

The International Journal for Direct Support Professionals

Risky Business

By Angie Nethercott and Andria Bianchi

What do you do when someone you support is making choices about their sexual behaviour that may place them at risk?

What if those choices also place others you support at risk?

What if you believe they are being taken advantage of by others?

These are the types of questions that many direct support professionals (DSPs) grapple with daily. This article will explore these questions from the perspective of a psychotherapist and clinical ethicist, using a case example.

Mya is a 23-year-old female with a mild intellectual disability (ID) who was referred by her DSP for a socio-sexual and consent assessment due to a question of her ability to provide informed consent to sexual behaviour. Mya identifies as female and uses she/her pronouns. She lives in an apartment attached to a group home, where three other females with more intensive service needs reside. The group home residents are supported by two staff during the day and one staff overnight. Mya receives a few hours of support per week for assistance with budgeting, grocery shopping, and appointment management. She is very close with her family who live one hour away. Her family has strong religious beliefs and attends church weekly.

Editors: Angie Nethercott, M.A., RP
Chanelle Salonia, M.A., BCBA



Hands | Mains

TheFamilyHelpNetwork.ca
LeReseaudaideauxfamilles.ca



At the initial information gathering meeting with the DSP, the staff expressed concern that Mya had several short-term relationships and multiple sex partners over the past couple of years with men who did not appear to have a disability. Mya met some of the men online, others at coffee shops, and a few through acquaintances. Mya became involved sexually and/or romantically with the men shortly after meeting them, and the DSP was concerned that they were taking advantage of her. Mya was aware that her family would not approve of her multiple relationships and sexual acts, so she kept this information a secret. In the recent past, some of Mya's sexual encounters occurred in public places such as parking lots, cars, public washrooms, parks, and building stairwells. On other occasions, Mya would go to her "boyfriend's" home or bring them to her apartment, which led to safety concerns for the attached group home residents. Although the DSPs ensure that Mya always has condoms in her purse and apartment, Mya reported that they are unnecessary since most of the men did not like using them. Mya's preferred form of birth control is the Depo-Provera injection, which she received every three months. Staff

accompanied her for this injection, and they also took her to a sexual health clinic every six months to be tested for sexually transmitted infections (STIs). In addition to their concerns about Mya's physical health, the DSPs were unsure of whether she was capable of providing informed consent to sexual acts. The DSPs spoke with Mya on multiple occasions about the potential risks associated with her actions, but they worry that she may not understand, since she continues to engage in the same risky acts.

As Mya's psychotherapist, I asked her at the first meeting about her therapeutic goals. In response, Mya stated that she wants to have a long-term relationship and eventually get married but, for now, she was enjoying meeting new people and exploring her sexuality. Mya confirmed that she had difficulty requiring men to wear a condom during sex when they didn't like them. A socio-sexual assessment was completed which assessed Mya's knowledge of anatomy, women's bodies, intimacy, birth control, sexually transmitted infections (STIs), healthy socio-sexual boundaries, sexual behaviours that are against the law, relationships, and ability to give informed consent. The results of the assessment indicated that she had some gaps in her knowledge relating to sexually transmitted infections (STIs), the development and maintenance of healthy relationships, sexual behaviours that are against the law, as well as abuse prevention and assertiveness skills.

Based on the results of the assessment, a Service Plan was developed with Mya, outlining the following educational goals:

- **STIs:** Mya requires education on the primary types of STIs, their symptoms, means of transmission, prevention (e.g., female condoms), and treatment.
- **Relationships:** Mya would benefit from learning additional information about the development and maintenance of healthy relationships.
- **Sexual Behaviours that are Against the Law:** It is important that Mya be aware that sex in public places such as parks is illegal, even if no one is around.
- **Trust:** It is important for Mya to learn about who she can and cannot trust. This entails an understanding of what it means to trust someone, who is trustworthy, how one's degree of trust may change, depending on your relationship with the person, and how to recognize when trust is broken.
- **Abuse Prevention and Assertiveness Education:** It is imperative that Mya understand how to recognize and handle potentially abusive situations. One strategy used to teach this concept is through the use of the "Sexual Abuse" curriculum developed by the James Stanfield Company. It teaches people to say, "No" when someone is violating their boundaries, "Go" and get away from the person, and "Tell" someone. It is very important that Mya be given ongoing opportunities to role play appropriate responses to potentially abusive and exploitive situations rather than just verbalizing them. It is also necessary that she develop the skills to be assertive in situations where it is warranted and be reinforced for doing so, as well as how to handle pressure or coercion.
- **Consent:** Upon completing the recommendations outlined in the Service Plan, it will be necessary to re-administer the consent assessment to determine if Mya has the necessary knowledge to provide informed consent to sexually intimate behaviour or if ongoing education may be necessary.
- **Safety:** It is unsafe for Mya to engage in sexual relations with partners in public settings or in the homes of men she does not know well. In order to promote Mya's safety, she should be discouraged to go to others' homes upon initially meeting them. Instead, she

will be encouraged to meet with others in public places and bring them to her apartment if she chooses to engage in sexual relations with them. Additionally, it may be important to establish a safety plan with Mya *and* the group home staff in advance of her bringing someone home, since DSPs have a responsibility to the safety of all residents. For instance, perhaps it may be determined Mya should have a signal to communicate if she needs help; at least one male staff may need to be present when Mya's sexual partners enter the premises, and/or perhaps Mya should introduce her sexual partners to the staff before they head to Mya's private space. Ultimately, enabling Mya to make autonomous, informed decisions about her sexual relations, while at the same time protecting her from harm/keeping her and others safe is important.

Following the provision of education in the areas outlined above, the consent assessment was re-administered, and Mya demonstrated that she had the necessary knowledge to give informed consent to sexual acts. Her DSP reported Mya continued to be involved in several short-term relationships and have multiple sex partners. In response to the DSP's concerns, Mya expressed that she enjoyed it, and that it is her right to have sex with whomever she wants.

In response to their concerns about Mya's decisions, education was also provided to the DSPs in the following areas:

- **Safety:** To ensure the safety of Mya and other residents in the home, DSPs were informed to lock the door between her apartment and the rest of the house when she has guests. Additionally, it may be prudent to request the names of anyone visiting Mya's home, and to give Mya an alarm she can use to alert staff if she requires help. Call emergency services if there is a concern with which staff are unable to deal.

The quality of a person's life is correlated with their ability to connect with others on an emotionally intimate level. A person who experiences a feeling of connectedness may be far less likely to look for emotional intimacy with strangers or choose unsafe behaviours that put them at risk.

- **Rights Related to Sexuality:** In 2008, the World Health Organization stated, "For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." The 2008 Canadian Guidelines for Sexual Health identified the following sexual rights:
 - Respect for bodily integrity;
 - Choose their partner;
 - Decide to be sexually active or not;
 - Consensual sexual relations;
 - Consensual marriage;
 - Decide whether or not and when to have children; and
 - Pursue a satisfying, safe and pleasurable sex life.

It may be important to note that every *right* has a corresponding *duty*. Consequently, if sexual acts are, indeed, a right, then we may want to ask: What is the corresponding duty? A simple response to this question may be that, if Mya has sexual rights, then others may have a duty to respect these rights accordingly. However, given Mya's ID and her decision to engage in particularly risky acts, perhaps the duty of DSPs may be to support Mya to engage in consensual sex, to make informed decisions, to promote her safety, and to maintain her trust, so that she will confide in them if any concerning consequences arise from her decisions. It is also important to keep in mind that people with ID (just like those without ID) have a "right to risk", though some additional supports and risk mitigation strategies may be necessary if people are in a position of increased vulnerability.

- **Consent:** My friend Dave Hingsburger stated the following in the introduction of the Tool for the Assessment of Levels of Knowledge-Sexuality and Consent-Revised (TALK-SC-R) (2019): *Because many people with disabilities have reported being punished for engaging in any form of sexual behaviour, and have not had the opportunity to learn about sexuality and sexual mores, the idea of healthy sexuality, and the concepts of consent and reciprocation may not be viable. Therefore, the issue of informed consent is even more critical.* For these reasons, it is important that people with intellectual and developmental disabilities (IDD) have the opportunity to demonstrate the ability to give informed consent to sexual behaviour through the TALK-SC-R, as well as to receive any required education to remediate any gaps in their knowledge.

Another response to Mya may involve giving DSPs education about what consent does and does not look like. For example: Do the two individuals seek each other's company? Do their faces light up when they see each other? Do they spend time in close proximity to one another? Do they touch each other? Do they attempt to spend time alone together? Are they able to verbally express a desire to be together? Intimacy comes in many forms; no matter what an assessment of intellectual functioning says, we all have the same basic human need for love and intimacy.

Mussack (2006) identified the following requirements of consent:

- Both parties have equal levels of information regarding sexual activity being proposed
 - Understanding extends both to the act and the long- and short-term consequences of the behaviour
 - Participants must be at similar developmental levels
 - Must have equality of power
 - Equal level of understanding
 - Equal ability to refuse/participate/end the sexual activity without repercussions
- **Staff Attitudes, Beliefs, and Myths:** Sex is a moralized and value-laden topic. As such, it is important for DSPs to be aware of their own attitudes, beliefs, and biases regarding sexuality in general, and more specifically, the sexuality of the persons they support. It is equally important to recall those attitudes, beliefs, and biases when entering your workplace and remember what your role is in relation to the people you support (e.g., not to inflict your own beliefs on clients but rather to aid them in exploring and striving to achieve their personal sexual health and relationship goals.) There are several myths related to sexuality and persons with disabilities; accurate information is a necessity for anyone promoting healthy sexual behaviours.
- **Agency Philosophy and Values:** In 1981, Johnson and Kempton encouraged those supporting individuals with ID to help them cultivate sexuality in which they would not only be permitted appropriate sexual activity, but they would also be helped to enhance it. The authors stated this would be accomplished through policies, training for parents and staff, sex education for individuals with ID, and sexuality counselling. In relation to Mya, it is important that the agency supporting her has policies and procedures, a philosophy, and values in place that support the rights of the people they serve to be sexual beings and have healthy, safe, and informed relationships.

Conclusion

There are many challenges inherent to the role of DSPs, perhaps few greater than having to support someone with ID who makes risky decisions related to their sexual behaviour, potentially placing themselves and others at risk. Keeping in mind that the role of the DSP is to support and educate, it may be difficult to offer factual information rather than one's own perspective when someone you support makes choices that are different than those you'd recommend; this may be particularly challenging when there is a high probability of their choices leading to negative consequences. Worrying that you will be held accountable by the person's family, managers, health care professionals, etc. for those risky choices is also a reality. In order to maintain your client's trust and relieve some of the responsibility that you (and others) may feel about any risky sexual decisions they make, it is important to consider how to support consensual sex, promote informed decision-making, mitigate potential risks, and encourage safety.

About the authors

Angie Nethercott, M.A., is a Registered Psychotherapist with the North Regional Clinical Services at Hands TheFamilyHelpNetwork.ca, specializing in sexuality and persons with intellectual disabilities and dual diagnosis. Angie provides assessment and treatment to individuals, as well as consultation to other clinicians, families, and caregivers.

Andria Bianchi, PhD, is a Clinical Ethicist at Unity Health Toronto. As part of her role, Andria provides ethics support to Surrey Place, where she consults with staff, clinicians, clients, and families who encounter complex ethical dilemmas in the developmental sector.

References

- Canadian Guidelines for Sexual Health Education. (2008). Ottawa: Public Health Agency of Canada.
- Hingsburger, D., Nethercott, A., Palmer, L., & Salmon, C. (2019). *Tool for the Assessment of Levels of Knowledge-Sexuality and Consent-Revised*. HandsTheFamilyHelpNetwork.ca, Toronto General Hospital, Toronto, Canada, Vita Community Living Services and Mackenzie Health – Centre for Behaviour Health Sciences.
- Johnson, W. & Kempton, W. (1981). *Sex Education and Counseling of Special Groups*, 2nd Ed. Springfield, Illinois: Charles Thomas.
- Mussack, Steven. (2006). Staff and Care Provider Training in Sexuality Issues. In G. Blasingame Ed., *Practical Treatment Strategies for Persons with Intellectual Disabilities*. Oklahoma City, Oklahoma: Wood "N" Barnes Publishing

Answers to FAQ's about the journal

- 1) The journal is intended to be widely distributed; you do not need permission to forward. You do need permission to publish in a newsletter or magazine.
- 2) You may subscribe by sending an email to anethercott@handstfhn.ca
- 3) We are accepting submissions. Email article ideas to anethercott@handstfhn.ca
- 4) We welcome feedback on any of the articles that appear here.

