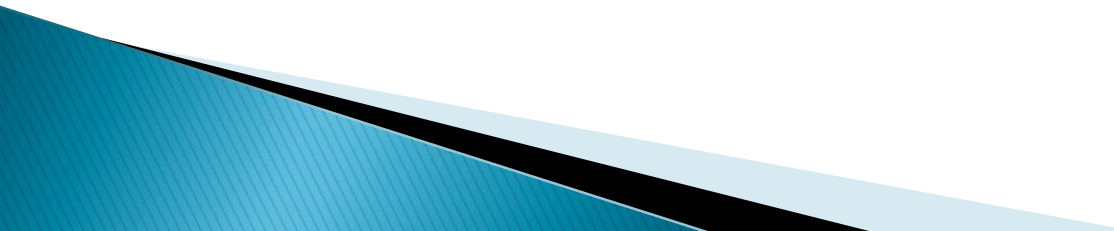


# Care of Sexual Offenders in the Primary Care Clinic

Ivan Wolfson, MD  
Caitlin Margaret May, RNP  
Crossroads Health Center  
Providence, RI

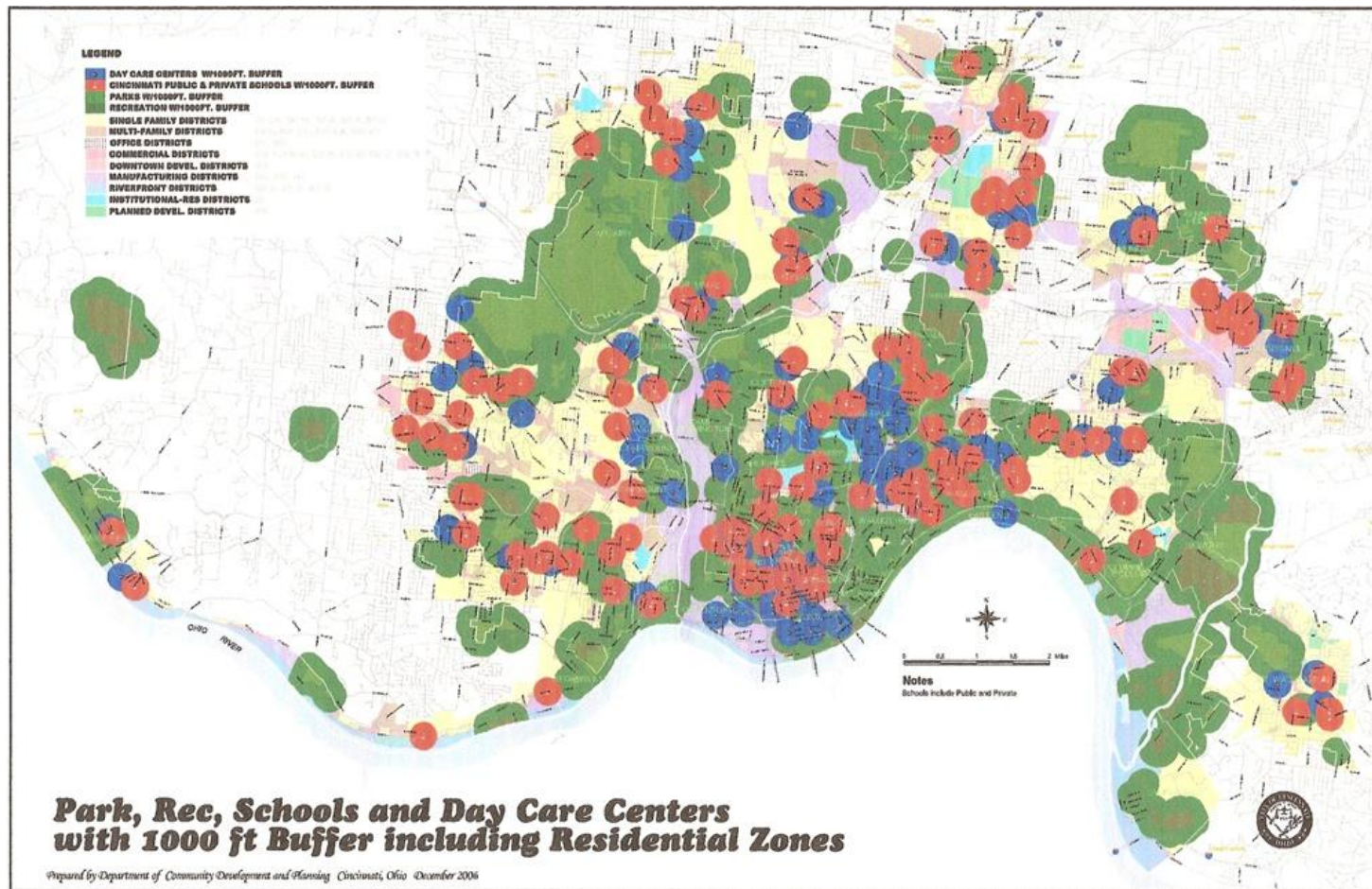
*“The area of a circle is pi times the square of its radius. Which means: if you’re required to reside 2,500 feet away from any place where children regularly gather—a school or a playground, for instance, or a video arcade—you have to live outside a closed circle of 9.25 million feet. Since every school, playground, or video arcade lies at the center of such a circle and nearly all of the circles partially overlap and often extend well beyond the others, when you step clear of one 9.25-million-square-foot forbidden zone, you immediately step into a part of another.*

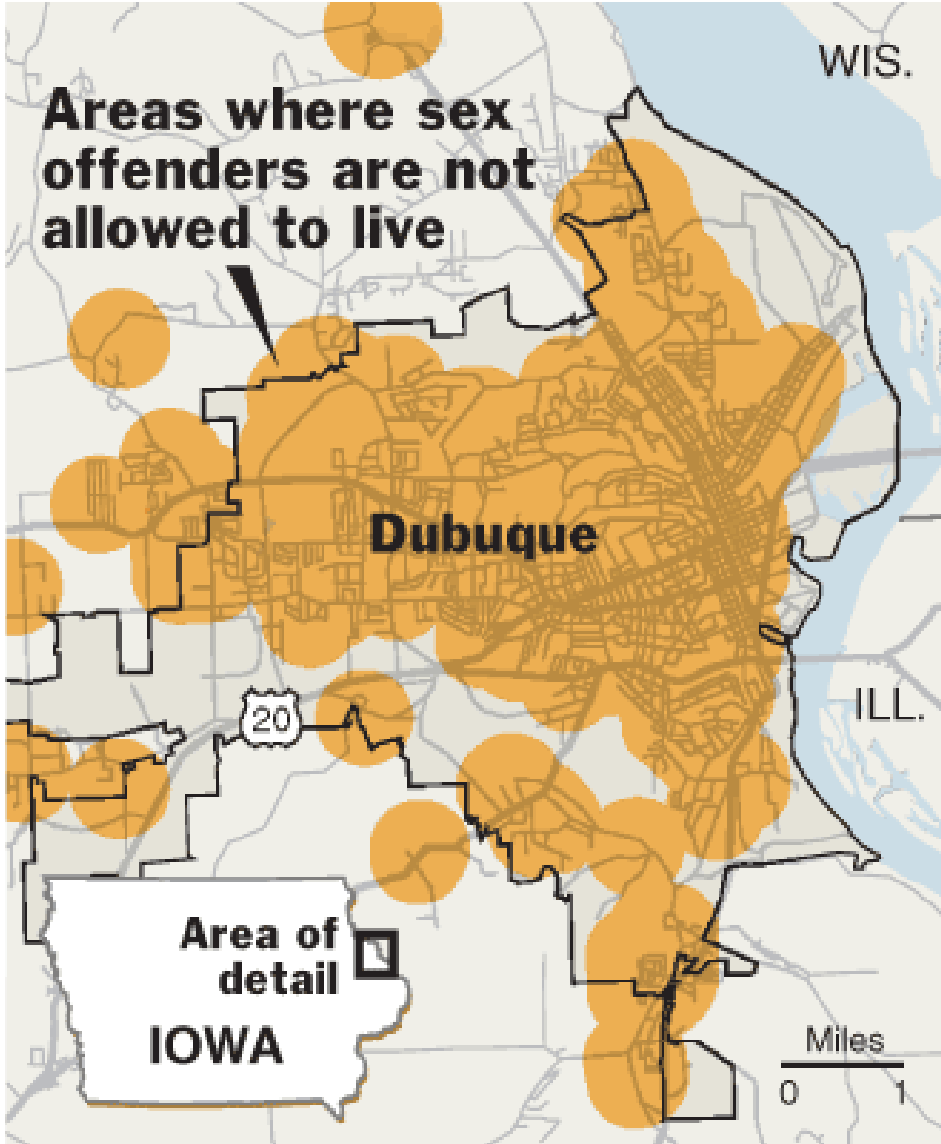


*Thus, if you're a sex offender tried and convicted in Calusa County and are required by the terms of your parole to stay in Calusa County, as is almost always the case, there are only three places where you can legally reside: under the Causeway that connects the mainland with the Barrier Isles; in Terminal G out at the International Airport; or in the eastern end of the Great Panzacola Swamp."*

Russell Banks, *Lost Memory of Skin*, describing the fate of a sex-offender in the fictional Calusa County, Florida. Banks got the idea for this novel after reading newspaper accounts of sex offenders living under the Julia Tuttle Causeway

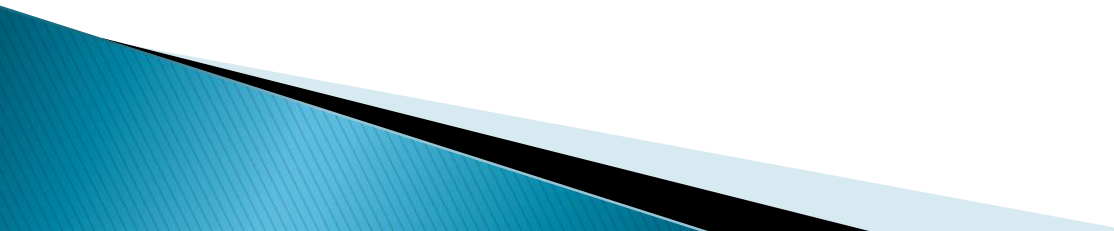
# Residency Restrictions



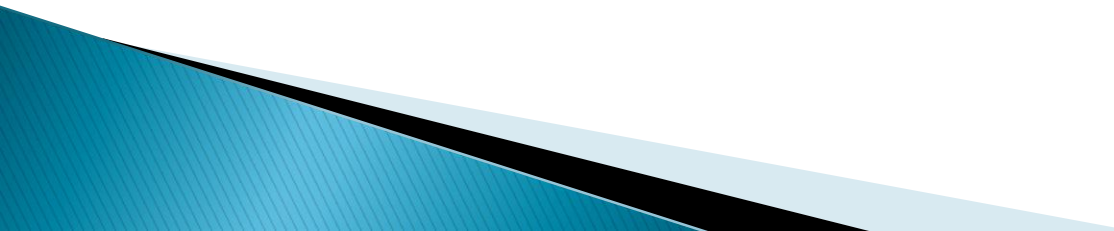




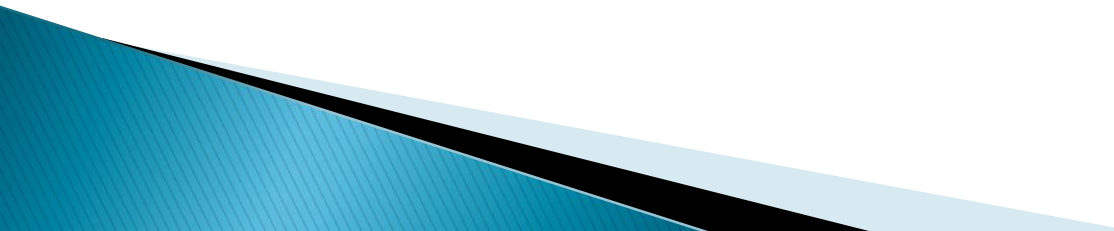
# Why are we talking about Sex Offenders (SO)?

- ▶ Our patients include sex offenders
  - ▶ We should know something about our patients' illnesses and treatments, even if we aren't providing the treatment (think of methadone)
- 

# We wanted to improve our understanding of:


- ▶ Who, and what exactly is, a Sex Offender?
  - ▶ What are the legal, social and behavioral issues surrounding the care of sex offenders?
  - ▶ What can we do in HCH, to provide care that enhances the safety of our patients, ourselves and our community?
- 

# What we asked ourselves:

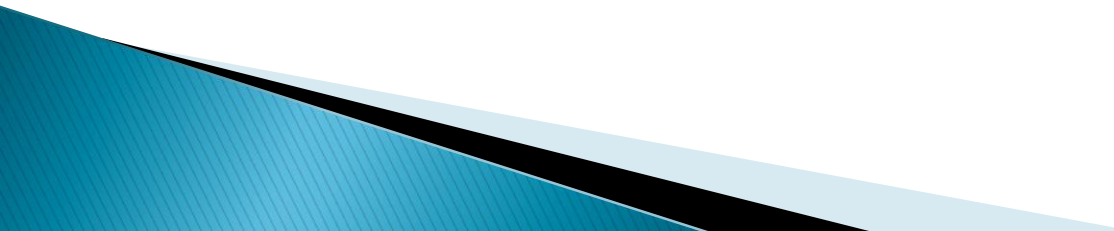
- ▶ Do all sex offenders molest children?
  - ▶ Why would non-pedophiles molest children?
  - ▶ What are the main differences between pedophilic and non-pedophilic sex offenders?
  - ▶ How likely are sex offenders to re-offend?
- 



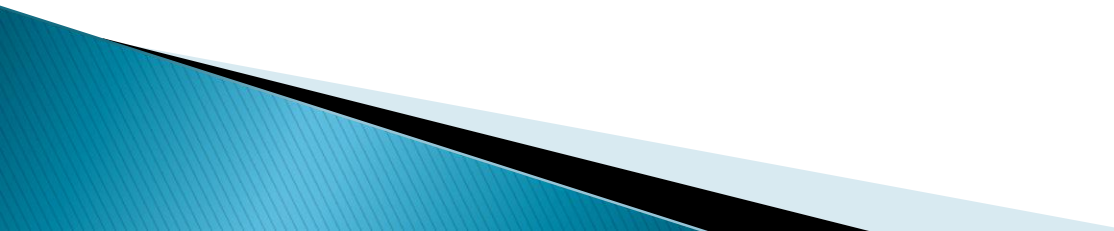
# What we asked ourselves:

- ▶ How does the “system” deal with sex offenders?
  - ▶ What does the “system” do well/not well?
  - ▶ What barriers do sex offenders face after incarceration?
  - ▶ What do we need to know in Primary Care and HCH programs to keep everyone safe?
- 

# What we found: The data is unclear

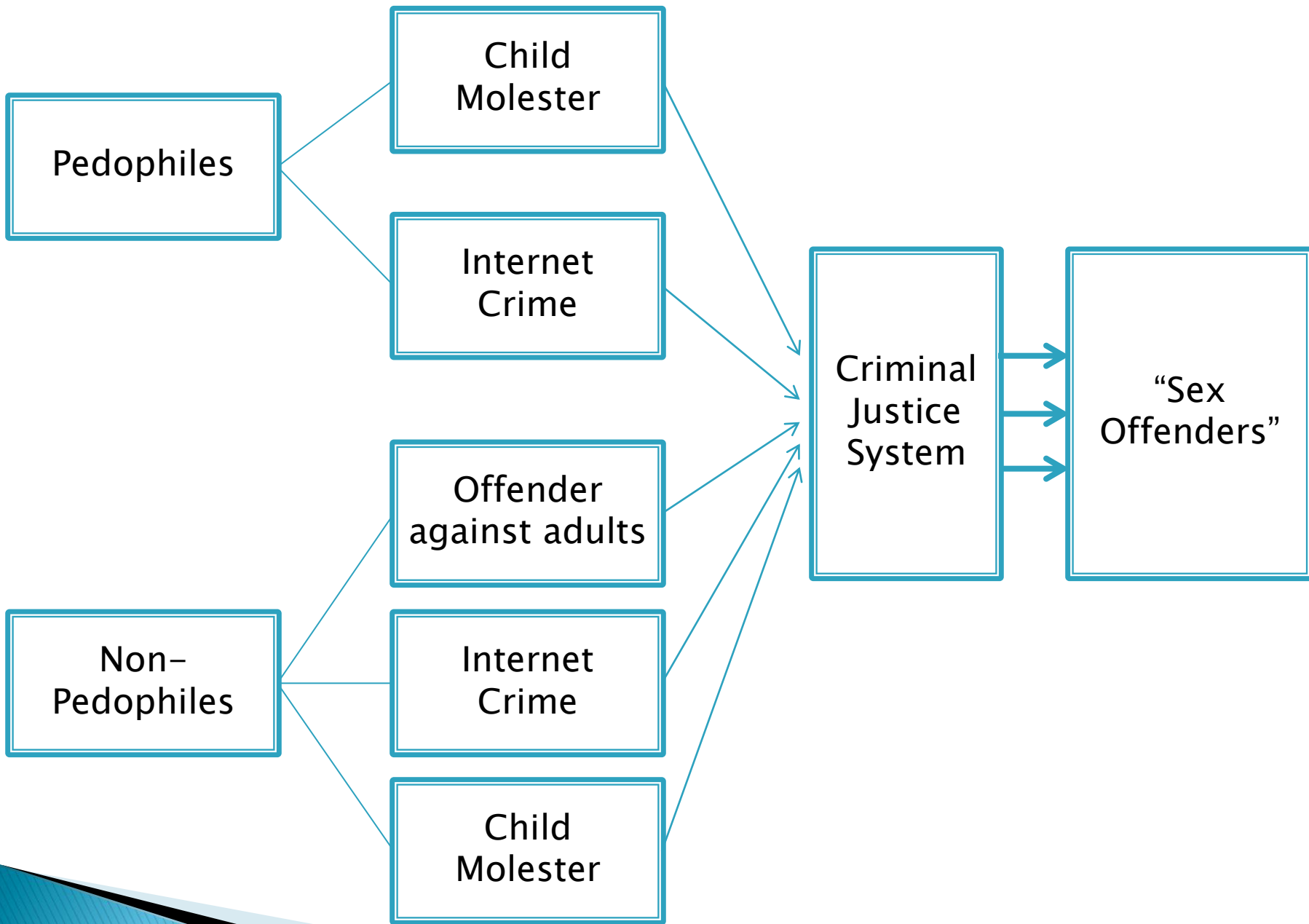
- ▶ Understanding who sex offenders are is challenging
  - ▶ Differing definitions– The clinical vs. the criminal justice picture
  - ▶ Studies come from clinical and/or prison samples (not full breadth of disease)
  - ▶ The legal issues are interpreted very differently State by State, Community by Community
- 

# What we found: The Criminal Justice System:



- ▶ “System”: a criminal justice answer to a complex, clinical problem
  - ▶ Not very good at accurately assessing risk of re-offense (it’s really bad)
  - ▶ Often ignores recommendations of treatment providers
  - ▶ Takes a wide variety of sex offenders and tries to apply a one-size-fits-all treatment
- 

# The Criminal Justice System

- ▶ Criminal Justice system tries to make us safer through:
  - Risk Assessment
  - Treatment of sex offenders
  - Residency restrictions
  - Reporting laws
- ▶ Due to the “broad brush” approach:
  - Treatment resources wasted on low risk offenders while high risk offenders do not get enough treatment
  - Laws designed to makes us safer are not effective
  - Offenders, after release, face huge social barriers to employment and housing



# Who is a Sex Offender?

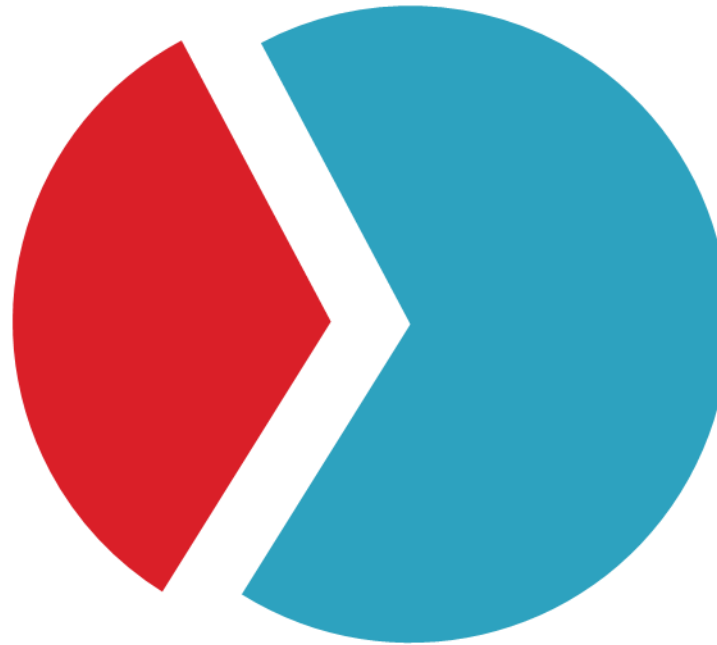
- 
- ▶ **SO = anyone convicted by the criminal justice system as having committed a sexual offense.**
  - ▶ Pornography/Internet/Exposure crime
  - ▶ Sexual crime against an adult
  - ▶ Sexual crime against a child
    - “Sexual assault is one of the most under reported crimes, with 54% still being left unreported” – R.A.I.N.N. 2012
- 
- ▶ **Do all sex offenders molest children?**
    - Sexual assault can be against an adult or a child.



# Reported Sex Offenses

1 / 3  
against children

2 / 3  
against adults





# Why would non-pedophiles molest children?

- ▶ 40%–50% of sex offenders arrested with child victims are not pedophilic
- ▶ Put another way.... almost half of offenses against children are committed by non-pedophilic offenders

# Sex Offenses Against Children



# Pedophiles vs. non-pedophiles

- ▶ Pedophile—sexually attracted to children
- ▶ Non-pedophiles—not attracted to children



# Pedophiles vs. non-pedophiles

- ▶ Generalization: two types of sex offenders
- ▶ Those motivated by preference
- ▶ Those motivated by situation/opportunity
- ▶ **Preferential**
  - Driven by sexual inclinations, compulsive, not usually other criminal acts
- ▶ **Situational**
  - Driven by power, anger, impulsive, antisocial, basic sexual needs
- ▶ Really a continuum of behavior, not one or the other

# Sex Offender Motivation Continuum

Offenders Driven By...

Power/Anger/  
Basic Sexual Needs

Specific Sexual  
Inclinations





# Situational/Opportunistic

- ▶ Non-pedophile Sex Offenders against Adults and Children
  - Sociopathic traits
  - Crimes of opportunity/lack of more appropriate partner
  - Drugs, Etoh, mental health issues
  - Involvement with criminal activity and past arrests for criminal behavior
- ▶ These are the 40%–50% of offenders against children who are not pedophilic

# Preferential

- ▶ Pedophilic Sex Offender
  - Driven by sexual inclinations
  - Compulsive
  - Scripted, ritualized behaviors
  - Grooming
  - Usually more intelligent, higher socioeconomic class


# Traits of Pedophilia

- ▶ Preferential
- ▶ Pedophilia: “a persistent sexual interest in prepubescent children, as reflected by one’s sexual fantasies, urges, thoughts, arousal or behavior”
- ▶ Prevalence
  - Very hard to know
  - Probably  $\leq 5\%$
  - Males  $\gg$  females (probably many more females the studies indicate)

# Traits of Pedophilia

- ▶ Most of those diagnosed with pedophilia will have another major psychiatric disorder
  - 60%–80%–Affective Disorders
  - 50%–60%–Anxiety Disorders
  - 70%–80%–Co-occurring Personality Disorder
  - 50%–60%–Substance Abuse or Dependence

# Traits of Pedophilia

- ▶ Pedophilia likely not an impulsive–aggressive personality trait...
  - ▶ More likely a compulsive–aggressive personality trait (behaviors planned to relieve internal pressures)
  - ▶ Mostly male (though there are females w/pedophilia)
  - ▶ 50%–70% have a second paraphilia (frotteurism, exhibitionism, voyeurism, sadism)
  - ▶ Typically do not engage in intercourse; most often touching
- 

# Traits of Pedophilia

- ▶ Gaining access to children
  - Child knows offender 60%–70% of the time (exceptions: violent offenses)
  - e.g. neighbor, relative, family friend or local individual with authority
  - Often intentionally place themselves where they can meet children
  - Access children by gaining trust–Grooming





# Do all those with pedophilia commit “contact” offenses (molest children)?

- ▶ No, but many think otherwise, based on false assumption:
- ▶ Anyone who is sexually interested in children would act upon that interest when an opportunity becomes available

# Pedophilia

No Criminal  
Offense

Contact Offense  
Sexual Assault/Touching, etc...

Non-contact Offense

Child pornography  
Internet related crime

Less sociopathic

More sociopathic

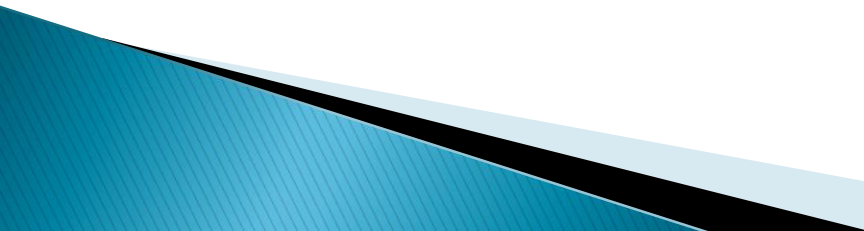
## ▶ Seto 2008 study suggests:

“Pedophiles who...pose the greatest risk of acting upon their sexual interest in children, are (those) more likely to engage in antisocial or criminal behavior of any kind—which include individuals who are impulsive, callous, and willing to take risks; individuals who become disinhibited as a result of substance misuse; and individuals who endorse antisocial attitudes and beliefs such a disregard for social norms or the laws....”

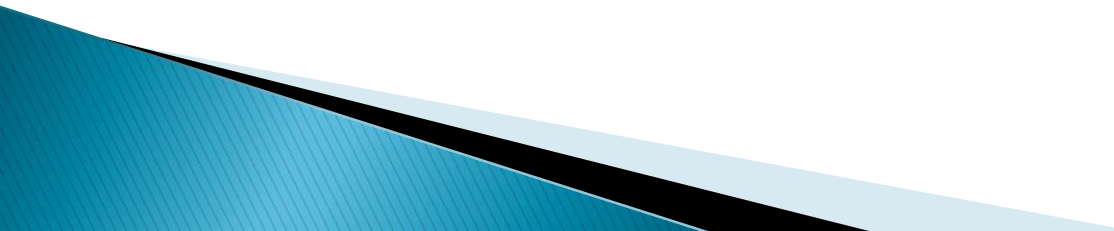
▶ **Seto 2008 study suggests:**

“In contrast, one would predict that pedophiles who are reflective, sensitive to the feelings of others, averse to risk, abstain from alcohol or drug use, and endorse attitudes and beliefs supportive of norms and the laws would be unlikely to commit contact sexual offenses against children”

# Traits of Non-Pedophilic SO

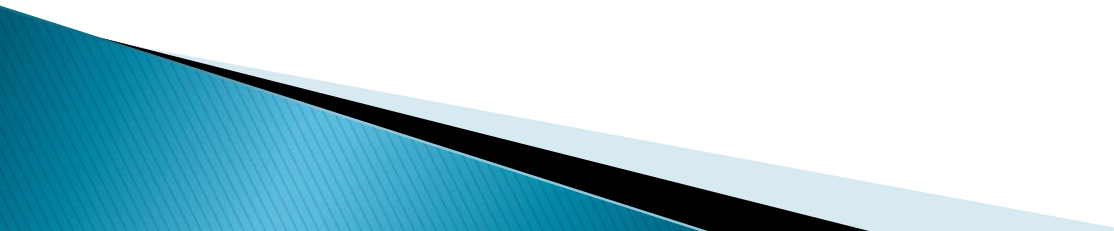
- ▶ **Opportunistic/situational sex offenders**
  - ▶ Less intelligent, lower socioeconomic class
  - ▶ Not pedophilic, though may offend against children
  - ▶ More likely violent, antisocial traits
  - ▶ More likely to commit/have committed other crimes
  - ▶ Impulsive, makes sloppy mistakes
- 

# Traits of Situational Offender

- ▶ **Regressed type**
  - ▶ Low self-esteem, poor coping skills
  - ▶ May turn to children as a substitute for preferred peer sex partner
  - ▶ Main victim criteria is availability
- 



# Traits of Situational Offender

- ▶ **Morally Indiscriminant type**
  - ▶ Antisocial, psychopathic
  - ▶ Sexual victimization of children part of general pattern of abuse in his life
  - ▶ Lies, cheats, steals—whatever he can get away with
  - ▶ Main victim criteria—vulnerability, opportunity
- 

# Traits of Situational Offender

- ▶ **Inadequate Type**
- ▶ Hardest to define
- ▶ Psychosis, eccentric personality d/o's, mental retardation, senility
- ▶ “Social misfit”
- ▶ Offends against children out of curiosity or insecurity
- ▶ Children seen as non-threatening
- ▶ Usually lack interpersonal skills necessary for grooming or coercion

# Treatment of Sex Offenders

- ▶ Need to differentiate and tailor treatment to different types of SO (pedophilic vs non-pedophilic, situational vs preferential)
  - Approximately 80% those in SOTP are non-pedophilic offenders –
- ▶ No treatment effective unless offender is willing to engage in treatment

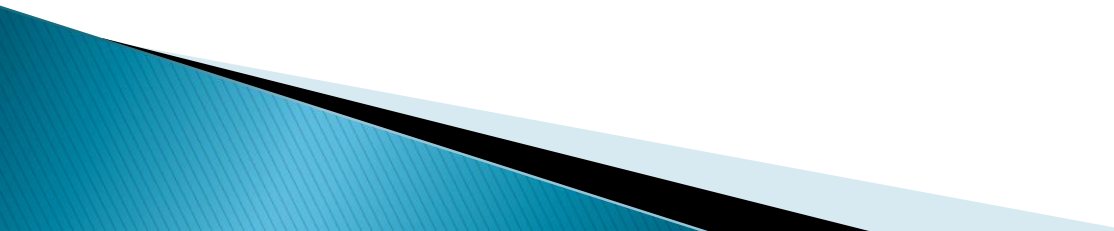
# Treatment of Pedophilia

- ▶ Assumption:
  - pedophilia needs to be thought of as a fixed trait, not something that can be changed (Axis II diagnosis)
- ▶ Goals of treatment:
  - decrease arousal
  - manage urges
  - refrain from acting
- ▶ Does not work
  - No good studies showing a statistically significant benefit to any form of treatment

# Treatment of Pedophilia

- ▶ Behavioral Treatment
  - Aversive conditioning
  - Cognitive Behavioral Therapy (CBT)
- ▶ Pharmacologic
  - SSRI's—may help OCD-type sx's, co-occurring d/o's
  - Hormones—chemical castration
    - Possibly helpful in certain cases
- ▶ Surgical—castration

# Treatment of Pedophilia

- ▶ What is the treatment of choice?
  - ▶ Relapse Prevention Model
  - ▶ A form of CBT
  - ▶ Most widely used treatment
  - ▶ Considered the only one that may be helpful (still no good studies)
- 

# Treatment of Pedophilia

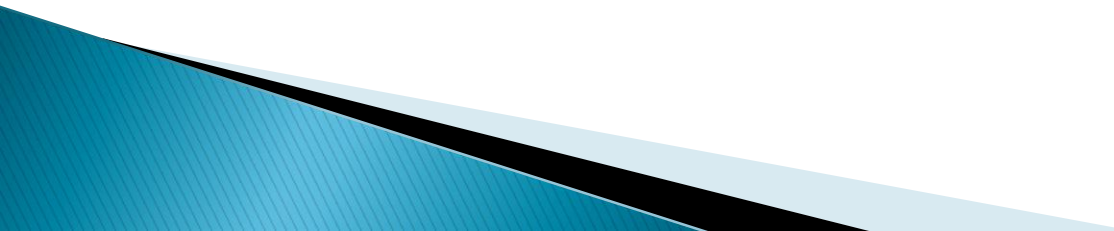
- ▶ Relapse Prevention Model
  - 1. Identify/Avoid triggers
  - 2. Identify/Avoid relapses
  - 3. Develop Strategies to avoid high-risk situations
  - 4. Develop coping strategies to use if high-risk situations cannot be avoided
  - 5. Responding effectively to relapses
- ▶ But...based on admitting one has a problem
  - Lots of reasons to deny
  - Lots of reasons to fabricate
  - Catch-22

# Treatment of Pedophilia

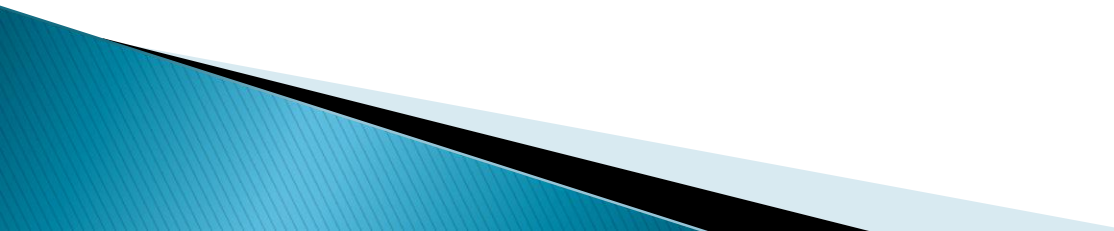
- ▶ Best practice is probably a combination of CBT (relapse prevention model) and meds
- ▶ Worth repeating: No treatment effective unless offender is willing to engage in treatment



# Treatment of Non-Pedophilic SO

- ▶ **Situational Offenders**
  - ▶ May have offended against children but usually not pedophilic
  - ▶ Those with SO against children need additional barriers to unsupervised contact with minors.
- 

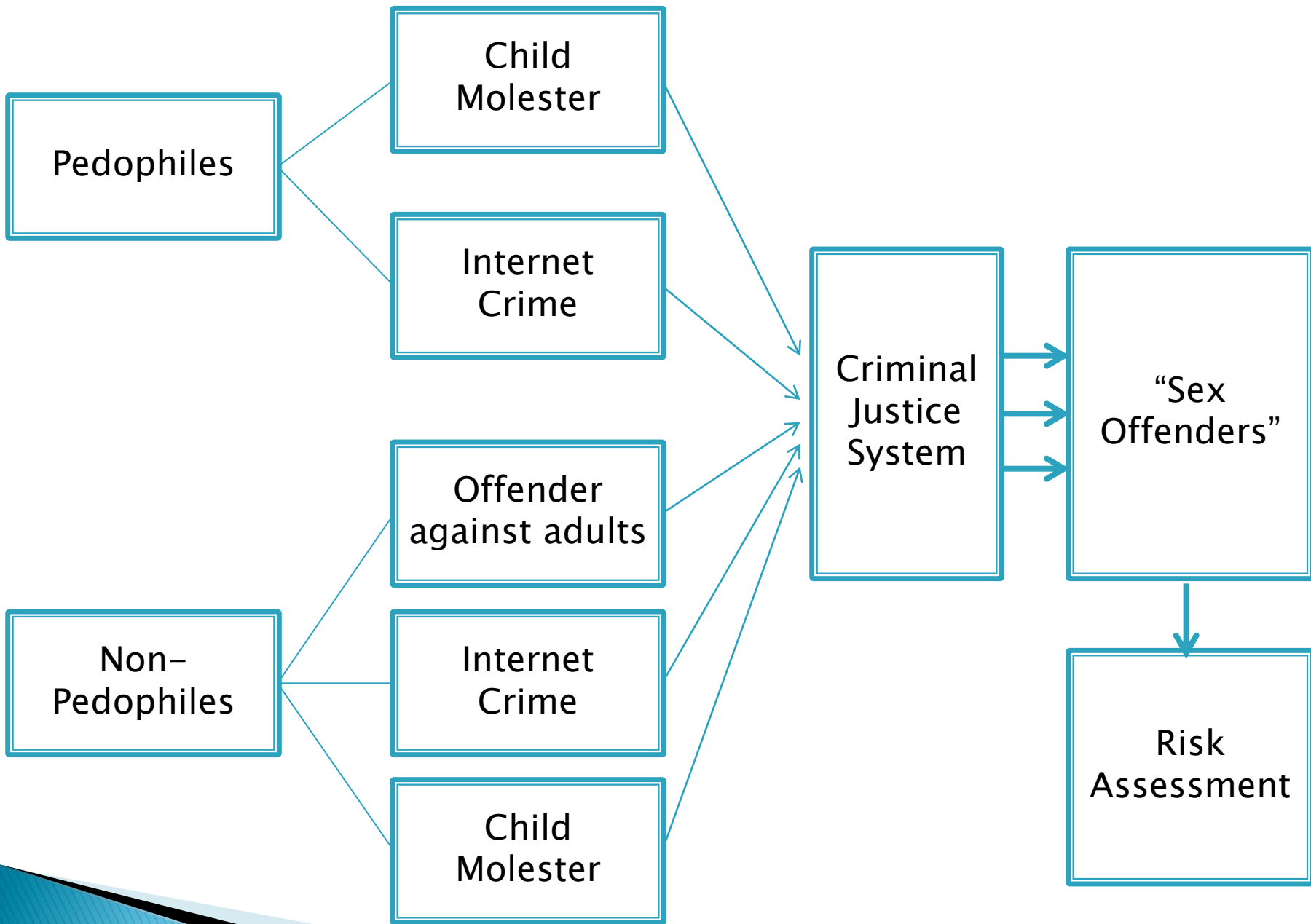
# Treatment of Non-Pedophilic SO

- ▶ Best served with certain CBT treatments that target specific antisocial behaviors:
  - ▶ Victim Impact Courses
  - ▶ Communications skills
  - ▶ Anger Management
  - ▶ Substance use treatment
- 

# The Real Issue is Re-offending



- ▶ How do we determine :
- ▶ Who will commit another sex crime?
- ▶ Who is at highest risk to commit another sex crime?
  
- ▶ By a process known as the **Risk Assessment**



# Risk Assessment

- ▶ Tools used by the Criminal Justice System to identify who has highest risk to commit another sexual crime
- ▶ They are preformed prior to release from incarceration, by clinicians for the Criminal Justice system
- ▶ Actuarial Table vs. Psychological Assessment
  - Motivation or typology
  - Engagement in Treatment
  - Community Plans

# Risk Assessment

- ▶ Clinical Social Service perspective vs. Criminal Justice perspective
- ▶ Written by former FBI agent (situational vs preferential descriptions)
  - “The purpose of this descriptive typology is not to gain insight or understanding about why child molesters have sex with children in order to help or treat them, but to recognize and evaluate how child molesters have sex with children in order to identify, arrest, and convict them.”

# Risk Assessment

- ▶ Static factors can never change on static risk assessment tool
  - Substance use history
  - Age at time of offense
  - Non sexual criminal history
- ▶ Dynamic factors do change and are not considered
  - Presence or absence of support network
  - Substance use treatment
  - Improvements in antisocial attitudes, intimacy deficits, and self-regulation through therapy

# Situational Sex Offender

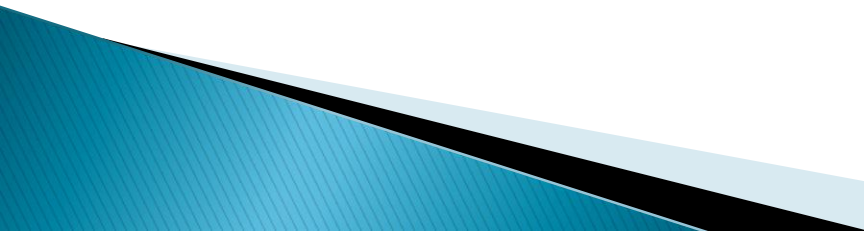
- 1. A highly antisocial, but sexually non-deviant offender who requires interventions focusing on antisocial attitudes and beliefs, lifestyle instability, association with criminal peers, self-regulation, problem solving, substance use, etc...



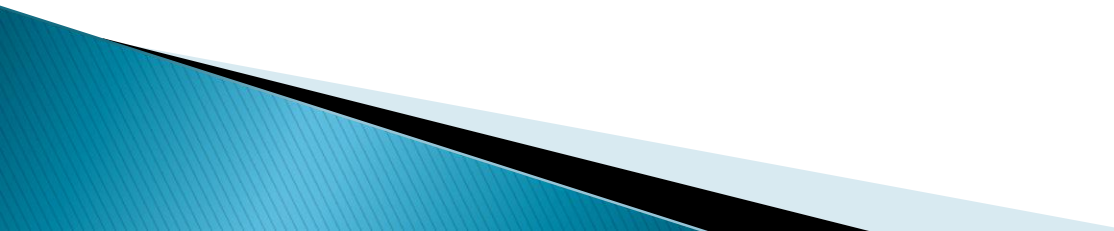
# Preferential Sex Offender

- 2. A relatively pro-social, but sexually deviant offender (pedophilia) who might derive less benefit from interventions aimed at antisocial behaviors, but could benefit greatly from treatments to increase their voluntary control over sexual arousal, sexual self-regulation, and strategies to avoid risky situations

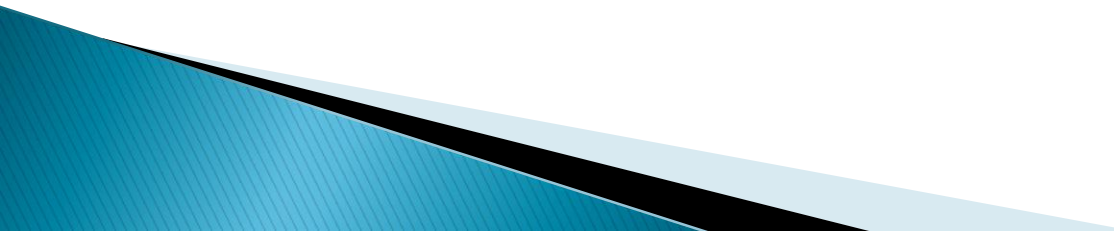
# Static Risk Assessment

- ▶ Do the risk assessments used offer real insight into who will offend again?
  - ▶ Do they allow for focus on true highest risk offenders?
  - ▶ What is the social cost?
  - ▶ Treatment– SOTP
  - ▶ Registry, Reporting and Residency Restrictions–SORN
- 

# Sex Offender Treatment Programs (SOTP)

- ▶ Programs most effective in reducing recidivism follow these principles:
  - ▶ More accurately identify risk by focusing on dynamic factors in addition to static ones
  - ▶ Provide bridges from incarceration to community
  - ▶ Allow for focus on higher risk offenders rather than “one size fits all”
- 

# Reporting, Registry and Residency Restriction Laws (SORN)

- ▶ What are they and do they work?
  - ▶ Adam Walsh ACT (AWA), Megan's Law, and Jacob Wetterling Laws
  - ▶ What are the theoretical pros and cons?
- 

# What are the SORN Laws?

- ▶ Adam Walsh Act (AWA): This law directs the Criminal Justice System to categorize SO as level 1, 2 or 3, based on that risk assessment. Sets guidelines for community registration
- ▶ Megan's Law– allows communities to publish/report SO living in neighborhoods
- ▶ Jacob Wetterling Law: residency restrictions that prohibit sex offenders from living within a certain distance of schools, churches, daycare centers, or “places where children may congregate”



# SORN Laws


- ▶ Are they effective?
- ▶ Do they decrease recidivism and prevent future sexual offenses?
- ▶ The data suggest: some restrictions that prevent opportunity to re-offend, and provide support, may decrease repeat sexual offenses
- ▶ But conversely, restrictions and their burdens that create a sense of “what have I got to lose” may actually increase re-offense

# Prescott , 2011

“The effectiveness of these laws will depend on how they are structured and applied.

If notification and its associated burdens make it more difficult for a registered sex offender to find victims, while at the same time not aggravating the risk factors known to lead to recidivism and not reducing a registered offender’s desire to avoid prison, then recidivism rates should drop.

But if these laws impose significant burdens on a large share of former offenders, and if only a limited number of potential victims benefit from knowing who and where sex offenders are, then we should not be surprised to observe more recidivism under notification.”



# Pros

# SORN

# Cons

- ▶ Reduced opportunities to re-offend
- ▶ Case management support to increase compliance
- ▶ Incentive not to return to prison
- ▶ Something to lose

- ▶ Increased restriction
- ▶ Inability to access support
- ▶ Isolation
- ▶ Reduced motivation to remain out of prison
- ▶ What have I got to lose?

“In fact, most studies investigating the effectiveness of sex offender registration and notification policies have found that they fail to meet their goals of reduced sexual recidivism”

2011 Zgoba and Levenson




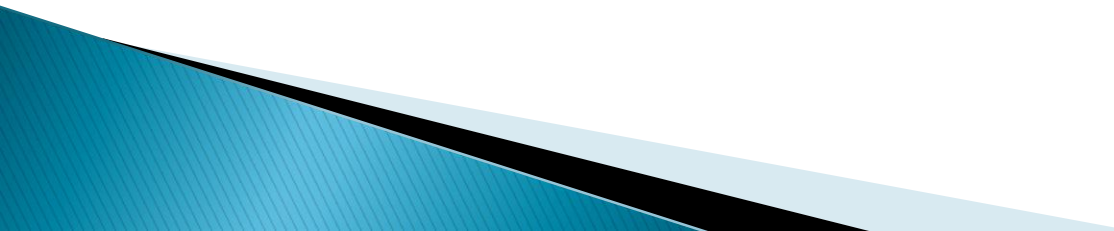
# Reporting, Registry and Residence Restriction

- ▶ SORN are designed to do two things:
  - Reduce recidivism
  - Reduce sexual offenses against children (keep us safer)
- ▶ They largely fail at both of these

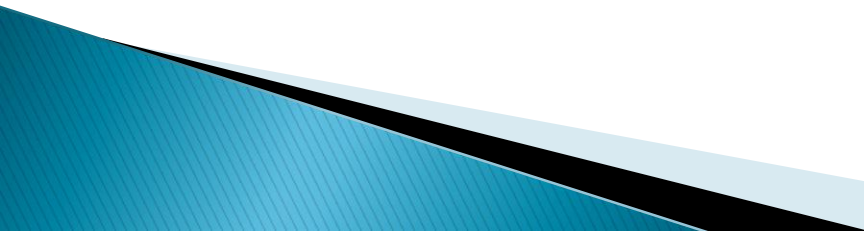
# Sex Offenders in HCH settings

- ▶ SORN create barriers to
  - Housing
  - Employment
  - Nursing Home and Long Term Care Placements
  - Community Integration
- SO status may create need for specific evaluations and referrals

# What can we do in HCH?

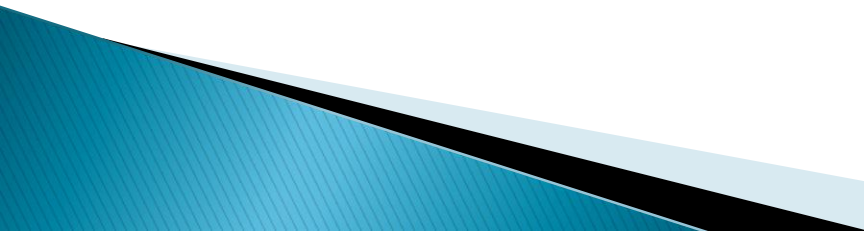
- 
- ▶ Learn about caring for clients with SO status.
  - ▶ Know the SOTP resources in your community (Just like you know the AA meetings or needle exchange locations)
  - ▶ Consider a Case Management approach
  - ▶ Consider Primary Care treatment in an Integrated setting if available
  - ▶ Establish boundaries for staff and patients
  - ▶ Be trauma informed
- 

# What can we do in HCH?

- ▶ Know the realities of SO clients
  - ▶ Ask the questions:
    - What is your level/status?
    - Are you registered?
    - How often do you have to see probation/parole officer?
    - Are you required to be in sex-offender treatment (SOTP)?
    - Even if you are not required– do you need to be in SOTP?
- 


# What can we do in HCH?

## Obtain Releases of Information

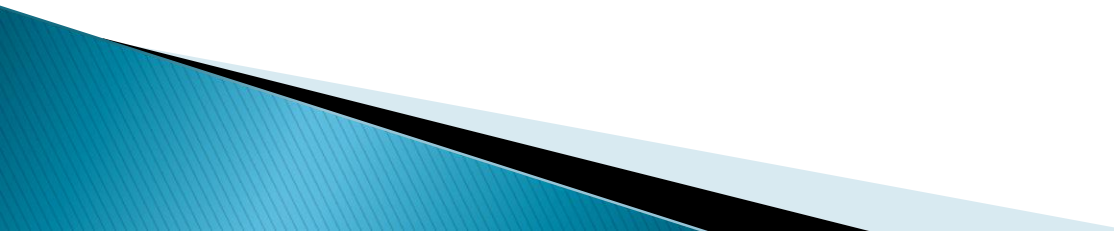
- ▶ Department of Corrections (DOC)
    - Any clinical/psych assessments/evaluations
    - SOTP– Treatment plans, Risk Assessment
  
  - ▶ Probation/parole: requirements
  
  
  - ▶ Community SOTP
    - Risk Assessment
    - Clinical Evaluation
    - Treatment Plan
- 

# What can we do in HCH?

## Clinical considerations

- ▶ Screen for Axis I and Axis II disorders
  - ▶ Treat any co-morbidities you *can* address: Depression, Anxiety, PTSD, OCD, Axis II
  - ▶ Refer to Substance Use Treatment
  - ▶ Refer to Counseling, Anger Management etc,...
  - ▶ Recommend Psychiatric Evaluation–the Risk Assessment is not a psych eval
- 

# What can we do in HCH?

- ▶ Advocate on a community level for laws and policies that correctly identify risk.
  - ▶ When SO are engaged in SOTP, Psych and SUD treatment and Primary Care, you will be in a stronger position to advocate for housing and other services.
- 

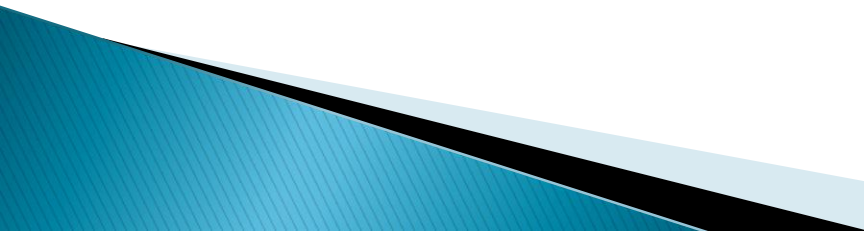
**The End**



MIAMI (Reuters, Feb. 6, 2008, Jim Loney) – *Alejandro Ruiz and his neighbors served their time for sex crimes but found themselves sleeping under a Miami highway bridge because laws meant to keep them away from children leave them nowhere else to live.*

*Their dismal tent camp, tucked under an overpass on a causeway linking Miami and Miami Beach, reeks of human waste and garbage. But it is the official home of a group of sex offenders caught in a dilemma echoed across the United States.*

*"Where are we supposed to go? The way they label you, sex offender, nobody wants you around," Ruiz said.*

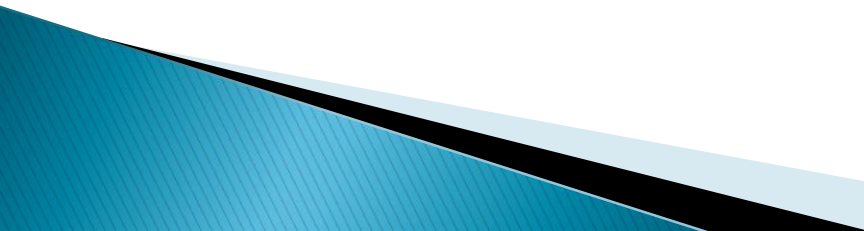


*Cities and states have enacted a hodgepodge of laws to keep sex offenders away from victims. In the Miami area, such laws ban them from living within 2,500 feet of schools, playgrounds and other places where children might gather.*

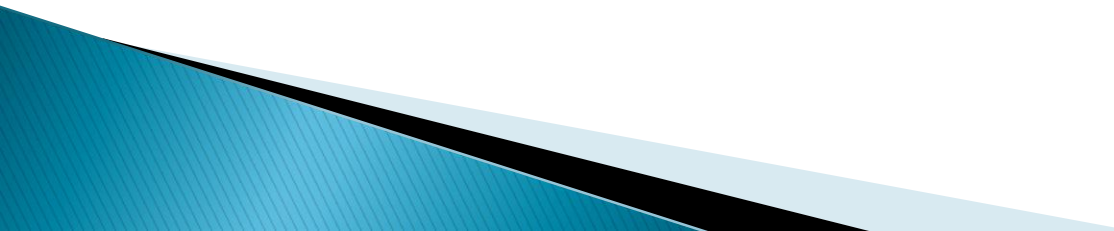
*The tiny bridge encampment, home to between 15 and 30 men on any given night, is one of the few places in the booming metropolis the paroled offenders can legally live.*

*In some cases, their probation officers have ordered them to live there. Several have it listed as their address on their driver's licenses -- "Under the Julia Tuttle Causeway."*

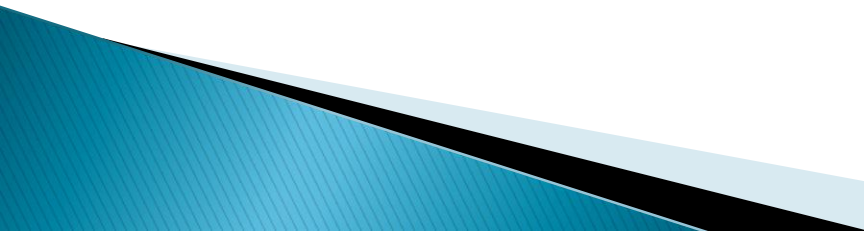
*"I am not a monster. I am not a leper," said Kevin Morales, 40, who was convicted of lewd and lascivious conduct with a 15-year-old relative.*



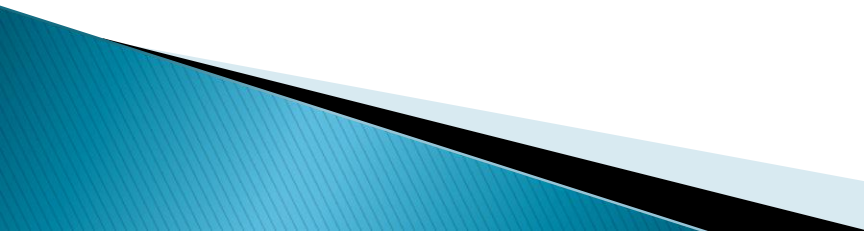
# SO Reporting Laws–Level I

- The individual is charged with a sexual offense that does not meet the Level II or III category
  - This is always an individual with no prior criminal record
  - Employment and housing barriers
  - Annual registration for 15 years
  - Level I crimes include statutory rape between adolescents of differing ages
- 

# SO Reporting Laws–Level II

- Minimum of one year incarceration, often for a crime that was identical to those of a Level I defendant, but this individual has
  - a prior criminal record or is a probation violator
  - charges related to pornography distribution (many no contact SO are level II)
  - Registration every 6 months for 25 years
  - Unable to apply for public or disabled housing
  - Legally required to tell any future employer (for the next 25 years) that he/she is a registered offender
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# SO Reporting Laws–Level III

- Any repeat Level II offender.
  - Abuse of a minor less than thirteen
  - Distribution of pornography of any minor less than thirteen
  - Lifelong registry every 90 days, for life
  - Lifelong probation in 30 states. No public or disabled housing
  - Often unable to receive long term care for illness, as they will be banned from any public, skilled nursing facility
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<b>Situational Sex Offender: (&gt;More Likely)</b>	<b>Preferential Sex Offender: (&gt;More Likely)</b>
Less Intelligent	More Intelligent
Lower Socioeconomic Status	Higher Socioeconomic Status
Personality Disorders Such As <ul style="list-style-type: none"> <li>■ Antisocial/Psychopathy</li> <li>■ Narcissistic</li> <li>■ Schizoid</li> </ul>	Paraphilias Such As <ul style="list-style-type: none"> <li>■ Pedophilia</li> <li>■ Voyeurism</li> <li>■ Sadism</li> </ul>
Varied Criminal Behavior	Focused Criminal Behavior
Violent Pornography	Theme Pornography
Impulsive	Compulsive
Considers Risk	Considers Need
Sloppy Mistakes	Needy Mistakes
Thought-Driven	Fantasy-Driven
Spontaneous or Planned <ul style="list-style-type: none"> <li>■ Availability</li> <li>■ Opportunity</li> <li>■ Tools</li> <li>■ Learning</li> </ul>	Scripted <ul style="list-style-type: none"> <li>■ Audition</li> <li>■ Rehearsal</li> <li>■ Props</li> <li>■ Critique</li> </ul>
Method of Operation (MO) Patterns of Behavior <ul style="list-style-type: none"> <li>■ Works</li> <li>■ Dynamic</li> </ul>	Ritual Patterns of Behavior <ul style="list-style-type: none"> <li>■ Need</li> <li>■ Static</li> </ul>

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