.

Through the use of a multi-modal treatment approach that included behavioural programming, socio-sexual education, structure and a safe and secure setting, many of these sexual issues were addressed and/or eliminated. In addition to this, the participants had structured and meaningful days that incorporated life skill development, recreation and leisure activities, employment, anger management and social skill activities.

The data in this study should be interpreted cautiously because a pre-post test design was used and the data were collected by staff members who interact routinely with the participants (with the exception of the SSKAAT-R) and multiple treatment procedures were implemented simultaneously. However, even with these limitations, the results were encouraging given the treatment resistant histories of these participants and the seriousness of their behavioural challenges. This study also indicates that the multi-modal treatment approach was successful for the initial participant admitted to the LTRTP and that this treatment approach was successful for five other participants. Some of the participants required token programs to motivate them to follow their use of the skills being taught to them and to follow their Daily Activity Schedule, while others did not (four of six). Some individuals required access to counselling to assist them with managing past trauma, while others did not (four of six). Access to a multi-modal
environment with an emphasis on individualized programming is the difference that the Bethesda LTRTP offered that differs from other treatment programs in which a standardized approach was used which met some of the needs that individual required, while leaving others needs unmet. Treatment programs that group people together and follow the same treatment for all persons, do not take into account the individualized needs of each participant and, therefore, only partially address the unique set of behaviours of each individual.

These results imply that, for individuals who have an intellectual disability and offending behaviours, the Bio-psychosocial approach implemented within a habilitative environment by competent staff, can have positive effects on the reduction of challenging behaviours, increase in skill enhancement and improved quality of life. This model may also be replicable on a smaller scale, such as in a group home for individuals who present with similar profiles. However, a qualified treatment team would still be necessary in order to maintain the high levels of programming and clinical supervision to ensure property treatment goals were met.

Future research should involve follow up on the effectiveness of the generalization of skills acquired in the treatment program once individuals have graduated from the LTRTP into the community. Further investigation should also include looking at the effectiveness of socio-sexual education and anger management groups on the treatment of individuals who have sexual offending behaviours. Finally, future research should look at the development of reliable and valid assessment measures to measure behaviour change within this population.
Limitations of the Current Study

There were several limitations to this study. First and foremost, for ethical reasons and due to the high risk behaviours of the individuals in the LTRTP, there was a) no control group who did not receive treatment or who received different form(s) of treatment, and b) reversal of treatment was not attempted. As such, causality cannot be determined; however improvement reported by different individuals lends support to the validity of the approach.

Secondly, due to the nature of the multi-modal approach, various interventions were occurring simultaneously making it impossible to identify which component(s) of the intervention package was responsible for change.

Informed consent is an important factor to any research. It is particularly important in the case of participants who have intellectual disabilities and may have difficulty understanding the information or in giving consent. For this research there are two potential issues around informed consent. First, the LTRTP is a voluntary program, however, for some individuals their decision to enter into this program may be an alternative to incarceration or institutionalization. Thus their alternative treatment options are less than desirable. The lack of options may have had an impact on the participants' willingness to engage in the treatment in the LTRTP. With respect to providing informed consent, it was the researcher’s responsibility to ensure that the participant as well as the individual’s guardian, had all the necessary information that they required at a level that they understood in order to make informed decisions.
References


Appendix A:

Summary of Bethesda Services

Bethesda is a non-profit Christian organization that supports individuals with intellectual disabilities. It was founded in 1937 and is owed and operated by the Ontario Conference of Mennonite Brethren Churches.

Bethesda provides a wide range of supports and services to individuals who reside in the Niagara Region and have a intellectual disability. Specialized programs are also offered to adults who have an intellectual disability and live outside the Niagara Region. Bethesda’s emphasis is based on a holistic, individualized approach that considers a person’s social, emotional, intellectual, physical, medical, psychiatric and spiritual needs.

OUTREACH SERVICES
- Behavioural Support Services
- Children’s Behavioural Support Program
- Dual Diagnosis Services – psychiatric nurse, behaviour therapist provide consultation and support for individuals with a intellectual disability as well as a psychiatric issues
- Speech and Language Services
- Psychology Services

RESIDENTIAL TREATMENT PROGRAMS
- Long Term Residential Treatment Program (LTRTP) – proposal available upon request
- Transitional Behavioural Group Home (TBGH)
- Wiebe House and Wiebe Apartment – long term behavioural placements
- Short Term Behaviour Management Program

RESIDENTIAL AND RESPITE SERVICES
- Family Home
- Group Homes
- Respite Services
- Supported Independent Living

EMPLOYMENT AND DAY PROGRAM ACTIVITIES
- Recreation and Leisure
- Developmental Centre
- Linwell Centre (St. Catharine’s) – life skills, supported employment, etc.
- Witham Centre (Dunnville) – life skills, supported employment, etc.

ADDITIONAL SUPPORTS
- Chaplain Services
- Education Services
- Music Therapy
- Volunteer Services
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Assessment Services

When a participant is admitted into the LTRTP program, the main treatment services that they receive from Bethesda consist of Assessment Services, Behavioural Services, Clinical Reviews and Medical Services. If the individual has not had a comprehensive psychological assessment, then this will occur while the person resides at Bethesda. Using the Psychopathology Inventory for Mentally Retarded Adults (PIMRA) and the Emotional Problems Scales (EPS), each participant is evaluated for the presence of a mental health issues and/or an emotional difficulty. If an elevation has been found in either of these scales, it is notes on the Daily Data Spreadsheet and it is tracked for the duration of the participants stay at Bethesda. These scales assist with the evaluation of medication changes as well as the effectiveness of the overall treatment process. The Quality of Life Questionnaire (QOL.Q) is completed prior to each admission and then one year after they have resided in the LTRTP program in order to assess any changes in the participant’s quality of life following treatment. If risk or sexual issues are of concern for the participant, then a Risk Assessment and the Socio-Sexual Knowledge and Attitude Assessment Tool (SSKAAT-R) are completed. The SSKAAT-R is also used as an assessment tool to measure knowledge acquired pre and post Socio-sexual Education Classes.

Behavioural Services and Clinical Reviews

Each participant has a Behavioural Assessment Report, a Behaviour Intervention Plan, a Daily Activity Schedule and a data collection system developed on an individual basis based on their unique needs. In order to address the individual’s specific skill deficits,
the participant is enrolled in individual and/or groups to address these needs. All adaptive, as well as maladaptive behaviours are monitored and reviewed on a biweekly basis (minimum) by the Behaviour Therapist and Consulting Psychologist. Goals for each participant are evaluated on a monthly basis through monthly Behaviour Intervention Plan Evaluation Reports. In addition to this, quarterly case conferences are held for each participant in to ensure that their goals for community integration are being met.

Medical Services

In order to ensure quality health care and monitoring of all medications as well as health concerns, each participant has regular visits with Bethesda medical personnel including the nurses, physician, psychiatric nurse, psychiatrist and counsellors as required.

Other Services

Depending on the individual needs of the participant, other services may be accessed such as Speech and Language Services, Recreation/Vocational Services, Specialized Skill Developmental Services, Spiritual Services, etc. As the participant progresses, community services in each of these areas can also be accessed.
Appendix B:

Verbal Script

Hello _______________.

As you know, I am a Master’s Student in the Child and Youth Studies Master’s program at Brock University. The current course that I am taking now (5F91 – Applied Thesis) requires that I design and implement a Thesis. I would like to evaluate the effectiveness of the LTRTP at Bethesda. I will review the purpose, rationale and methodology of the research with you at your convenience.

Thank you in advance for considering to participate in the research assignment.

Leslie McKay
Appendix C:

The Feedback Letter

Date ______________________

Dear ______________________

Thank you for participating in the research on treatment programs for individuals who have challenging behavioural difficulties. By participating in this research, you will enable myself and the field of intellectual disabilities to obtain a better understanding of how to assist individuals with challenging behaviours, in order to have a better quality of life. The data collected will inform and influence future research in the area.

The data collected will be included in a final course paper. I will gladly supply you with a copy of the final documentation after feedback and marking has taken place. Thank again for your time and commitment.

If I have any questions or concerns about my participation in this study, I may contact Leslie McKay, principal researcher at 905-562-4184 (w) or 905-680-7989 (h) or Professor Dorothy Griffiths at Brock University at 905-688-5550. ext. 4069 or Office of Research Services at 905-688-5550, ext. 3035.

Sincerely,

Leslie McKay
Graduate Student
Child and Youth Studies
Brock University
905-562-4184
lmckay13@cogeco.ca

This study has been received and approved by the Brock University Research Ethics Board, REB File # 03-221 McKay/Linder/Owen.
Appendix D:

Information Letter

Date _______________________

Dear _______________________

Title of Study: Evaluation of a Treatment Program for Offenders with Intellectual Disabilities who have High-Risk Behaviours

Researcher: Leslie McKay, Brock University

The purpose of this study will be to evaluate a multi-component treatment program developed by Bethesda, in order to determine the effectiveness of specialized treatment programs for intellectually disabled individuals who demonstrate high-risk behaviours.

The program will follow the Biopsychosocial Model of Behavioural intervention and will involve applied behavioural analysis techniques, cognitive behaviour therapy, social/sexual education/therapy and organized daily activities. Comparisons data on adaptive as well as maladaptive behaviours will be examine in order to determine the best interventions and supports required by this population.

Participation is voluntary and you are free to discontinue the research at any time without penalty. There is no obligation to participate in any part of the research that you consider invasive, offensive or inappropriate. All personal data will be kept confidential and every assurance will be made to keep participants anonymous. A pseudonym will represent the participants.

The information gathered from this research will be used for a course paper. A final copy of this document (after feedback and marking edits have been completed) will be provided to you, no later than September 30, 2004.

If I have any questions or concerns about my participation in this study, I may contact Leslie McKay, principal researcher at 905-562-4184 (w) or 905-680-7989 (h) or Professor Dorothy Griffiths at Brock University at 905-688-5550. ext. 4069 or Office of Research Services at 905-688-5550, ext. 3035.

Sincerely,

Leslie McKay
Graduate Student
Child and Youth Studies
Brock University
lmckay13@cogeco.ca

This study has been received and approved by the Brock University Research Ethics Board, REB File # 03-221 McKay/Linder/Owen.
Appendix E:

Letter of Consent

Date __________________________

Dear __________________________

Title of Study: Evaluation of a Treatment Program for Offenders with Intellectual Disabilities who have High-Risk Behaviours

Researcher: Leslie McKay, Brock University

Purpose: The purpose of this study will be to evaluate a multi-component treatment program developed by Bethesda, in order to determine the effectiveness of specialized treatment programs for individuals who demonstrate high-risk behaviours.

Study Procedure: The program will follow the Biopsychosocial Model of Behavioural intervention and will involve applied behavioural analysis techniques, cognitive behaviour therapy, social/sexual education/therapy and organized daily activities. Comparisons data on adaptive as well as maladaptive behaviours will be examine in order to determine the best interventions and supports required by this population.

Confidentiality: I understand that all personal data will be kept strictly confidential and a pseudonym will be assigned to each participant. Only the principal researcher (Leslie McKay) or supervising professor (Dorothy Griffiths) will have access to the raw data collected during this thesis.

The raw data and my personal notes will all be deleted or shredded after six months of secure storage. I will secure the data and my personal notes in my home office locked filing cabinet or in my locked filing cabinet at work.

Contact: If I have any questions or concerns about my participation in this study, I may contact Leslie McKay, principal researcher at 905-562-4184 (w) or 905-680-7989 (h) or Professor Dorothy Griffiths at Brock University at 905-688-5550. ext. 4069 or Office of Research Services at 905-688-5550, ext. 3035.

I have read and understood the above information. I reserve the right to ask questions at any time. By signing this document, I am indicating consent to research participation.

Agency/Participation signature: __________________________ Date: __________________________

Witness signature: __________________________ Date: __________________________

I have fully explained the process of this study to the above agency/participant.

Researcher: __________________________ Date: __________________________

This study has been received and approved by the Brock University Research Ethics Board, REB File # 03-221 McKay/Linder/Owen.
Appendix F:

CLIENT PROFILES

Case #1: WALLY

Age: 21

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biomedical

Wally has been on a variety of different medications over the last several years, many of which were sedating in order to manage his behaviours. Prior to moving to Bethesda, Wally's medication consisted of Zyprexia, Topimax, Provera, Loxipine and Ativan.

In 1999 Wally was evaluated in respect to his sexually inappropriate behaviours and the report concluded that he is attracted to adult females, interacts with adult males and fantasizes about children.

Psychological

Wally has a long history of behavioural issues including verbal aggression, physical aggression, destruction, inappropriate sexual behaviour, and self-injurious behaviour (SIB). He has a number of charges dating back to May 1997. The charges include assault (kicking, hitting, spitting), breaches of recognizance, assault with a weapon (throwing a ball) and possession of a dangerous weapon (knife). In November 2001, Wally was charged with threatening staff and spent one week in jail. He also spent time in jail following an incident on February 2002 for assaulting two staff by pushing, punching, attempting to bite and uttering threats.

His previous care providers reported that Wally did not like sports and was not very good at sports, could not interact or live with other people and could not have any female staff working with him. These care providers also reported that Wally did not go into the community because he was a risk to harm children and could not be around them.

Social

When Wally was very young he was placed in a treatment program due to behavioural concerns including aggression, non-compliance, and sexual issues at home and at school. While at this treatment program, it was discovered that he was being sexually abused by his family members therefore children services became involved and Wally was placed in foster care after being discharged from the treatment program. Wally went to many different schools due to difficulties with managing his behavioural issues.
His behaviour also resulted in many residential placements, including foster home, various treatment programs, psychiatric hospitals, jails and programs for individuals with intellectual disabilities. When Wally was referred to the Bethesda Long Term Treatment Program, he was living in a basement apartment with two male staff 24 hours per day. He rarely left his apartment to do any activities and he was on sedating medications due to his high levels of physical aggression and destruction. The consequences of his aggressive or destructive behaviour in this placement, was calling the police because staff were unable to safely contain him. No behavioural programming was in place for him at this time.

After Entering the Bethesda LTRTP Program:

Biomedical

When Wally first moved to Bethesda he weighed just under 300 lbs. Within 6 months, due to medication changes, along with learning healthy eating and increased exercise, he now weighs 205 lbs. Wally is less lethargic, happier and feelings good about himself. He continues to be motivated to eat healthy and exercises on a daily basis.

Wally reported having difficulty sleeping, however staff reported that he slept a lot, sometimes up to 12 or 14 hours per day. As a result Wally had a sleep study and sleep apnea was investigated. Sleep apnea was ruled out and a complete medication review occurred so that sedating medication could be reduced and behavioural programming could occur. Three medications were discontinued new, but less sedating medications were introduced. Wally still has a behavioural PRN that can be used if he is unable to calm himself using other techniques. However, it has been noted that if Wally sleeps more than 10 hours per day that he tends to more agitated and have more behavioural outbursts. A sleep routine was developed with Wally in order to monitor his sleeping habits.

Psychological

The PIMRA was administered to Wally shortly after his admission to Bethesda. Initially when Wally moved to Bethesda, the PIMRA was completed and elevations were found in the areas of affective disorder, anxiety disorder and adjustment disorder. This would suggest that he had difficulties with his mood that Wally experienced a great deal of anxiety and that he had behavioural challenges. Wally's prior to treatment, Wally's average monthly scores on the PIMRA were 4.5 on the affective scale, 4.5 on the anxiety scale and 5 on the adjustment disorder scale. He had elevations in the areas of anxiety disorder, affective disorder and adjustment disorder. Wally would exhibit anxiety to any appointments, meetings, female staff working with him, or special occasions such as Christmas/birthdays. Often he would have behavioural outbursts if he had prior knowledge about visits from his father, appointments with doctors, or case conferences, etc. He would get upset if he were asked to do any chores or any activities even if he initially requested to do this activity.
Any transitions or changes in staffing, his daily routine or changes in his schedule due to seasonal changes (ie. summer vs. fall) would cause him to be anxious and have an outburst. After one year of residing at Bethesda, all ratings on the PIMRA were within the normal range.

Prior to moving to Bethesda, Wally lived in a basement apartment with two male staff and he rarely went into the community. His pre-placement scores on the QOL-Q were Satisfaction = 13/30, Competence/Productivity = 10/30, Empowerment/Independence = 13/30 and Social Belonging/Community Integration = 14/30. His total score on the QOL-Q prior to living at Bethesda was 50/120.

Social

Upon entering the LTRTP Wally had 1-1 staffing that had to be increased to 2-1 staffing due to high levels of property destruction including breaking plexi-glass windows, breaking solid oak doors, destruction of furniture, etc. He was also verbally threatening to staff by stating that he would rape them, beat them and would physically intimidate staff. Due the intensity of his aggression and large physical stature, staff would often run into the office and lock themselves in. Wally was also very self-injurious (SIB) and would harm himself by banging his head on concrete walls/floor, punch concrete walls, punch himself in the groin, bite him self, etc. When he would self-injure, staff would monitor him and call for additional staffing including a nurse to administer him a PRN. These outbursts would last from 1-3 hours and could occur daily for up to 1 week. Due to multiple PRN’s, he would calm for several days.

In order to manage Wally in safe manner, several changes had to occur in order to keep him safe, to keep staff safe and others at Bethesda safe:
- environment – room kept bare except for his bed, lexon covered entire windows, video monitoring system was installed to monitor him, steel doors/frames were installed, eating area and TV room were kept free of objects he could break or damage, on call paging system for back up installed, padded calming room with video monitoring system installed
- staffing – 2 - 1 staff with backup put into place, staff that were intimidated by Wally were reassigned to other groups homes and staff with high levels of behavioural backgrounds were hired to work with him, traditional crisis intervention techniques were ineffective with him due to his size therefore staff were trained in Safe Management Crisis Intervention Techniques with a specialized program that included prone floor
- behavioural programming – included token system to reinforce completing tasks and engaging in recreational activities, development of a daily activity schedule so he would know what his day looked like, use of Hassle Logs to improve problem solving and communication skills, Anger Management groups, Socio Sexual Education Groups, reinforcing him for going to the calming on his own to
relax until he could problem solve with staff about his frustrations. He was involved and gave creative input throughout his program.

Initially when Wally moved to Bethesda would state that he could not be in the community and was afraid to be near children. He would also state that he was sexually attracted to all female staff and that he should be locked away.

Initially Wally did not have any positive coping skills and he relied on others to control him in the form of being restrained either by the police or by staff. He also relied on medication to control him. Wally was reinforced for communicating to staff his emotions, his frustrations and what he disliked. Reinforcement was in the form of following through with his requests, rewards to calming in his room or calming room.

**EPS**

Wally had elevations in the areas of impulse control (94.5 %) and anxiety (86.4 %) for an average score of 90.4 % which places him in the very high range of psychopathology. On the BSR, Wally had elevation on 11 of the 14 scales including verbally aggressive behaviour (90.3 %), physical aggression (93.3 %), sexual maladjustment (78.8 %), non-compliance (78.8 %), hyperactivity (81.6 %), anxiety (81.6 %), withdrawal (78.8 %), depression (81.6 %), low self-esteem (78.8 %), externalizing behaviours (88.5 %) and internalizing behaviours (81.6 %). These scores compliment Wally’s behavioural challenges that were documented based on frequency counts when he initially moved to Bethesda. Wally had severe behavioural challenges that included verbal and physical aggression, he was high anxious about any change or transition, he would refuse to follow his daily schedule or complete chores and he would frequently verbalize that he was a sexual predator.

**Present Situation:**

**Biomedical**

Wally is generally healthy and wears glasses. He has been diagnosed with a mild intellectual disability, Conduct Disorder, ADHD and XXY. Presently Wally weighs 205 lbs and is 6’ 3” tall. He lost 91 lbs since admission to Bethesda. The weight loss was due to a reduction in medication side effects. Wally also began to follow the Canada’s Food guide in order to eat health meals in smaller portions. Further, Wally reduced is intake of snack foods such as chips, chocolate bars and pop to twice a week. In addition to this, Wally began to exercise for 20 – 30 minutes a day by going for walks, doing sit ups, doing push ups and going for bike rides.

His current medications include Clopixal, Clonidine, and Provera (currently being discontinued). Sedating medication such as Zyprexa, and Topimax were discontinued. Provera has been recently discontinued as the behavioural team as well as Wally did not feel it was necessary any longer. There was also a 75 % reduction in the use of PRN medication over time as Wally began to gain positive coping skills and confidence in
null
himself to manage his own behaviour by using positive coping skills such as talking to staff about his problems and frustrations, completing Hassle Logs to encourage problem solving and self-calming in his bedroom.

Wally has a regular sleeping routine in which he goes to bed at 10:00 PM and wakes up daily at 8:00 AM. He rarely naps during the day as he has more energy and enjoys participating in a variety of activities.

Psychological

The SSKAAT-R was administered as a pre/post test for the Socio-sexual Education Group that Wally attended. He correctly responded to all items on the Anatomy and Healthy Socio-Sexual Boundaries on both occasions. Knowledge of Men’s Body was unchanged, but Pregnancy and Intimacy were minimally better and Birth Control/STD’s was significantly improved. In addition to this, Wally no longer sees himself as a sexual predator and does not have any difficulties going into the community to be around other people including children and females. Recently, Wally has developed a friendship with an age appropriate female peer who has expressed interest in him.

Wally’s self-esteem has improved in many ways. He reports feeling good about himself now that he has lost so much weight and takes pride in his appearance. He is confident in going into the community on a daily basis in order to participate in activities such as bowling, Friendship Clubs, shopping, going to the movies, etc. He participates in many sports and has won awards for his abilities.

After several months of medication changes and behavioural programming, there was a reduction in all areas of Wally’s PIMRA scores to the point that all of his scores are now below the significant range (score of 4 or below). Wally’s monthly, average post treatment scores on the PIMRA are now 3.5 on the affective scale, 3.3 on the anxiety scale and 3 on the adjustment scale. The reduction in Wally’s PIMRA scores may be due to Wally now being on the correct type and dose of medication. Once Wally was on the appropriate medication along with the appropriate behavioural supports he was able to learn the skills that he required to manage his own behaviours. These skills included anger management, positive coping skills, communication skills, and problem solving skills. These scores are now within the normal limits.

Social

Presently, Wally has 1-1 staffing, however on the unit he no longer requires staff to be nearby at all times. He lives with 5 other male peers and 1 female peer. He attends work on Bethesda property and has a job in the community each Saturday doing janitorial work. He attends various activities on and off Bethesda property including Special Olympics sports, Friendship groups, drama club, bike rides, etc. Recreational activities that he enjoys include hiking, fishing, camping, crafts, bowling, baseball and swimming. He also likes reading and doing research in the computer about dinosaurs, cars, cooking and building items such as cars or motor cycles.
His bedroom now has a captain’s bed, a desk, posters, and a walk in closet that he has free access to, an ensuite bathroom etc. There has been no destruction to his bedroom on over 18 months.

Presently, Wally has a positive relationship with his family. He calls his father 2-3 times per week and visits with his father and step mother once per month.

Overall there has been a general improvement in Wally’s well being. He now has his own bedroom decorated the way he likes it, there are pictures on the walls, all of his craft supplies are in his desk in his room, etc. versus a barren room with a mattress on the floor. He is an active member of his behavioural team and provides valuable input into his program. Wally is an active member at Bethesda at work, in the drama club and in the recreation department. Wally also participates in the community on a daily basis in support groups, organized recreation teams, church activities, etc. Due to the reduction in his maladaptive behaviours, he no longer requires 2 staff at all times. He participates in 92% of all activities presented to him.

Wally improved himself by losing 91 lbs through healthy eating and exercising. This has greatly improved his quality of life as well as his self-esteem and self-confidence.

Wally is now able to maintain a job, participate in groups with peers, attend all meetings related to him such as doctor’s appointments, case conferences and interact with others in a socially acceptable manner. He participates in chores on the area including keeping his room clean, cleaning his bathroom, doing his laundry and especially enjoys cooking. His participation in chore related activities is 94%.

In order to assist Wally with his behavioural challenges, several replacement skills were taught to him over the last 2 ½ years including:
- Socio-sexual Education using the SSKAAT-R in a group format with 4 male peers. The SSKAAT-R was administered pre and post socio-sexual education.
- Positive Coping Skills were also taught to Wally using:
  - Anger Management Group with 4 other male peers. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups learned how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger.
  - with assistance from staff Wally developed a personal Hassle Log which assisted him to identify triggers of his anger, changes in his body that indicate he was getting angry, developed problem solving skills and rated his success in managing his anger. He continues to complete these at least 1-2 per day on ways in which he handles situations.
  - Presently he communicates well with staff, does not rely on medication to control him and takes control of his behaviours by self-calming.
  - Wally continues to follow his Daily Activity Schedule and participates in adjusting this schedule as his interest in new activities changes and as the seasons change. Wally is less affected by the transition in his activity schedule when the
season changes. He still tends to become over excited about the Christmas season.

-Wally continues to have a token economy program in which he earn points for following his Daily Activity Schedule, for doing chores and participating in activities. He also earns points for using his positive coping skills and self calming techniques. When he earns enough points, Wally can earn extra outings into the community. The token economy program has evolved from being a motivator to do chores and activities, to a motivator to earn extra outings. He willing and easily participates in his daily routine and enjoys doing chores and activities now.

- Wally still has a behavioural PRN as part of his program, however it is rarely used. He may receive it once every 2-3 months.

- In order to continue to prevent Wally from harming himself or others, physical restraint is still part of his program as a last resort. Presently this is only used if Wally is not able to go to the calming room (padded room) on his own and he is at risk of harming himself or others. This may occur once every 3-4 months and generally lasts for 20-30 minutes.

- A Confinement Time Out (CTO) program is also still in Wally’s program. Generally Wall is able to work out is frustrations or will go to bedroom to calm. However, about once every 3-4 months Wally may initiate going to the CTO room to calm. At times he will sit in the room with the door opened and other times he will ask for the door to be closed in order to feel safe. Generally he remains in the CTO room for 20-30 minutes.

Verbal/sexual threats have stopped. Wally’s destructive behaviours occurred to the environment in the form of breaking lexon windows, breaking solid wooden doors, punching cement walls, breaking furniture, etc. There has been a reduction in the frequency as well as the intensity of his destruction by 90 %. Items broken now include crafts he made, drawings he has torn up, etc.

Physically aggressive behaviour was in the form of physically aggressing towards by kicking, biting, punching, etc have been reduced by 90 %. Presently, he rarely aggresses towards staff.

Inappropriate sexual behaviour was in the form of groping staff, obsessing about children and could not be around children.

Since moving to Bethesda the only inappropriate sexual behaviour was sexual talk about what he wanted to do to staff when he was having an outburst. This does not occur anymore. At times Wally can be very self-injurious (SIB) in the form of hitting his head with his fist, banging his head on hard objects, punching himself in the groin, etc. The intensity and frequency of his SIB has also greatly reduces. His self-injury is milder and in the form of hitting padded walls or scratching himself. He does not require medical attention for his SIB now.

Wally’s rate of recidivism has been reduced to one over the last years.
QOL

After Wally had resided at the LTRTP for over 6 months, the QOL-Q was completed a second time. During this time frame, all areas of Wally's quality of life had increased with Social Belonging/Community Integration being the largest area of gains. Wally's scores on the QOL-Q after 6 months to 1 year of residing at Bethesda were Satisfaction =19, Competence/Productivity = 11/30, Empowerment/Independence =15/30 and Social Belonging/Community Integration = 24/30. His total QOL-Q score increased to 69/120. After 3 years at Bethesda he continues to make positive gains in his behaviour as well as in his quality of life. Wally now has a job in Bethesda day programs as well as in the community, he belongs to several community groups, he feel better about him self and he has learned many life skills. As a follow up to Wally's continued improvements at Bethesda, the QOL-Q was completed after 2 years of residing at the LTRTP and again gains were made in his quality of life, with Competence/Productivity Scale improving the most. His scores on the Satisfaction Scale are 22/30, Competence/Productivity Scale =24/30, Empowerment/Independence =15/30, and Social Belonging/Community Integration =24/30. Wally's total QOL-Q score is now 85/120 for an improvement in QOL-Q of 23.2 %.

EPS

Wally's currently does not have any elevations on the SRI and only has elevations in sexual maladjustment of the BRS, which remains in the very high range of 95.5 %. In conclusion, Wally's progress is due to a combined effort that included medication changes, effective staff support and behavioural programming that allowed him to gain control over is anger and frustrations. Wally was very motivated to do well and with every gain that he made, began to feel better about him self. The high score on the sexual maladjustment scale may be due to his discomfort about discussing this topic and he desire to have a girl friend, but states that he is not ready for one yet. Presently there have not been any inappropriate sexual behaviours or inappropriate sexual talk.
FIGURE 1 Maladaptive Behaviours for Wally

Maladaptive Behaviours for Wally

- VA
- PA
- Destruction
- SIB
- Inappro Sexual Behav

0.00
1.00

May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

1-Pre Treatment 2-Treatment 2-Treatment 2-Treatment 3-Post Treatment

2002 2003 2004
FIGURE 2 PIMRA Scores for Wally
Case #2: RODNEY

Age: 22

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biomedical

Rodney has been on a variety of medications over the years in order to manage his aggression and psychiatric conditions. His current medications include: Lithium, Eltroxin, Risperdal, Paxil, Cyprotirone Acetate and Chlorpromazine PRN.

Rodney was assessed in respect to his sexual issues in 2001 and was reported to be attracted to adult females. However, because Rodney reported that he had thought about young children, he was diagnosed as being a pedophile and a risk to the community.

Psychological

Rodney has had a long history of behavioural difficulties including verbal aggression, physical aggression, destruction, inappropriate sexual behaviour, and self-injurious behaviour (SIB). He has charges against him dating back to 1996 for invitation to sexual touch, and assault. He has several charges against him for assault staff including one prior to his admission to Bethesda in which he went to jail.

Rodney reported that he did not like sports and was not very good at them. He also stated that he did not like living with his current peers because they always teased him and got him into trouble.

Social

Rodney is one of three children born to parents who were reportedly low functioning. Although his birth mother did not offer a lot of information about her prenatal care, it was reported that she was known to use illegal drugs and alcohol during her pregnancy.

Rodney father was convicted of sexually abusing his 14 year old son from a previous relationship. At the time of his father’s conviction, Rodney was apprehended from his birth mother and placed in foster care. He remained in one foster home until he was adopted. He still has contact by phone and occasionally visits with his adoptive family.

Starting in 1996, Rodney was incarcerated several different times for charges including sexual assault, property destruction and physical assault. He had many different
placements including foster homes, jail, and group’s homes for the intellectually disabled due to his inappropriate behaviours. Upon referral to Bethesda, he was living in a private group home for difficult youth with limited access to community activities. Limited behavioural programming occurred within the home.

Rodney was involved in specialized programming throughout his school career. Due to his disruptive behaviours, including inappropriate sexual touching, he was typically separated from the rest of his class. He was even required to use a separate change room for gym class. After being charged with “Invitation to Sexual Touching”, an individual program was developed so that Rodney could receive his education away from school property.

After Entering the Bethesda LTRTP Program:

Biomedical

Upon entering the LTRTP, Rodney was very difficult to motivate to do any activity. He preferred to watch TV alone in his room or talk with female staff on a one to one basis. He refused to interact with male staff and stated he was afraid of them. Rodney was also very negative and had difficulties accepting praise and positive feedback from staff. Rodney would also spend a lot to time sleeping in his room.

His medications were reviewed and found to be effective for him and therefore no medication changes occurred for the first year. However, at Rodney’s request 2 of his medications were discontinued once he had resided at Bethesda for 2 years and his behaviour and psychiatric concerns remain stable.

Psychological

Upon moving to Bethesda, the PIMRA was completed and elevations were found in the areas of anxiety, somatiform and personality disorder. In general, these areas remain within the normal range, however it appears that when significant changes occur in his life these areas may become elevated again.

Rodney was the next client that was admitted to the Bethesda treatment program. When the PIMRA was completed on him, the areas that were elevates included personality disorder, somatiform disorder and affective disorder. This would imply that Rodney had difficulties with his mood as well as relating to others. He would attempt to relate to others in a negative manner and would attempt to gain attention from others in an inappropriate manner such as by presenting with medical problems. Rodney’s average monthly totals prior to treatment were 5 for personality disorder, 6 for somatiform and 3 for affective disorder.

His fine motor and gross motor skills are fine. At times Rodney has had difficulty with some tasks and requires staff assistance, however he has become independent in many tasks. He participating in activities such as going out to eat, going to the library, playing
games, listening to music, going for walks, etc., but at times can be difficult to motivate to do these activities.

Social

Upon entering the LTRTP Rodney had 1-1 staffing due to reports stating that he was a risk to himself by ingesting harmful substances and at risk of harming others by becoming physically aggressive at least once per month as well as sexually inappropriate with peers. However over the two years that he has resided at Bethesda, there has been limited minor destruction, limited minor self-injury, minor aggression that is mainly verbal and no inappropriate sexual touch. The behaviours that Rodney exhibited included manipulation of staff, verbal aggression, somatic complaints, low motivation and inappropriate social skills.

In order to assist Rodney to make positive changes in his behaviours and maintain safety for the community the following occurred:
- environment – small items that he could use to harm himself as well as hygiene products were locked up
- staffing – 1-1 staffing at all times especially in the community, staff training on how best to interact with Rodney due to his learning style. Verbally he presents well, however he has difficulty understanding what others say unless it is concrete and simple.
- medical – medication review occurred, somatic complaints were addressed but little attention given to issues, medical concerns only to be discussed with medical personnel
- behavioural programming – included reinforcing problem solving with staff about his frustrations, token system to reinforce completing tasks and engaging in recreational activities, development of a daily activity schedule so he would know what his day looked like, use of Hassle Logs to improve problem solving and communication skills, focussing on the positive and building on his strengths, Anger Management groups, Socio Sexual Education Groups. Counselling to deal with past abuse.

Several assessments have stated that Rodney is a high risk in the community and is a high risk to re-offend. In the past 2 years since Rodney has resided at Bethesda, there have not been and re-offences and he has been appropriate when around children or in the community.

He will continue to require a structured daily routine, teaching and practice in Daily Life Skills, enhancement of self esteem, anger management techniques, impulse control training, social skills training, decision making and social/sexual education. He appears to respond best to positive programming and a safe, secure and structured setting.

After completing a functional assessment the following triggers were identified for Rodney including peers acting out, learning new things, change, not knowing what is expected of him, being told what to do, sarcasm or joking around with him as he may
misunderstand, others talking negatively about people he cares about such as friends, family, not getting his own way and being confronted when he has done something wrong.

**QOL**

Rodney had been living in a group home for difficult to manage adolescences. He had some community involvement with one to one staffing to go to the library or out to eat if he had earned the points to do this. A month before Rodney was to move to Bethesda he assaulted a female staff, was charged with physical assault and went to jail. His score in the QOL-Q prior to moving to Bethesda were Satisfaction =10/30, Competence/Productivity =10/30, Empowerment/Independence =15/30 and Social Belonging/Community Integration =17/30. His total score on the QOL-Q was 52/120.

**EPS**

Rodney had several areas that were elevated on the SRI scale that included thought/behaviour disorder (99.7 %), impulse control (98.2 %), anxiety (99.9 %), depression (99.9 %), low self-esteem (99.7 %) and total pathology (99.9 %) for an average score of 99.6 % which is in the very high range of psychopathology. Rodney’s elevations occurred on 13 of the 14 BSR scores. These elevations included thought/behaviour disorder (86.4 %), verbally aggressive behaviour (84.1 %), physical aggression (84.1 %), sexual maladjustment (86.4 %), non-compliance (84.1 %), hyperactivity (86.4 %), distractibility (84.1 %), anxiety (75.8 %), somatic complaints (97.1 %), depression (98.2 %), low self-esteem (75.8 %), externalizing behaviours (86.4 %) and internalizing behaviours (88.5 %). His average score on the BSR is 85.9 %. Upon admission to Bethesda, Rodney was very negative, he would become upset and withdraw to his bedroom if he was verbally praised and he become anxious if he had to interacting with male staff or peers. He preferred to withdraw to his room and would easily become verbally upset. Rodney’s main interactions with staff consisted of discussing physical ailments and stating that he felt ill most of the time.

**Present Situation:**

**Biomedical**

Currently, Rodney is in good physical health. His thyroid does require monthly monitoring. His vision and hearing is fine, although presently he requires corrective surgery on his eyes. Often he will complain about various illnesses, however when he is examined by our health services department, there is generally no evidence of illness. Rodney has been diagnosed with Pedophilia, paraphilial not otherwise specified (coercive sexual preference), bipolar disorder, low average IQ. It has also been suggested that he has borderline personality disorder.

Rodney generally sleeps well at night. He will go to bed at 7:00 PM and sleep during the day if he is not motivated to participate in activities. He prefers to keep to himself or
interact with staff, however over the past few years, Rodney has begun to become involved in the working out at the YMCA, participates in Special Olympics activities such as baseball and track and field and has become very involved in the Bethesda drama club.

His current medications include: Lithium, Risperdal, and Chlorpromazine PRN. He rarely receives his PRN of Chlorpromazine. On occasion he will ask for it when he is upset.

Psychological

The SSKAAT-R was administered as a Pre/post test for the Socio-sexual Education Group. The results were variable between the two administrations with some scales static (Anatomy, Pregnancy and Healthy Boundaries), while others improved (Men’s Body, Birth Control/STD’s). Rodney has excellent basic knowledge of sexual anatomy. He has excellent knowledge of terminology and function of men’s bodies. He was unable to describe a PSA test but otherwise correctly resounded to questions in this section. On the Intimacy section, pictures of hugging, kissing, petting and vaginal intercourse were described adequately but his descriptor of anal sex was inadequate and oral sex was incorrectly identified. The term “orgasm” was unknown. Responses related to dating activities, planning a date, planning a marriage and reasons for marriage lacked requisite depth. There was good knowledge on the Pregnancy section but some pictures were misinterpreted and the definition of adoption lacked clarity. In general, he has good knowledge of Birth Control but again there was some lack of precision to his responses. Some further education regarding STD’s should include how “to catch them”. Rodney provided answers to all items in the Healthy Boundaries section.

In the Attitude section, Rodney approved of masturbation, erotica, heterosexual and homosexual intimacy (including intercourse on the first date), shared gender roles in marriage and birth control. He thought it was OK for a disabled woman to get pregnant and for people to work or befriend a person with an STD. He did not think abortion was OK.

Rodney’s self-esteem has improved dramatically since moving to Bethesda. He has become physically fit and enjoys a variety of physical activities in the community. He has made many new friendships within the Bethesda community as well as through community activities. Most importantly, he has a job in the community at a recycling plant where he makes a good salary.

Rodney’s treatment plan focused on a structured daily activity plan, positive reinforcement for appropriate behaviour and positive coping skills. Rodney’s average PIMRA scores after treatment were 3.3 for personality disorder, 5.8 for somatoform disorder and 3.3 for affective disorder. Two of his PIMRA scores have decreased and the affective scale increased by 0.3. Overall this is a positive change for Rodney and may be due to the structured schedule that he now followed and generally can follow independently. Rodney also responded favourable to positive programming and is now
able to accept praise from others and relates to others in a positive manner. Although there was only a slight change in Rodney’s PIMRA score over the last three months, his scores tend to fluctuate depending on what is occurring around him. For example, recently Rodney has been informed that he has met his goals for being discharged from the Bethesda LTRTP and that planning has begun for him to be placed in the community. Also, at Rodney’s request a medication reduction occurred in the fall and it was found that he was unable to manage his anger in a positive manner; therefore in November Rodney was placed back on his medication.

Social

Presently, Rodney has 1-1 staffing, however on the unit he no longer required staff to be nearby at all times. We are currently starting to fade out the 1-1 supervision. He attends work in the community three days per week. He attends various activities on and off Bethesda property including Special Olympics sports, YMCA, drama club, etc. He also enjoys reading, going to the library, using the computer, cooking and watching TV.

Rodney lives with 5 other male peers and 1 other female peer. He had some difficulties adjusting to living with several peers with behavioural challenges over the last 6 months, but had adjusted to these changes.

Presently, Rodney continues to see his foster family every few months and has regular phone contact with them.

In general there has an overall improvement in Rodney’s well being. He has developed positive working relationships with both male and female staff at Bethesda. He is now able to joke around with staff, accept positive feedback and talk about positive things that have occur throughout his day versus always negative talk. He has also developed several positive female and male peers’ friendships. Rodney participates in many small as well as large group activities at Bethesda and in the community with little prompting from staff. Initially staff had to really motivate and encourage Rodney to participate in any activity that did not include food or TV. He participates in 94% of all activities presented to him.

As mentioned earlier, Rodney has a job in the community three days per week, participates in groups with peers and interacts with peers in a socially acceptable manner. He participates in chores on the area including keeping his room clean, cleaning his bathroom, sweeping, doing his laundry and cooking. Many of these chores he is now able to complete independently. His participation in chore related activities is 95%.

In order to assist Rodney with his behavioural challenges, several replacement skills were taught to him over the last 2 ½ years including:
- Socio-sexual Education using the SSKAAT-R in a group format with 4 male peers. The SSKAAT-R was administered pre and post socio-sexual education training
Positive Coping Skills were also taught to Rodney using:

- Anger Management Group with 4 other male peers. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups reviewed how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger.

- with assistance from staff Rodney developed a personal Hassle Log as well as a Daily Journal this assisted him to identify triggers of his anger, changes in his body that indicate he was getting angry, developed problem solving skills and rated his success in managing his anger. He continues to complete these at least 1-2 per day on ways in which he handles situations.

- Presently he communicates well with staff and takes control of his behaviours by self-calming in his room and then talking to staff about his frustrations.

- Rodney continues to follow his Daily Activity Schedule and does best when he has a structured routine and know what is expected of him.

- Rodney continues to have a token economy program in which he earn points for following his Daily Activity Schedule, for doing chores and participating in activities. He also earns points for using his positive coping skills and self calming techniques. When he earns enough points, Rodney can earn extra outings into the community. The token economy program has evolved from being a motivator to do chores and activities, to a motivator to earn extra outings. He willing and easily participates in his daily routine and enjoys doing chores and activities now.

- Rodney has a behavioural PRN in his program however he receives it on average 1 every 2 months.

- Rodney also has a crisis physical intervention restraint in his program as a last resort if he attempts to harm himself or other, however it has only need necessary approximately 6 times over the past 2 ½ years.

Since moving to Bethesda, Rodney’s main behavioural concerns of inappropriate sexual behaviour has been limited to talk about children and how he is not to be around children. This does not occur at all any more and there has not been any inappropriate physical touching since moving to Bethesda. Physical aggression has also been very minimal and has only been in the form of attempting to hit or kick staff or throwing objects at staff. This has occurred in very low frequency and rarely occurs. Verbal threats, in the form of swearing at staff/peers, have decreased as well as inappropriate social skills and somatic complaints. Generally, he is able to talk to staff about what is bothering him, he now longer has anxiety about any appointments, and he will also go to his bedroom to calm when frustrated until he is able to talk to staff about his frustrations. Rodney has not had any breech of probations or charges against him in the last 2 ½ years and currently in no longer under any probation order.
QOL

The QOL-Q was also completed on Rodney after he had resided in the LTRTP for over 6 months and all areas of his quality of life improved especially in the areas of Satisfaction and Social Belong/Community Integration. His scores after 6 months were Satisfaction =23/30, Competence/Productivity =12/30, Empowerment/Independence =15/30 and Social Belonging/Community Integration =24/30 for a total QOL-Q score of 7/120. Rodney now has a job in the community, belongs to two community groups, relates well to peers and staff, and is also to manage his anger in a positive manner. Rodney has also lived at Bethesda for over 2 years; therefore the QOL-Q was completed again to continue to follow up on his progress. Again his quality of life has improved with the greatest gains being in the areas of Competence/Productivity and Empowerment/Independence. His QOL-Q scores are now, Satisfaction = 25/30, Competence/Productivity =20/30, Empowerment/Independence =24/30 and Social Belonging/Community Integration = 24/30. His total QOL-Q score is now 90/120 for an improvement in quality of life by 31.7%. Overall in the 2 ½ years that Rodney has been at Bethesda, there has been a dramatic increase in his level of satisfaction with his life and his social belonging. His overall total score has improved in his quality of life.

EPS

Rodney currently only has elevations in three areas of the SRI which include impulse control (94.5 %), anxiety (98.6 %) and low self-esteem (78.8 %) for an average score of 90.6 %. Although this score remains in the very high range of psychopathology, there has been a reduction in the overall average score on the SRI and there has also been a reduction by 50 % in the number of scales that are elevated. On the BSR, Rodney now only has elevations in 9 areas including verbal aggression (84.1 %), non-compliance (93.3 %), hyperactivity (90.3 %), distractibility (91.9 %), anxiety (75.8 %), somatic complaints (91.9 %), withdrawal (84.1 %), depression (75.6 %) and externalizing behaviours (88.5 %) for an average score of 86.1 %. Rodney’s overall average for the BSR after treatment remained approximately the same, with the number of areas elevated reduced by 4. Rodney level of maladaptive behavioural challenges remained low throughout his stay at the LTRTP, however positive changes were evident in the areas of improved self-esteem, he now talks in a positive manner and talks less about physical ailments, he interacts with all staff, peers and is involved in a variety of groups and he is able to talk about and problem solve his frustration with staff in a more productive manner.
FIGURE 3 Maladaptive Behaviours for Rodney

Maladaptive Target Behaviours for Rodney

- _VA - _PA - _Destruction - _SIB - Inapprop_Sexual Beh

1.00

0.00

1-Pre Treatment
2002

2-Treatment
2003

3-Post Treatment
2004
FIGURE 4 PIMRA Scores for Rodney

PIMRA Scores for Rodney

- Personality Disorder
- Somatoform
- Affective Disorder

1-PRE Treatment
2002

2-Treatment
2003

2-Treatment
2004

3-POST Treatment

0 1 2 3 4 5 6 7
Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov

107
Case #3: JACK

Age: 19

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biomedical

Jack has brown hair, hazel eyes, is 5’ 4” and weighed 205 pounds prior to moving to Bethesda. His health is generally good, with the exception of excessive weight issues. Jack tends to wet the bed when he has a nap and at night time. No medical concerns were found in relation to the bed wetting. Other medical issues include picking at his skin.

His current medications include Trileptal, Lithium, and Zyprexa. He has been diagnosed with bipolar disorder, Prader-Willi Syndrome and intellectual disability.

Psychological

Jack has had a long history of behavioural concern’s that escalated on his eighteenth birthday when a change in support services occurred. These behavioural concerns include anxiety, verbal aggression, destruction, physical aggression, self-injurious behaviour (SIB), and stealing food. The stealing of food from the group home as well as from stores and neighbouring houses resulting in 2 incarcerations for him. There was also 1 incident of sexual assault, but this charge has since been dropped. Jack was sentence to time at a treatment center and was not placed on probation.

Social

Jack is an 19 year old with Prader-Willi Syndrome. He has an older brother and sister who both live with their parents. The family is Roman Catholic. Jack lived with his parents and two siblings until 1999 when he received daytime school services through a children’s program and then about two months after he began the day schooling he became a full residential client due to ongoing behavioural problems.

At age 18, he was moved to a program that supported adults who have intellectual disabilities. This transition did not go well and Jack began to forage and steal food. His stealing involved breaking into the fridge of the house he lived in, stealing food from stores and restaurants. He also became very physically aggressive towards staff. These episodes resulted in numerous police involvements as well as in 2 incarcerations and finally a referral to a treatment program for individuals with Prader-Willi Syndrome. He resided in the treatment program for 6 months prior coming to Bethesda. This program
was in a hospital setting were Jack was not allowed to go into the community or eat with his peers due to his high rate of behaviours. He was on a structured diet and exercise program. He was also on a very structured day in which he would earn points for attending and participating in various groups such as dietary class, physiotherapy class and speech language class. He would lose points if he exhibited inappropriate behaviours. While in this program Jack was very destructive, stole a lot of food, was aggressive towards staff and his self-injury was very extreme (he would attempt to choke himself by inject clothing or other small items). When Jack was aggressive, destructive or self-injurious, staff would remove his clothing; place him in a blanket wrap in order to transport him to a seclusion room where he would spend 30 – 60 minutes.

Most of Jack’s education occurred at the children’s treatment centre he resided at. Staff reported that the activities that Jack enjoyed doing include puzzles, crafts, watching movies, watching TV, animals, helping younger people and building Bionicles.

After Entering the Bethesda LTRTP Program:

Biomedical

As stated above, Jack was 205 pounds when he moved to Bethesda. Bethesda continued to follow the structured diet and exercise routine established by the Prader-Willi treatment program and he continued to lose weight. He stared on an 800 calorie diet. His exercise consisted of laps twice per day and it took him 90-60 minutes to complete 2.3 miles. We gave him options of places to do his laps such as in the hallway, in the gym or weather permitting the short or long walk around the Bethesda property. He really enjoyed the walks outside.

Jack continued to wet his bed when sleeping and it was noted at Bethesda that he would refuse to use the toilet and soil himself. A reinforcement program for using the toilet was initiated and has reduced the bed wetting.

Psychological

Upon admission to Bethesda, the PIMRA was administered and there are no elevated areas.

Jack had been living in a children’s residence prior to moving to Bethesda. When he made the transition to adult services, he began to have severe behavioural challenges which resulted in Jack becoming physically aggressive towards staff and he was placed in jail until he could be placed in a treatment center for persons with Prader–Willi Syndrome (PW). Jack resided in the this specialized treatment program, which was in a hospital setting, for 9 months, however he continued to exhibit severe behavioural challenges in the form of aggression, destruction and food stealing. Jack’s QOL-Q scores prior to moving to Bethesda were Satisfaction =16/30, Competence/Productivity =10/30, Empowerment/Independence = 10/30 and Social Belonging/Community Integration =13/30. His total QOL-Q score was 49/120. Upon moving to Bethesda, Jack continued
to follow the structured diet and exercise program established by the PW treatment program. He also had a structured day the included life skills, activities that he enjoyed and the ability to earn weekly outing into the community.

Social

Upon entering the LTRP, Jack had 1-1 staffing to ensure his safety as well as the safety of others. It was also necessary in order to supervise him around food. The kitchen was locked at all times and a staff sits with him and his peer during all meal times. Jack in not involved with any meal preparation due to his inability to control his appetite around food. On occasion when staff have not been watching, Jack will steal food, but he has not made any attempts to get into the locked kitchen. After 3 months he was able to enter the kitchen and get items he wanted and put his dishes away without any food related issues.

Bethesda could not follow the rigid token program offered at the treatment program and did not have the ability to offer the same classes for him. However a Daily Activity Schedule (DAS) was developed for him and he would earn points by following this schedule. We continue to offer him dietary classes one per week also. His DAS includes a morning routine, chores, exercise, meal times, recreational and leisure activities, dietary class, crafts, church, taking care of the animals in the Learning Center at Bethesda, etc. This schedule may change as his wants and needs change.

Jack also participated and completed an Anger Management Group and Fire Safety Group within this time frame.

At times Jack was difficult to motivate to get out of bed in the mornings, therefore a token program was put into place in order to motivate him to get out of bed. He would earn points towards extra outings.

Initially Jack did not have the coping skills to manage his frustration and anger and he would aggress towards staff, break his personal items and/or bang his head on hard objects. Physical Intervention Techniques had to be used on a weekly basis to keep him and others safe. However after 3-4 four months Jack no longer requires Physical Intervention and communicates to staff his frustrations.

Jack also had several one area on the SRI scale that was elevated and it was impulse control at 78.8 %. He had elevations in all 14 areas of the BSR. Jack's percent scores on the BSR were thought/behaviour disorder (91.9 %), verbally aggressive behaviour (86.4 %), physical aggression (93.3 %), sexual maladjustment (93.3 %), non-compliance (81.6 %), hyperactivity (88.5 %), distractibility (78.8 %), anxiety (84.1 %), somatic complaints (90.3 %), depression (93.3 %), low self-esteem (88.5 %), externalizing behaviours (90.3 %) and internalizing behaviours (91.9 %). His average score on the BSR is 88.3 %. When Jack moved to Bethesda, he had a great deal of difficulty adjusting to all of the changes that had occurred such as a new living situation, new staff, new peers, a change in his daily routine as well as a change in how his meals would be presented. He was
also upset that he was not moving to his home community yet as he had expected. However, once Jack became familiar with his new setting, he became less anxious, was able to communicate his frustrations with staff and he was able to cope with change in a more appropriate manner.

**Present Situation:**

**Biomedical**

Overall, Jack is a very healthy person. He wears glasses to read and his hearing is fine. He had been diagnosed with a mild intellectual disability, bipolar disorder and Prader-Willi Syndrome. Present he is 5' 4'' and weighs 145 lbs. He has lost 60 lbs since moving to Bethesda. The weigh loss is due to follow a very strict diet established for individual with Prader-Willi syndrome. Initially he was on an 800 calorie diet and now he has just started a 1600 calorie diet. He is also a structured exercise program in which he exercises for at least 30 minutes twice each day which mainly consists of walking at least 2.5 miles each time. Jack still tends to wet the bed when he sleeps and tends to pick at his skin when he is stressed, however these are very minor concerns at this time. Jack uses the bathroom on a regular basis and no longer requires an incentive to do so.

His current medications consist of Trileptal, Lithium, and Zyprexia. Jack is a good sleeper and will sleep between 9 – 12 hours per day.

**Psychological**

The SSKAAT-R was administered as a Pre/post test for the Socio-sexual Education Group. The results were variable between the two administrations with some scales static (Anatomy, Pregnancy and Healthy Boundaries), while others improved (Men’s Body, Birth Control/STD’s). Jack’s t-scores on the SSKAAT-R prior to the Socio-sexual Education Group were Anatomy = 51, Men’s Body = 36, Intimacy = 50, Pregnancy = 48, Birth Control = 40 and Healthy Boundaries = 45 for a total t-score of 48. His knowledge of Anatomy, Men’s Body and Healthy Boundaries improved, but Pregnancy and Intimacy scores remained the same. Jack’s t-scores on the SSKAAT-R after the group was completed were Anatomy = 68, Men’s Body = 44, Intimacy = 50, Pregnancy = 48, Birth Control = 47 and Healthy Boundaries = 67 for a total t-score of 53.

Jack is very proud that he has lost so much weigh and has been able to continue to reach his ideal weight. He is also proud that he has been able to manage his behaviours to the point that he is able to go in to he community on a regular basis including outings that involve food. He participates in activities such as outing out to eat, bowling, going to the movies, shopping, Special Olympics Baseball, etc.

Presently there are no elevations on the PIMRA, although staff continues to complete these scales on a monthly basis.
Social

Jack has 1-1 staffing however due to his low rates of inappropriate behaviours, he no longer requires staff to be nearby at all time and often is with one staff and another peer. He lives with 5 other male peers and 1 female peer. He attends various activities on and off Bethesda property including Special Olympics sports, crafts, bowling, swimming, activities in the gym, eating out, etc. He also likes building Bionicles, watching movies, doing basic academics, and playing cards.

Jack continues to regular contact with his family through phone calls, writing letters and visits with his parents about once every month.

Overall there has been a general improvement in Jack’s well being. He now has is own bedroom decorated the way he likes it. He is an active member at Bethesda in the recreation department and in the specialized programming department where he assists in taking care of a variety of animals and attends different groups. Jack also takes part in many organized programs in the community. He participates in 93% of all activities presented to him. Presently he has not had any desires to attend school or a work placement.

Jack participates in groups with peers, attends all meetings related to him without anxiety, and is now able to participate in events that have food involved without incidents. Jack also takes part in life skills such as keeping his room clean, cleaning his bathroom, doing his laundry, sweeping floors, etc. His participation in chore related activities is 95%.

Some trigger that would cause Jack to have outburst include having demands placed on him, change, inconsistency, not knowing what is expected of him, when he is asked to do something he does not want to do, any issues related to food and knowing about upcoming events too soon. To address these issues, Jack has a structure diet and exercise routine, a Daily Activity Schedule and is on a token economy program in which he earns points for following and participating in his daily routine, completing chores and for exhibiting appropriate behaviours behaviour. He can earn points to choose an extra outing of his choice. He continues to require that all food be locked in order to prevent him from being tempted to over eat.

Jack has also participated in a Socio-sexual Education using the SSKAAT-R in a group format with 5 male peers. The SSKAAT-R was administered pre and post socio-sexual education training. Positive Coping Skills were also taught to Jack using an Anger Management Group with 5 other male peers and 1 female peer. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups reviewed how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger. Jack has developed problem solving skills, self calming techniques and positive communication skills to manage his anger in an appropriate manner. Jack does not require any behavioural PRN to manage his aggression and simple blocking techniques are occasionally required when Jack attempts to harm himself.
There has not been any inappropriate sexual behaviour since Jack came to Bethesda. His verbal aggression had deceased by 25 % and in now only in the form of raising his voice or swearing at staff. Physical aggression has been reduced by 50 % and is mainly in the form of intimidating staff or raising his fist to staff. Destruction has been decreased by 25 % also with 7 months and does not result in the damage of any item only banging on his desk. Self-injury rate in low and has slightly decreased in frequency but in intensity is very minor. His main form of SIB is now just picking at his skin if he is anxious versus banging his head on hard objects.

QOL

After Jack had resided at the LTRTP for 6 months, the QOL-Q was completed again and improvement was noted in all areas. Jack’s current QOL-Q scores are Satisfaction = 30/30, Competence/Productivity = 12/30, Empowerment/Independence = 21/30, and Social Belonging/Community Integration = 26/30. Jack’s total score on the QOL-Q is now 80/120, which is a 25.9 % increase in quality of life over a 6 month period of time. Jack completes and enjoys his exercise program now that he has choices of what he can complete, he completes chores, he belongs to several community groups and goes into the community 3-4 times per week.

EPS

Presently, Jack continues to have a very high in the area of impulse control (93.3 %) scores on the SRI scale. He only has elevations in two areas of the BSR which are verbal aggression (75.8 %) and distractibility (94.5 %) for an average score of 85.2 %. Although Jack’s score in impulse control is very high, he is demonstrating self control especially around food. He is able to portion control his food when in a buffet setting in the community, will ask for diet items such as salad dressing if he forgets to bring his dressing and will hold onto staff’s arms if in a large setting with a lot of food present. On the BSR scale there is an overall reduction in his average score as well as a reduction in the number of items elevated on this scale.
FIGURE 5 Maladaptive Behaviours for Jack

Maladaptive Target Behaviours for Jack

- VAB
- Destruction
- PAB
- SIB
Case #4: Paul

Age: 18

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biomedical

Paul is generally healthy and does not have any medical concerns at this time. He is 6'4" and weighs 205. He reports that at times he has difficulty sleeping and that he wets his bed at night.

Paul has been diagnosed with a mild intellectual disability, post traumatic stress disorder and borderline personality disorder. He also has had a long history of sexually inappropriate behaviours.

He has self reported to suffer from nightmares about past abuse and that he is sometimes afraid to go to sleep. It is also reported that nervousness is often triggered by events such as thunderstorms and that he is extremely sensitive to noise.

His current medication includes Zyprexa, Paxil, Cyproterone Acetate and Oxybutynin.

Psychological

Paul has a long history of displaying inappropriate sexual behaviours as well as aggression, attention seeking, lying, destruction and self abuse. The most predominant appears to be behaviours of a sexual nature. There has also been incidence of animal cruelty, in which he has been charged. He has gone to the extent of killing small animals by decapitating them. His present probation order prohibits him from being in the presence of children and animals. He also has several charges of sexual assault against females in the community. Many of these incidents appeared to occur when he was unsupervised in the community. Paul reports to be remorseful about these events and knows it was wrong.

Triggers of Paul’s behaviours that staff reported included: loud noises, other clients being loud and/or aggressive, not having any meaningful programs, sexual talk by peer’s, having sexual thoughts, thunderstorms, certain smells i.e. barn yard smells, lack of meaningful activities, and lack of supervision.

Social

Paul is the fifth of nine children. Due to a number of incidents reported involving abuse in the household, the Children’s Aid Society became involved. At this time it was
reported that Paul was suffering from extreme physical, emotional and sexual abuse, along with emotional neglect, at the hands of his father, uncle and older brother. There was also reported physical abuse to him by his mother. He has limited phone contact with his mother and all six of his sister’s at his request.

There is limited information on file in regards to formal education. Paul stated that he is not really being interested in classroom education. He is more interested in work programs. He has also developed a strong interest in aquarium’s and fish. He is happiest when he is working and kept busy. Paul enjoys physical labour, and this gives him a sense of pride and accomplishment.

Paul resided in many residential programs, due to his behavioural challenges including foster homes, various treatment programs, psychiatric hospitals and jail. When Paul was referred to the Bethesda LTRTP, he was living in an apartment above the administration building of a youth agency. He had 1-1 male staff in his apartment and 2-1 staffing in order to go into the community. Paul only left his apartment to go to appointments and very rarely to do recreational activities. He was not allowed to walk around the facility because there were programs being held there for youths and he was not to near anyone under the age of 18 years. No behavioural programming was in place for his during this placement, nor any other treatments.

**After Entering the Bethesda LTRTP Program:**

**Biomedical**

When Paul first moved to Bethesda, he had a psychiatric assessment and his medication was reviewed. Initially, Paul was pleasant, compliant and did not exhibit any psychiatric or behavioural concerns. However as additional peers moved into the program, Paul began to keep to himself, go into a fetal position and cower if peers were having outburst and his mood would get very depressed for a few days. If these episodes were not identified quickly, Paul would become very destructive, self-injurious and at times aggressive if he thought others were going to harm him. Counselling and psychiatric medications were initiated.

Paul continues to be on Zyprexa, Paxil, Cyproterone Acetate and Oxybutynin. Paul was also place on nasal spray to reduce his bed wetting which has assisted with this problem.

**Psychological**

Paul has been in the Bethesda LTRTP since May 2004. Initially when he moved to Bethesda, he appeared to cope well with the adjustment to a new living environment and new staff. He enjoyed being able to work at job that he liked which involved doing maintenance jobs. No elevations were found on the PIMRA for the first few months that he resided at Bethesda. However, staff did continue to complete the full PIMRA and elevations were found in the areas of affective disorder and personality disorder. Around this time also, Paul’s staff who had worked with him for several years informed him that
they would no longer be coming to see him. After this, Paul started to exhibit withdrawal from others, post traumatic stress disorder type behaviour and behavioural challenges in the form of verbal and physical aggression. Paul’s average monthly scores for the first two months on the PIMRA that were elevated were: on the affective disorder scale 4.6 and 5.5 on the personality disorder scale.

**Social**

Upon referral to Bethesda, Paul was under constant supervision and had limited access to the community until we could assess his difficulties and get to know him better. He is now residing with male peers and 1 female that are close to his age. He is also able to go into the community on a regular basis with one staff.

Paul did start assisting with small jobs within the Bethesda Maintenance department. He also started his own garden and planted many vegetable which he would pick and eat. He assisted a peer to develop and grow their own garden too.

Presently, Paul has chosen not to have any contact with his family since moving to Bethesda. He states that they only attempt to take advantage of him. He continues to have some contact with previous staff who had worked with him.

**QOL**

Paul had been living in an adolescence setting prior to moving to Bethesda, however due to his inappropriate sexual behaviour he was moved to an apartment like setting in the administrative office of the agency. He had one to one male staffing most of the time with two to one staffing if he went into the community which was only for appointments. Paul’s QOL-Q scores prior to moving to Bethesda were Satisfaction = 11/30, Competence/Productivity = 10/30, Empowerment/Independence = 14/30 and Social Belonging/Integration = 16/30 for a total QOL-Q score of 54/120.

**EPS**

Paul had elevations on the SRI that included impulse control (96.4 %), anxiety (81.6 %), depression (91.9 %) and total pathology (86.4 %) for an average score of 89.1 %. Jack also had elevations in 12 of the 14 BSR items that averaged 88.6 %. These items included thought/behaviour disorder (91.9 %), verbal aggression (91.9 %), sexual maladjustment (81.6 %), non-compliance (99.9 %), hyperactivity (81.6 %), anxiety (78.8 %), somatic concerns (78.8 %), withdrawal (84.1 %), externalizing behaviour (94.4 %), depression (99.7 %) and internalizing behaviour (99.7 %). Paul’s average score on the BSR was 88.6 %. Paul had difficulties adjusting to his new living situation, new staff and new daily routine. His biggest adjustment was living with peers who had behavioural challenges. Paul had been used to living on his own with at least one to one staffing. Many times with Paul’s peers would have outbursts, he would withdraw to his bedroom, curling up into a ball and be unresponsive to staff. On rare occasions Paul would also become physically aggressive during these times. Although Paul has been big
changes in his behaviour including very low rates of maladaptive behaviours especially in the area of inappropriate sexual behaviour, he reports that he had many difficulties to overcome.

**Present Situation:**

**Biomedical**

Paul has been diagnosed with a mild intellectual disability, post traumatic stress disorder and borderline personality disorder.

Paul is generally healthy and does not have any medical concerns at this time. He is 6'4" and weighs 185 pounds. He generally sleeps very well since moving to Bethesda. Initially he wet the bed at night; however this has improved with medication as well as his comfort level increasing since he moved to Bethesda. His current medication includes Zyprexa, Paxil, and Cyproterone Acetate. He also has a PRN to assist him calming if required which he only needs on average once per month.

**Psychological**

The SSKAAT-R was administered as a Pre/post test for the Socio-sexual Education Group. The results were variable between the two administrations with some scales static (Anatomy, Pregnancy and Healthy Boundaries), while others improved (Men’s Body, Birth Control/STD’s). The results for Paul’s SSKAAT-R scores were showed great improvements in most areas (Men’s Body, Intimacy, Pregnancy, Birth Control and Healthy Boundaries) with the exception of Anatomy which decreased. His SSKAAT-R t-scores prior to the Socio-sexual Education Group were Anatomy = 81, Men’s Body = 49, Intimacy = 56, Pregnancy = 51, Birth Control = 60 and Healthy Boundaries = 67 for a total t-score of 58. Paul showed excellent basic knowledge of sexual anatomy. Significant increases in knowledge occurred in the areas of Men’s Body, Intimacy, Birth Control and Healthy Boundaries. Paul’s SSKAAT-R t-scores after the group were as follows Anatomy = 73, Men’s Body = 77, Intimacy = 73, Pregnancy = 55, Birth Control = 75 and Healthy Boundaries = 74 for a total t-score of 65.

Paul’s self-esteem has improved now that he has been living with peers of his age group and has a job in the Bethesda Maintenance Shop. He feels good about his job of cutting the grass, taking care of the gardens and developing a vegetable garden of his own. He is now confident to go into the community on a daily basis with staff and participates in activities such as shopping, going to the movies, eating out, bowling, etc. He no longer has fears that he will touch or harm females while he in the community.

Presently, his scores on the affective scale are 4 and 5 on the personality scale. Although there has been a slight reduction in these scores, it is still too soon to tell if the medication and behavioural changes that were implemented for Paul will continue to remain low. Paul continues to have counselling to assist him in dealing with his past abuse, he has a
structured day that includes activities that he enjoys and he continues to work on skills to effective cope with and problem solve his anger issues.

Social

Presently, Paul has 1-1 staff, however on the unit he no longer requires staff to be nearby at all times. However, he still has 1-1 staffing in the community. He lives with 5 other male peers and 1 female peer. As stated earlier, Paul assists with jobs provided to him by the Maintenance Staff at Bethesda such as cutting the grass, weeding and planting flowers at Bethesda, moving furniture, etc. 3-5 days per week depending on the amount of work there is available. Paul also delivers flyers in the community twice per week with another peer.

He does not attend many organized activities on or off Bethesda property, but he does take part in the Special Events offered at Bethesda, bike rides, goes hiking, takes care of his vegetable garden, plays sports with staff, cooking, fishing, etc. He is also very interested in fixing motors and other broken items such as toasters which he does with the assistance of the Maintenance staff.

Presently, Paul has started to have some contact with his family since moving to Bethesda. He hopes to visit with his family over the holiday season.

Overall, there has been a general improvement in Paul’s well being since moving to LTRP. He is able to socialize with peers his age, he has developed a positive rapport with several staff at Bethesda from various departments, he has a job that he enjoys and he is able to go onto the community on a regular basis. His participation in activities presented to him is 92%.

He has also developed some positive life skills such as cleaning his room, taking care of his bathroom, doing his laundry, cooking, and budgeting. He also shares others chores on the area such as sweeping floor, doing grocery shopping and cleaning the vans. His participation in chores related activities is 96%.

In order to assist Paul with his behavioural challenges, several replacement skills were taught to him over the last 5 months including:

- Socio-sexual Education using the SSKAAT-R in a group format with 5 male peers. The SSKAAT-R was administered pre and post socio-sexual education training
- Positive Coping Skills were also taught to Paul using:
  - Anger Management Group with 6 other male peers and 1 female. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups reviewed how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger.
  - with assistance from staff, Paul developed a Daily Journal which assisted him to identify triggers of his anger, changes in his body that indicate he was getting angry, developed problem solving skills and rated his success in
managing his anger. He continues to complete this daily.
- Presently he communicates well with staff and takes control of his behaviours by self-calming in his room and then talking to staff about his frustrations.
- Paul continues to follow his Daily Activity Schedule and does best when he has a structured routine and know what is expected of him.
- Paul has a behavioural PRN in his program however he receives it on average 1 every month mainly when he is feeling scared and has a PTSD reaction to a certain situation
- Paul also has a crisis protocol to use restraint and/or confinement time out (CTO) as a last resort if he attempts to harm himself or others. However, staff and Paul are not able to identify when he is having a PTSD reaction and they are able to talk him out of the reaction and on occasion Paul may go to the calming room on his own with the door open to ensure that he will not harm himself. Restraint and CTO were only used once in 5 month when he was attempting to cut himself with a sharp object.
- Paul also receives regular counselling sessions in order to assist him with addressing his past issues.

Paul’s destruction, aggression, self injury and inappropriate sexual behaviours remain at low levels in frequency and intensity. At times he may be defiant towards staff and swear at them or refuse to complete tasks. These episodes seem to last for a few days were he seems very sad and possible depressed. He talks a lot about his past during these days and likes to keep to himself. Then he will wake up happy and ready to follow his regular routine.

Paul has not breeched his probation order since residing at Bethesda and has not had any inappropriate sexual behaviour since moving to Bethesda.

QOL

After Paul had resided at the LTRTP, he started a job in the maintenance department at Bethesda and began to get involved in activities at Bethesda such as swimming, basketball gardening, etc. He also had the opportunity to go into the community on a regular basis with one to one staffing as his maladaptive behaviours remained low. After 6 months, Paul’s QOL-Q scores improved in all areas to Satisfaction = 27/30, Competence/Productivity = 28/30, Empowerment = 22/30 and Social Belonging/Community Integration = 20/30. Paul’s total QOL-Q score is now 97/120 for an increase in quality of life by 35.8%.

EPS

Presently, on the SRI he has elevations in the areas of thought/behaviour disorder (81.6 %), impulse control (96.4 %), anxiety (94.5 %), depression (91.9 %) and low self esteem (78.8 %) for an average score of 88.6 %. On the BSR, Paul has elevations on thought/behaviour disorder (93.3 %), verbal aggression (90.3 %), physical aggression
(78.8 %), non-compliance (91.9 %), hyperactivity (81.6 %), distractibility (75.8 %), anxiety (91.9 %), externalizing behaviours (88.5 %) and internalizing behaviour (86.4 %) for an average score of 87.0 %. Although it appears that Paul still has high rates on the EPS and needs to continue to require further treatment, he has gained many skills in the short period of time that he had been at the LTRTP. Skills that Paul has acquired include communication his frustrations with staff versus withdrawing to his room, openly talking about his past and trying to deal with his past abuse, making good choices about who he has contact with, attending and participating in all groups, and participating in many job at Bethesda. It is hoped that by continuing the further develop positive coping skills, continue to develop his problem solving skills and continuing to deal with his past that Paul will make positive behavioural gains.
FIGURE 6 Maladaptive Behaviours for Paul

Maladaptive Target Behaviours for Paul

- VAB
- PAB
- SIB
- Destruction
- InapproSexBehav

0.00 1.00 2.00 3.00 4.00


1-Pre Treatment 2-Treatment 3-Post Treatment
FIGURE 7 PIMRA Scores for Paul

PIMRA Scores for Paul

- □ Affective Disorder
- □ Personality Disorder

1-Pre Treatment  2-Treatment  3-Post Treatment
Case #5: JASMIN

Age: 19

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biological

Overall Jasmin is a healthy woman and has very few health concerns. She has asthma, however upon investigation, the asthma is not severe. She sleeps well and does not nap during the day.

Jasmin is short in stature and moderately overweight. Jasmin has been diagnosed with Conduct Disorder, Anxiety Disorder, Attachment Disorder, and Borderline Intellectual Disability. Her current medications include Zyolis, Epival, Prozac, Cogentin, Anafranil and Depo Provera. On numerous occasions she has stopped taking her medications, which resulted in her making telephone death threats, and attempts to harm others with a knife. This is also what caused her incarceration.

Psychological

Jasmin has a long history of displaying inappropriate behaviours such as aggression, attention seeking, lying, destruction and self abuse. The most predominant appears to be behaviours of physical aggression that has caused to be incarcerated on several occasions.

Social

Jasmin has had no contact with her parent since 1993. Her father attempted to reinstate his visitation privileges, but was denied due to allegations of sexual abuse towards Jasmin and her siblings. She also has two half siblings, age 28, and 26. She has no contact with them. She also has one biological sister, age 22. She has limited contact with the biological sister and the paternal grandparents. She reports that her family is upset with her behaviours and wish to have limited contact with Jasmin.

Jasmin has had numerous foster placements, jails terms, psychiatric facilities, lodging homes and placements in treatment centers, due to her behaviours including sexual overtones. Her schooling lacked in continuity due to the numerous residential placements and foster homes. In1992, she was identified as an exceptional student in a number of basic area's such as reading, math and spelling.

Jasmin has been displaying aggressive and destructive behaviours since 5 years of age, which has caused numerous foster placements to be unsuccessful. Recently, she has been
unable to manage relationship and tends to form unhealthy attachments with her workers. This has also resulted in Jasmin making death threats to her workers. Jasmin also displays self-injurious behaviours. She also will throw herself to the floor, screaming and crying when she doesn’t get her way. She will act out verbally or physically at times.

Triggers that have been identified as antecedents to her behaviours include being told “no”, not having set limits, change, loss of freedom, not being given enough time to process information, waiting for items that she wants immediately, not knowing what’s expected of her, and not getting what she wants.

Prior to moving to Bethesda, Jasmin lived in a boarding home with no supervision being provided by the home. Limited supervision was provided one per week with Jasmin by her probation officer and a social worker. This placement ended when Jasmin became physically aggressive towards her worker which resulted in Jasmin going to jail.

**After Entering the Bethesda LTRTP Program:**

**Biological**

When Jasmin first moved to Bethesda, she had a psychiatric assessment and her medication was reviewed. Initially, Jasmin was pleasant, and compliant however she quickly began to have difficulties complying with taking her medication as well as not being able to eat as much as food as she preferred whenever she wanted. Jasmin's mainly focused on wanting to eat chips, chocolate and pop and would refuse any other foods. Healthy eating habits, dietary classes and menu planning with Jasmin were initiated.

**Psychological**

Upon residing at Bethesda, the PIMRA was completed and there were elevated scores in the following areas: Affective Disorder, Adjustment Disorder, Anxiety Disorder, Somatoform and Personality Disorder. Jasmin was the first female to be admitted to the LTRTP. Initially when the full PIMRA was completed no elevations were found for Jasmin, however staff members continued to complete the full scale on her each month. After a period of time elevations were found on several areas of the PIMRA including affective disorder, adjustment disorder, anxiety disorder, somatoform disorder and personality disorder. This would suggest that Jasmin has difficulties in many areas including mood, negative attention seeking anxiety and behavioural challenges. Her average monthly PIMRA scores prior to treatment were 2 for affective disorder, 5 for adjustment disorder, 3 for anxiety, 4.5 for somatoform and 4 for personality disorder.

**Social**

Jasmin expressed interest in obtaining a part time job as well as wanting to go back to school. She began assisting with cleaning job on Bethesda Property one day per week and
volunteered walking a staff’s dog. Due to Jasmin’s inability to manage her behaviour she
decided to wait until a later date to attend a school program.

Jasmin expressed enjoying crafts, eating out, shopping, interacting with animals, and
reading. She also started gardening and took care of her own garden with the help of a
peer. She was highly motivated to do activities that she enjoyed, however was less
motivated to complete tasks such as keeping her room clean or area chores.

Jasmin also initially had difficulties budgeting and would outburst when she could not go
out as soon as she received her check and spend it all on food. Budgeting classes her also
established with her.

Jasmin’s destruction, aggression, and self-injury remained at very high levels in
frequency and intensity for the first months that she resided at Bethesda. She had a great
deal of difficult adjusting to a high structured program and was very definite towards
staff and peers. Jasmin would outbursts for hours over issues such as taking her
medication, demanding that staff do what she wanted immediately, not allowing her
unlimited access to food, etc. During these outbursts Jasmin would aggress towards staff
and peers by attempting to bite them, scratching others, kicking, hitting others, and
throwing objects at others. She would also spit, verbally insult and threaten to harm
others. Jasmin would also ingest harmful objects such as hair clips, tie string or clothing
around her neck, drink nail polish remover, etc. As a result her bedroom was kept free of
harmful objects, she was often restrained to prevent her from harming herself and due to
the long duration of the outbursts (3 – 12 hours), a confinement time out (CTO) program
was put into place.

QOL

Jasmin had been living in board homes prior to moving to Bethesda until she attempted to
physically assault her social worker and psychiatrist with a knife. Jasmin was charge
with physical assault with a deadly weapon and sent to jail. When in jail, Jasmin was
kept in solitary confinement for her own protection. She was often aggressive towards
her self and others in jail that resulted in Jasmin being placed in mechanical restraints for
long periods of time. Her QOL-Q score prior to moving to the LTRTP were Satisfaction
= 15/30, Competence/Productivity = 10/30, Empowerment = 17/30 and Social
Belonging/Community Integration = 16/30 for a total QOL-Q score of 58/120. Initially
Jasmin’s had a difficult time adjusting to the structure of residing at Bethesda; however
she did learn the benefits of budgeting, healthy eating, learning to compromise instead of
becoming aggressive and learning to take care of her belongings. She also enjoyed the
benefits of being able to assist in taking care of the animals at Bethesda and having a job

EPS

When Jasmin came to Bethesda, she had elevations in the SRI in the areas of impulse
control (84.1 %) and depression (97.1 %) for an average score of 90.6 % that is on the
very high range of psychopathology. She also had elevations on the BSR in the areas of
verbal aggression (97.1%), physical aggression (99.2%), sexual maladjustment (81.6%), non-compliance (88.5%), hyperactivity (78.8%), somatic concerns (84.1%) and externalizing behaviours (95.5%). Her average score on the BSR was 89.3%. Jasmin was very verbally and physically aggressive when she moved to Bethesda and her outbursts would last from two to ten hours where she would harm staff, damage her property and severely injure herself by ingesting harmful objects such as plastic, hair clips, nail polish remover, etc. The outbursts would also occur on and off for up to a week. Often Jasmin’s behavioural outbursts would start when she did not get what she wanted immediately and were often food or money related.

Present Situation:

Biological

Overall Jasmin remains healthy. She continues to sleeps well and does not nap during the day.

Currently Jasmin continues to work at changing her life’s style to make healthy eating choice and exercise regularly. She now eats all meals provided for her, assists with cooking and limits her intake of “junk” food. Jasmin has also set up a daily exercise program for herself and follows it regularly. She has lost 30 pounds in 6 months.

Her current medications include Zyolli, Epival, Prozac, Cogentin, Anafranil, Depo Provera and Haldol. A behavioural PRN was introduced in order to assist Jasmin with calming when she became upset.

Psychological

The SSKAAT-R was administered as a Pre/post test for the Socio-sexual Education Group. The results were variable between the two administrations with some scales static (Anatomy, Pregnancy and Healthy Boundaries), while others improved (Men’s Body, Birth Control/STD’s). Jasmin had good general socio-sexual knowledge in particular in the areas of anatomy, pregnancy and birth control. Her SSKAAT-R scores prior to attending the Sex Education Group were Anatomy = 68, Women’s Body = 66, Intimacy = 59, Pregnancy = 68, Birth Control = 71 and Healthy Boundaries = 62 for a total t-score of 64. Jasmin further improved her knowledge in all areas with significant improvement in the areas of Women’s Body, and Pregnancy. Her SSKAAT-R t-scores after the group were Anatomy = 73, Women’s Body = 74, Intimacy = 62, Pregnancy = 81, Birth Control = 78 and Healthy Boundaries = 67 for a total t-score of 67.

After treatment all of Jasmin’s PIMRA scores were lower and were within the normal range with the exception of personality disorder. Jasmin’s average monthly scores after treatment were 1.5 for affective disorder, 3 for adjustment disorder, 3.5 for anxiety disorder, 2.5 for somatoform disorder and 7 for personality disorder. These changes in PIMRA scores may be due medication changes that she experienced. Jasmin had high behavioural challenges for several months, however when new medication was
This is a sample page of a document with some natural text. The content is placeholder text, often used in design mockups before the final content is determined. The text is designed to be indistinguishable from real content to ensure that any design or layout elements are not skewed by the actual content. This page is intended to show how the final document will look, with all necessary design considerations taken into account. The text is formatted in a way that mimics typical prose, with paragraphs, sentences, and punctuation to provide a natural reading experience. It is essential to maintain this level of detail to ensure that the final product is as visually appealing and user-friendly as possible.
introduced, she able to cope better with frustration in her life and was able to communication, problem solve and compromise with others better.

Social

Presently, Jasmin has 1-1 staff, however on the unit she no longer requires staff to be nearby at all times. She still staffing in the community, however this generally occur with another peer. She lives with 6 other male peers.

Jasmin has several small jobs at Bethesda including delivering flyers in the community twice per week with another peer, taking care of her garden, walking a staff’s dog, and cleaning as required by the house keeping department.

She does not attend many organized activities on or off Bethesda property, but he does take part in the Special Events offered at Bethesda, goes hiking, takes care of her vegetable garden, plays sports with staff, cooks, does activities in the gym, etc.

Presently, Jasmin has regular contact with he sister as well as with her grandparents since moving to Bethesda. These relationships have become very positive and talks with them on the phone, writes letters and has regular visits.
Overall, there has been a general improvement in Jasmin’s well being since moving to LTRP. She is able to socialize with peers better, she has developed a positive rapport with several staff at Bethesda, he has a job that he enjoys and he is able to go onto the community on a regular basis. Jasmin has also been able to develop positive recreation and leisure activities. Her participation in activities presented to her is 86 %.

She has also developed some positive life skills such as cleaning her room, taking care of her bathroom, doing laundry, cooking, healthy eating habits, and budget skills. She also shares others chores on the area such as sweeping floor, and doing grocery shopping. Her participation in chore related activities is 88 %.

In order to assist Jasmin with her behavioural challenges, several replacement skills were taught to her over the last 6 months including:
- Individual Socio-sexual Education using the SSKAAT-R. The SSKAAT-R was administered pre and post socio-sexual education training
- Positive Coping Skills were also taught to Jasmin using:
  - Anger Management Group with 6 other male peers. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups reviewed how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger.
  -with assistance from staff, Jasmin developed a Daily Journal which assisted her to identify triggers of her anger, changes in her body that indicate she was getting angry, developed problem solving skills and ways to compromise with others.
  - Presently she communicates well with staff and is starting to take control of her behaviours by talking to staff about her frustrations.
Jasmin continues to follow her Daily Activity Schedule and does best when she has a structured routine and know what is expected of her.

- Jasmin has a behavioural PRN in her program to assist her with calming
- Jasmin also has a crisis protocol to use restraint and/or confinement time out (CTO) as a last resort when she attempts to harm herself or others. Initially this occurred on a regular basis 2-3 times per week as Jasmin would attempt to bite, kick and scratch staff as well as to harm herself by ingesting inedible objects. However, with a medication change, this appears to be assisting Jasmin with gaining control of herself behaviours and she is able to talk to staff about her frustration as well as to self calm.
- She is also now able to take part in relaxation session 2-3 times per week in which she listens to calming music of her choice in a quiet, calm place of her choice. In the future it is hoped that she will be able to self calm in her room when she becomes upset by listening to calming music.

Jasmin’s destruction, aggression, and self injury remain at low levels in frequency and intensity this month. Jasmin has not breeched her probation order since residing at Bethesda.

QOL

Due to Jasmin’s success at Bethesda, her family has become involved in her life again. Jasmin’s current QOL-Q scores have improved and are now Satisfaction = 17/30, Competence/Productivity = 16/30, Empowerment = 30/30 and Social Belonging/Community Integration = 23/30. Her total QOL-Q score is 86/120 which is an increase of 23.4 % since she has been involved with the LTRTP.

EPS

Presently, Jasmin has elevations on the SRI that include positive impressions (84.1 %), impulse control (90.3 %), anxiety (81.3 %) and depression (90.3 %). There is a slight increase in the numbers of items that are elevated on the SRI; however the overall average score has been reduced to 86.5 %. Jasmin has also had a reduction in the number of items elevated on the BSR scale. Her elevations on the BSR include verbal aggression (94.5 %), physical aggression (99.2 %), non-compliance (97.1 %), somatic complaints (90.3 %) and depression (78.8 %). These scores average 91.9 % which is in the very high range of psychopathology. Jasmin has had a medication change within the last month and there has been a positive change in her behaviours. Jasmin is now able to communicate her frustrations with staff, control her anger, self calm in the calming room and her inappropriate behavioural outbursts have been reduced in both frequency and duration.
FIGURE 8 Maladaptive Behaviours for Jasmin

Maladaptive Target Behaviours for Jasmin

- VAB
- PAB
- SIB
- Destruction
- InapproSexBehav

10.00
9.00
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00

1-Pre Treatment
2-Post Treatment
FIGURE 9 PIMRA Scores for Jasmin

PIMRA Scores for Jasmin

- Affective Disorder
- Adjustment Disorder
- Anxiety Disorder
- Somatiform Disorder
- Personality Disorder

1-Pre Treatment
2-Post Treatment

Case #6: DOUG

Age: 25

Functioning Level: Mild Intellectual Disability

Prior to Entering the Bethesda LTRTP Program:

Biological

Doug was born with an intellectual disability, Fetal Alcohol Syndrome and failure to thrive. He was placed in Foster care as a baby and adopted at a young age. As a Preschooler, he was also diagnosed with hyperactive with ADD.

Doug is generally healthy but he does have allergies to bee stings and has seasonal allergies. He also has some sensitivity to foods such as too much sugar, flour and some fruits and vegetables. He is also lactose intolerant. Doug has a seizure disorder.

He sleeps well and enjoys being very physically active. His current medications include Respiradol, Ritalin, and Tegretol.

Psychological

Doug has had a long history of behavioural issues that including verbal aggression, physical aggression, destruction, and inappropriate sexual behaviour. He has had a number of charges dating back to before he was 18 years of age. The charges include physical and sexual assault, breaches of recognizance. Since the age of 18, he has spent more time in jail then he has in any of setting.

Social

Doug went into foster care at 6 months of age. He was apprehended by children services because of maternal deprivation, failure to thrive and low weight. It was reported that the mother was a violent, aggressive person and who experienced violence during her pregnancy. She was also abusing drugs and alcohol when she was pregnant. The biological father is a known criminal who has a drug and alcohol problem and has been in and out of jail. Doug is one of three children all born 10 months apart. He was born with Fetal Alcohol Syndrome and failure to thrive.

At age 4 the Doug was adopted by a foster family. He was described as a quiet, passive child until he was 4. At this time he became extremely overactive, impulsive and had a low frustration tolerance. He was diagnosed with hyperactivity with ADD. His adoptive family has two other natural children who are older than him. The Doug’s adoptive
family has been very supportive and committed to him and they continue to be very involved in his life.

Due to behavioural challenges, Doug was placed in a group home for the intellectually disabled, at age 16 where he did well in a highly structured and supervised setting. On his 18 birthday he was informed that he could make his own decisions and as a result, he left the group home to live independently. Since this time, Doug has lived in numerous settings such as apartments, hotels, on the street, but has spent most of his time in jail for various charges.

Doug attended school in special education classes until age 18 when he graduated from high school. School records stated that he has had a history of language and behavioural difficulties including impulse control, aggression and inappropriate sexual behaviours. Structured settings and supervision assist in decreasing these issues.

Since graduating from school, he had various summer jobs including flyer deliveries, farm labourer, lawn cutting jobs and camp counsellor in training. At this time, Doug is looking for a part time job.

He enjoys activities such as floor hockey, basketball, bowling, soccer, baseball, and swimming. He is an all round athlete. Other activities that Doug enjoys include socializing with his peers, music, dances, and playing his guitar. He has been banned from any organized activities due to aggressive and sexual behaviours.

Doug has had long standing difficulties with aggression, non-compliance, hyperactivity, impulsivity and inappropriate sexual behaviour. In 1995 he was charged with and convicted of sexual assault, sexual interference, indecent acts and assault. He was put on probation for three years. Since residing on his own, Doug has had multiple charges and incarcerations due to physical and sexual assaults.

It has been noted that antecedents to his behaviours include attention from others, transitions, if he has too much free or unstructured time, if he has too much freedom and responsibilities, if there has been a change in routine/staffing, if he does not has clear limits and expectation, being informed of an upcoming event ahead of time or if he has had a disagreements with a peer.

**After Entering the Bethesda LTRTP Program:**

**Biological**

When Doug first moved to Bethesda is medication was reviewed and determined to appropriate. He also had a medical and found to be physically fit. He slept and ate well.
Psychological

The PIMRA was administered soon after Doug moved to Bethesda and there were no elevation found on this scale. Doug would show anxiety if he found out about appointments too early, however delay this information and developing a daily routine for him reduced his anxiety.

Social

Upon entering the LTRTP Doug has 1-1 staffing to monitor his inappropriate sexual behaviours as well as provide safety to his peers. Doug adjusted to moving to Bethesda and his inappropriate behaviours remained low.

His Behaviour Intervention Plan consisted of developing a structured daily routine that included activities that he enjoyed. This provided structure and kept him busy doing productive activities. Doug also participated in groups such as Anger Management, and Socio-sexual Education.

QOL

Doug has been participating in the LTRTP since July 2004. He had been living on the streets, in board homes, but mainly in jail since he was 18 years of age. His incarcerations were due to physical assault, sexual assault and breach of probation. Doug’s QOL-Q prior to moving to Bethesda were Satisfaction = 12/30, Competence/Productivity = 11/30, Empowerment = 12/30 and Social Belonging/Community Integration = 11/30 for a total QOL-Q score of 46/120. Since moving to Bethesda, Doug has had very low rates of maladaptive behaviours and he has adjusted well to a structured and supervised setting. Due to his successes at the LTRTP, he has been able to become involved in a variety of community sports clubs, goes to church, has a job, and participates in a variety activities on Bethesda property also. He also has a positive relationship with his family again.

EPS

Doug was the last person to be admitted to the LTRTP. His elevations on the SRI were only in the area of impulse control (84.1 %). He also had elevations on the BSR that included thought/behaviour disorder (90.3 %), verbal aggression (93.3 %), physical aggression (75.8 %), sexual maladjustment (91.9 %), non-compliance (97.7 %), hyperactivity (97.1 %), distractibility (99.4 %), somatic concerns (81.6 %) and externalizing behaviours (94.5 %). His average BSR score was 92.3 %. Doug spent most of time in jail for various reasons including breach of probation, sexual assault or physical aggression. When he was not in jail, he lived in a variety of settings such as hotels, with friends or on the street.
Present Situation:

Biological

As stated earlier, Doug was born with an intellectual disability, Fetal Alcohol Syndrome and failure to thrive. He was also diagnosed with hyperactive with ADD as a young child.

He is generally healthy but he does have allergies to bee stings and has seasonal allergies. He also has some sensitivities to foods such as too much sugar, flour and some fruits and vegetables and is lactose intolerant. Doug also has a seizure disorder.

He sleeps well and enjoys being very physically active. His current medications include Respiradol, Ritalin, and Tegretol. He does not have any behavioural PRN’s.

Psychological

The SSKAAT-R was administered as a Pre/post test for the Socio-sexual Education Group. The results were variable between the two administrations with some scales static (Anatomy, Pregnancy and Healthy Boundaries), while others improved (Men’s Body, Birth Control/STD’s). Doug’s SSKAAT-R t-scores prior to the Socio-sexual Education Group were Anatomy = 58, Men’s Body = 49, Intimacy = 56, Pregnancy = 47, Birth Control = 64 and Healthy Boundaries = 62 for a total t-score of 57. The results for Doug were variable between the two administrations with some scales improving (Anatomy, Men’s Body, Intimacy and Pregnancy), while others remained the same or decreased (Birth Control, Healthy Boundaries). Doug’s scores after he attended group were Anatomy = 73, Men’s Body = 66, Intimacy = > 80, Pregnancy = 65, Birth Control = 64 and Healthy Boundaries = 56 for a total t-score of 62.

Doug’s self-image has improved in many ways. When he is in a structured and predictable setting, he takes great pride in his appearance. He is now involved in many community groups and team sports that he had been asked to leave in the past due to his behaviours. Currently he is involved in bowling, and power lifting. Over the summer months he participated in track and field as well as baseball. Doug also enjoys shopping, going to the movies, and eating out. He like his job delivering flyers and is looking for further employment.

Presently Doug does not have any elevations on the PIMRA scale.

Social

Presently, Doug has 1-1 staffing available however he no longer requires staff to shadow him at all times. He lives with 5 other male peers and 1 female peer. He attends many activities on Bethesda property as well as off property such as chapel, hiking, swimming, drama club bowling, going to the library, etc.
He has his own bedroom with a bed, desk and many personal possessions such as poster, a radio and a small TV. He takes pride in keeping his room clean and has not damages any of his property since moving to Bethesda.

Doug continues to have a positive relationship with his family. He calls his parents on a regular basis and has visits with them every two weeks. He is working towards developing a positive rapport with his sister who has not wanted any contact with him over the past few years due to his behaviours.

Overall there has been a great improvement in Doug’s well being. He now has a stable place to live which he has not had for 7 years. He has his own room which he takes good care of. He is an active member of his behavioural team and provides valuable input into his program. As stated earlier, Doug is a very active member at Bethesda as well as in the community. He is now able to be a part of many clubs and teams that he had been asked to leave in the past due to his inappropriate behaviours. He is also able to have a positive relationship with his family now versus his family continually trying to find services for him, trying to find where he is or visiting him in jail. Doug’s rate of participation in activities is 87 %.

Doug is also now able to maintain a job delivering flyers, he participates in educational/support groups with his peers and is interacting with others in a more social acceptable manner. He participates in chores on the area including cleaning his bedroom, cleaning his bathroom, doing laundry, and he especially enjoys cooking. His participation in chores related activities is 92%.

In order to assist Doug with his behavioural challenges, several replacement skills were taught to him over the last 6 months including:
- Socio-sexual Education using the SSKAAT-R in a group format with 4 male peers. The SSKAAT-R was administered pre and post socio-sexual education training
- Positive Coping Skills were also taught to Doug using:
  - Anger Management Group with 4 other male peers and 1 female peer. The group lasted for 10 weeks and used curriculum from the BeCool video series. These groups reviewed how our body reacts to anger, triggers to our anger, positive coping skills and consequences of anger.
  - with assistance from staff Doug developed a personal Hassle Log as well as a Daily Journal this assisted him to identify triggers of his anger, changes in his body that indicate he was getting angry, developed problem solving skills and rated his success in managing his anger. He continues to complete these at least 1-2 per day on ways in which he handles situations.
  - Presently he communicates well with staff and takes control of his behaviours by self-calming in his room and then talking to staff about his frustrations.
Doug continues to follow his Daily Activity Schedule and does best when he has a structured routine and know what is expected of him.

Doug also has a crisis physical intervention restraint in his program as a last resort if he attempts to harm himself or other, however it has only need necessary approximately twice over the past 6 months.

Verbal, physical, sexual and environmental aggression has all remained low. His inappropriate sexual behaviour is in the form of talking about sexual orientation or talking about sharing “girlfriends” with his peers.

Doug has not had recidivism since moving to Bethesda.

QOL

Even though Doug has only resided at the LTRTP for just over 5 months, all of his QOL-Q scores have increased dramatically and his total QOL-Q score has increased the greatest compared to his peers. Doug’s current QOL-Q scores are now Satisfaction = 25/30, Competence/Productivity = 26/30, Empowerment = 2/301 and Social Belonging/Community Integration = 28/30. His total QOL-Q score is now 100/120 for an increase of 45 %.

EPS

Once he had a stable place to reside with consist staffing and a consistent routine, he had an overall reduction in maladaptive behaviours. Currently, Doug has elevations on the SRI in the area of impulse control (81.6 %) and depression (75.8 %) for an average score of 78.7 %. Doug’s elevations on the BSR have also decreased and are now; verbal aggression (84.1 %) sexual maladjustment (78.8 %), non-compliance (99.4 %), hyperactivity (91.9 %), distractibility (94.5 %) and externalizing behaviours (90.3 %) for an overall average score of 89.8 %.
FIGURE 10 Maladaptive Behaviours for Doug

Maladaptive Target Behaviours for Doug

- VAB
- PAB
- SIB
- Destruction
- InapproSexBehav

3.00
2.00
1.00
0.00

1-Pre Treatment
2-Post Treatment

02/06/2004
03/06/2004
16/06/2004
23/06/2004
30/06/2004
07/07/2004
14/07/2004
21/07/2004
28/07/2004
04/08/2004
11/08/2004
18/08/2004
25/08/2004
01/09/2004
08/09/2004
15/09/2004
22/09/2004
29/09/2004
06/10/2004
13/10/2004
20/10/2004
27/10/2004
03/11/2004
10/11/2004
17/11/2004
24/11/2004
Appendix G:

TABLE 7

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<th>Participant</th>
<th>Anatomy Pre</th>
<th>Anatomy Post</th>
<th>Women's Body Pre</th>
<th>Women's Body Post</th>
<th>Men's Body Pre</th>
<th>Men's Body Post</th>
<th>Intimacy Pre</th>
<th>Intimacy Post</th>
<th>Pregnancy Pre</th>
<th>Pregnancy Post</th>
<th>Birth Control Pre</th>
<th>Birth Control Post</th>
<th>Healthy Boundaries Pre</th>
<th>Healthy Boundaries Post</th>
<th>Total Scores Pre</th>
<th>Total Scores Post</th>
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<td>62</td>
<td>56</td>
<td>57</td>
<td>62</td>
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</table>
FIGURE 11: TOTAL AND SUBSCALE SCORES ON THE SSKAAT-R PRE AND POST EDUCATION

Average SSKAAT-R T-Scores

- Pre  - Post

0  10  20  30  40  50  60  70  80

Anatomy  Women's Body's  Man's Body's  Intimacy  Pregnancy  Birth Control  Healthy Boundaries  Total SSKAAT-R T-Scores
Appendix H:

**TABLE 8**
MEASUREMENT OF OVERALL QUALITY OF LIFE UTILIZING THE QUALITY OF LIFE QUESTIONNAIRE (Schalock & Keith, 1993)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Satisfaction (30)</th>
<th>Competence/Productivity (30)</th>
<th>Empower/Independence (30)</th>
<th>Social Belonging/Community Integration (30)</th>
<th>Total Score (120)</th>
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<tr>
<td></td>
<td>Pre-placement</td>
<td>6 month-1 yr Follow Up</td>
<td>Pre-placement 6 month-1 yr Follow Up</td>
<td>Pre-placement 6 month-1 yr 2 yr</td>
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</tr>
<tr>
<td>Wally</td>
<td>13</td>
<td>19</td>
<td>22</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Rodney</td>
<td>10</td>
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<tr>
<td>Jack</td>
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<td>15</td>
<td>17</td>
<td>10</td>
<td>16</td>
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</tr>
<tr>
<td>Doug</td>
<td>12</td>
<td>25</td>
<td>11</td>
<td>26</td>
<td>12</td>
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<td>Group Average</td>
<td>12.8</td>
<td>23.5</td>
<td>10.2</td>
<td>17.5</td>
<td>13.5</td>
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FIGURE 12: QUALITY OF LIFE SCORES PRE, POST AND AT FOLLOW-UP

Average QOL-Q Scores

- Pre
- Post
- F/U

Satisfaction  Competence  Empowerment  Social Belonging  Total Score
Appendix I

FIGURE 13 Total Average EPS Scores
Appendix J:

TABLE 9

DAILY DATA SHEETS

LTRTP
Daily Data Sheet

Name: ____________________
Date: ____________________ Shift: ____________________

<table>
<thead>
<tr>
<th>TARGET BEHAVIOURS</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>VAB</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Target Behaviours □ Staff Signature: ____________________

- Record each target behaviour as a frequency count. Do not put check marks, use only numbers.
- Record both the date and the time the behaviour starts and finishes for each display of target behaviours.
- For each target behaviour, record what the response was for that particular behaviour.
- Please leave a blank row when starting a new day – this will help us calculate daily totals.
- Staff will complete one Daily Data Sheet per shift. If client does not display any target behaviours, staff will check off the box at the bottom of the chart.
**LTRTP**

**POSITIVE BEHAVIOUR CHECKLIST**

| NAME: | ____________________ |
| WEEK: | ____________________ |

**Anger Management**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Weekly Totals</th>
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<tbody>
<tr>
<td>D</td>
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<td>A</td>
<td>D</td>
<td>A</td>
<td>D</td>
<td>A</td>
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</tbody>
</table>

- Talking with staff about feelings
- Hassle Log
- Problem Solving with Staff

**Social Skills**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<td>D</td>
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</table>

- Social Stories Prior to Outings

**Activities**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>D</td>
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<td>D</td>
<td>A</td>
<td>D</td>
<td>A</td>
<td>D</td>
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</tbody>
</table>

- # of activities offered
- # he participated in
- % of participation
- # of chores required
- # of chores completed
- % of chores completed

* Please do not leave blank spaces *
Only use frequency counts – do not use checkmarks.*