Journal of Advanced Generalist Social Work Practice
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In our approach to advanced generalist social work practice, we hope to capture the connections among individuals, the community, and social problems. Within this framework, a social worker understands that interventions intended to improve the lives of individuals, also impact the lives of people in the community. The opposite is also true. When the community is healthy and manages problems well then individuals thrive. Advanced generalist social work practice, with its emphasis on the interplay of micro, mezzo, and macro systems, is a model of practice that emphasizes this dynamic.

There is no standard method to identify and name each social problem that exists in a community, but generally, social problems become identified when the community recognizes that it is not an individual’s problem alone, but a problem that belongs to many members of the community. As this happens, some in the community view the social problem as urgent and begin to search for solutions. The identification of a social problem is strengthened when there is data on prevalence and incidence to support its occurrence. These numbers highlight the nature of the social problem and help to delineate certain aspects. For example, this data can define who is impacted by the problem and how it might affect the community at large.

The profession of social work has traditionally addressed several significant ongoing social problems. For example, the social work profession considers poverty and mental illness as major social problems upon which much of its professional activity is based. Other social problems tend to emerge and fade in importance. The process of identifying a social problem can be best understood by an example. Currently, in Massachusetts and across the country, there is increasing awareness of the “opioid crisis.” Newspapers report daily about specific situations where community members have become dependent on opioids. There are stories about people who progress from opioids to heroin and then take lethal overdoses and die. Police are now equipped with an
antagonist medication that reverses the impact of heroin. The Massachusetts Department of Public Health reports that in 2000 there were 338 confirmed deaths, but by the year 2015, there were 1,379 deaths of opioid-related overdoses (Massachusetts Department of Public Health, 2016). This represented an 8 percent increase from the previous year. On March 14, 2016, Gov. Baker signed a new law that limited the supply of opioid medication that can be prescribed. It also emphasized treatment parameters.

Most services are delivered by social workers at agencies which have mission statements. These can be understood as the way an agency chooses to address the social problem. Typically, social workers meet with individuals and families to address their immediate needs, but it is noteworthy that social workers in their daily work may lose sight of the fact they are also working on a larger social problem.

In the above discussion, we emphasized the relationship between individual problems and larger social problems. We can also apply this at the level of social work intervention. As indicated earlier, advanced generalist practitioners place great value on both micro and macro systems. Consistent with that view, advanced generalist practitioners utilize both direct practice and policy practice interventions for the client’s benefit. Social work interventions are most effective when they integrate multiple sources of knowledge. The person-environment construct requires the social worker to draw upon multiple ways of assessing and intervening. More specifically, the term “integrative competencies” (Vecchiolla, Roy & Mullin, 2012) highlights skill-based elements of a micro-macro practice. These competencies exist only in interaction with one another and are applied simultaneously to meet client need, as in for example, apply human rights/social justice focus and match intervention to need. Clearly, an advanced generalist social worker who seeks to skillfully intervene must have an integrated and comprehensive knowledge of individual and community problems.

In this journal, there are five articles that demonstrate the interplay of micro and macro interventions with the goal of improving clients’ functioning. In the first article, the author describes an intervention with a 5-year-old girl who has daytime anxiety and nightmares. This child was a witness to her brother’s tragic abuse. Being aware of the significant impact of child abuse as a social problem, at the individual level, the author skillfully addressed the child’s needs by reducing her symptoms.
In the second article, the author presents the case of 7-year-old Connor with severe behavioral issues and disrupted foster care placements that contributed to poor educational outcomes. Connor’s behavioral issues were finally stabilized by interventions in a unique intensive treatment program for children. Noteworthy, children with a history of multiple foster care placements are less likely to graduate from high school. This highlights the need for action. We note that it was a legislative act (Individuals with Disabilities Education Act) that provided an advocate (Educational Surrogate Parent) for Connor that ultimately led to a consistent and stable educational environment. Thus it was through the combined micro- and macro-level interventions that provided Connor with stability.

In the third article, the author describes the perspective of service providers who work with trafficked children. It is a qualitative study that looks at the report of five providers who work with these children. According to service providers, the most effective route to recovery involves building a trusting connection, family work, group work, and skill building. On the macro level, bringing awareness to the social problem of trafficked children to emergency personnel, police, and service providers makes it more likely that such children will be identified and treated. This has begun to happen with the implementation of human trafficking task forces, federal and state enforcement, and campaigns to enhance public awareness. Thus the confluence of micro and macro interventions, as described by this author, has the potential to address the significant social problem of trafficked children.

In the fourth article, the author discusses the views of service providers on sexuality and persons with intellectual (ID) and developmental disabilities (DD). The main point is that while there is growing awareness among direct care personnel that sexuality is a quality-of-life issue, there remains much resistance in the institutions that provide the care. Service providers reported that they received no professional education in matters of sexuality among the ID/DD community. At the macro level, better interventions, such as employment and community housing, have become the norm. However, there remains a need at the micro level to incorporate greater acceptance of sexual expression of persons with ID/DD, while at the same seeking channels of change on the administrative level.

Finally, in the fifth article, the author describes how drug sentencing has contributed to an enormous increase in incarceration for nonviolent offenders in the last 30 years, and how it has disproportionally impacted minority groups. The article highlights that the enactment of the Smarter
Sentencing Act in 2014 represented a major change in policy for addressing nonviolent drug offenders. The majority of Americans now oppose mandatory minimum sentences for nonviolent drug offenders, and many favor treatment for drug abuse rather than punishment. Thus, along with a macro change in national policy, there has been a societal-level shift towards micro intervention.

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References
STATEMENT OF THE PROBLEM

Anna is a 5-year-old Caucasian female who was placed in foster care through the Department of Children and Families after her infant brother was found unresponsive in his crib. Subsequently, he was pronounced dead from suffocation. The autopsy report showed an undiagnosed and untreated femur fracture, which was caused by a blunt force trauma. Based on this, Anna was placed in foster care and eventually released for “open adoption.” The foster parents were supportive and willing to advocate for her needs. At the time of this report, Anna was experiencing severe nightmares that disrupted her sleep and caused anxiety during the day following supervised visitation with her birth mother. She was diagnosed with post-traumatic stress disorder (PTSD). Anna completed a 10-week grief and loss group for children and was enrolled in Trauma Focused Cognitive Behavioral Therapy (TF-CBT). The intervention goal was to decrease Anna’s nightmares and thereby decrease her daytime anxiety.

LITERATURE REVIEW

The DSM-5 describes diagnostic features of PTSD as “the development of characteristic symptoms following exposure to one or more traumatic events” (American Psychiatric Association, 2013, p. 274). Recurrent or excessive dreams, otherwise described as nightmares, are a common symptom of PTSD. Children who are exposed to life-threatening situations, or situations that cause
fear, are often diagnosed with PTSD and frequently report having nightmares.

Imagery rehearsal treatment (IRT) is an intervention used to alleviate nightmares. Schredl (2009) stated this is the “most effective and simplest treatment strategy” (p. 1148). Once the details of the nightmare are clear, the child is asked to write about them and create a drawing that represents the dream. Next, the child is asked to add a new ending for the dream, either by writing or drawing. This approach encourages the child to take action steps based on visualization, which are intended to help her cope. Finally, the child is asked to utilize new strategies for five to 10 minutes a day for a two-week period.

Although several studies have demonstrated the effectiveness of IRT for the reduction of nightmares in children with PTSD and sexual trauma, most research has been conducted with adults (Simard & Nielson, 2009; St-Onge, Mercier & De Koninck, 2009). More research is needed to establish the effectiveness of IRT with children (Krakow, Hollifield, Johnston, & et al., 2001; Krakow, Johnston, Melendrez, Hollifield, Warner, Chevex-Kennedy, & et al, 2001; Krakow, Kellner, Neidhardt, Pathak, & Lambertz, 1993; Krakow, Sandoval, Schrader, Kuehne, McBride, Tau, & et al., 2001). Based on this literature review, the hypothesis is as follows: The implementation of IRT and coping strategies will decrease Anna’s daytime anxiety.

INTERVENTION AND MEASUREMENT

The overall goal of treatment was to reduce Anna’s daytime anxiety. The symptoms of her daytime anxiety consisted of wetting her pants, staying in the same room as her foster parents, and complaining that she was not feeling well physically. She also struggled with attendance at school and some behavioral infractions. The source of her anxiety was believed to be her nightmares. The content of her nightmares continued to expose Anna to her original trauma. She frequently dreamed of her brother dying, her mother hitting her in the leg, hiding in dark closets, and being placed in foster care.

Anna met with a social worker once a week for one-hour sessions over a six-week period in her foster home. This social worker engaged Anna in IRT treatment. To measure the success of treatment, several steps were taken. Anna’s foster parents completed a standardized pre-test and post-test using the Children’s Sleep Habits Questionnaire (Owens, Spirito & McGuinn, 2000) to measure if her overall sleep habits improved. This questionnaire assessed Anna’s routine sleep habits. It asked about bedtime routines, the number of times she awoke, and her experiences returning to sleep. It also asked
questions about teeth grinding, snoring, and attitude upon wakening.

During the week, Anna’s foster parents helped her keep a nightmare journal. They recorded the content of her dreams, allowing Anna to draw a picture of her dreams while the foster parents recorded them. This facilitated tracking the specific content of her dreams. The foster parents also recorded the number of times she awoke during the night and how long it took her to fall back to sleep.

Anna completed a rating scale every morning describing her distress level upon wakening. The scale rated her distress from 1-5 using a smiley face chart and a small description regarding her emotional reaction to her dreams the previous night. For example, “1” represented that she had a happy dream, and a “5” represented a distressed dream.

During each session with Anna, I reviewed her drawings and journals. We then re-wrote her dreams to have happier content and a safer ending. The foster parents and Anna re-read the happier dreams at least once a day. Anna then drew pictures of the new scenes. The foster parents encouraged Anna to think about coping that helped her to feel safe. When possible, they incorporated those coping mechanisms into their daily living.

**METHODS**

Prior to the start of the study, a training session was held to ensure understanding of intervention and measurement. An A-B single system design was used. Consecutive, daily measurements were taken. A Likert scale was created to record these measurements. Baseline measurements were taken for two weeks (day one through 14) at which time only TF-CBT treatment was being utilized. The intervention phase was conducted for four weeks (days 15-42). During this phase, IRT and various coping strategies were introduced on a daily basis. A pre-test and a post-test were provided to help validate the results.

**RESULTS**

Anna’s foster parents implemented various coping strategies requested by Anna. For example, the foster parents installed door alarms, and nightlights throughout the house. Daily Likert scale measurements were obtained during this study (see Chart 1). During baseline, a rating of 5 was found to be the modal response. This indicated that on eight out of 14 days she experienced nightmares. The baseline results are evidence of Anna’s high level of distress.
During the intervention phase, the modal response was 3 (eight out of 28 days), indicating that her dreams were moderately distressing. Anna experienced two days of happy dreams, which she had not experienced before. Results consistently show that Anna’s distress level decreased during intervention (see graph below).

Intervening factors influenced Anna’s level of distress. As plotted on the graph at days one, 14, 24, and 35, Anna’s level of distress was triggered by visitation with her mother, and a peak in the line coincided with each intervening factor.

Graph 1- Anna’s Daily Dream Distress
Overall, however, the pre- and post-test administered to the foster parents confirmed that Anna’s distress level was reduced. Throughout the study, Anna’s bedtime routine remained consistent, both in the pre-test phase and after the intervention was complete. However, the pre-test revealed that at bedtime, she was restless, needed to sleep with someone, and frequently awoke during the night. The post-test results indicated that Anna was receiving a more restful night’s sleep, confirming a decrease in distress.

CONCLUSION

In conclusion, it is important to acknowledge that traumatic life experiences can lead children to have distressing nightmares, which impact their daily functioning. The results of this study suggest that in a 5-year-old female with severe PTSD-related nightmares, the use of IRT, in combination with TF-CBT and coping strategies, was associated with a decrease in nightmare distress levels. The results show that after the intervention, Anna attended school more regularly and did not have any behavioral outbursts in class. While she still displayed some symptoms of anxiety, her overall daily functioning greatly improved. At the conclusion of her treatment, Anna agreed to continue with IRT.

Since single-system studies are based on the responses given by one individual, it is impossible to conclude that these results can be generalized to other children. In addition, environmental factors may influence results. Still, these findings suggest that it was the combination of the three treatments together that resulted in a reduction in distress.

References


Massachusetts children in foster care placement are twice as likely to fail the Massachusetts Comprehensive Assessment System (MCAS) as compared to their peers. They are three times as likely to receive special education services, and almost half of all children in foster care in the state of Massachusetts do not graduate from high school (Fostering Media Connections, 2011). The Massachusetts Department of Children and Families (DCF) Quarterly Report (Felix, Taylor & Walter, 2013) for the third quarter of fiscal year 2013 showed that there were 8,947 children in foster care placement in the state of Massachusetts. This included 7,728 children under the age of 18. There were 1,669 young adults between the ages of 19 and 23 who remained in foster care. When addressing educational reform, it is important to address the needs of both children under age 18 and young adults in foster care.

In 2014, Massachusetts DCF was highly scrutinized in the wake of the death of a young boy in its care. As a result of this death, the state of Massachusetts undertook a close look at its foster care system. The Child Welfare League of America concluded that educational reform was an area of concern and in need of further study.

Foster children in the school system often have no consistent advocate or voice. The state of Massachusetts has one of the highest-ranked educational systems in the country. A report by the organization Fostering Media Connections (2011) noted that Massachusetts public school students outscored students in other states on the SAT in 2010. Since 2005, fourth and eighth graders in the state scored the highest on the National Assessment of Educational Progress exam. It is clear, however, that foster children are not
reaping the benefits of this otherwise successful educational system as they consistently perform at lower academic levels. It is, therefore, important to examine why this is occurring, and what type of reform might be implemented to ensure foster care children are performing on the same level as their peers.

Children in foster care placement face a seemingly endless series of challenges and barriers to success. Having been removed from abusive and/or neglectful homes, these children are then confronted with a lack of permanency in placement and general instability that greatly impacts their education. The purpose of this paper is to highlight the need for educational reform. The case of Connor will be used to illustrate the complexity and difficulty of meeting educational needs for children in foster care. Following that, several efforts to enact legislation intended to address the needs of children in foster care will be discussed.

CASE STUDY

Connor is a 7-year-old boy who currently resides in an intensive residential program in Massachusetts where he also attends school. Connor currently has a diagnosis of post-traumatic stress disorder, attention deficit hyperactivity disorder (ADH), sensory processing disorder, and possibly autism. He has a complex medication routine, intended to address the symptoms of these diagnoses.

Connor was removed from his father’s care by DCF in July 2013 after repeated reports were filed alleging neglect and physical abuse. DCF had concerns regarding inappropriate discipline of Connor, and his father’s difficulty managing his own anger while parenting. Connor was initially placed in a residential program where he resided until December 2013. He was then placed in an intensive foster care (IFC) home. In January 2014, Connor was hospitalized due to increasingly aggressive behaviors and he remained hospitalized until the beginning of March. Although he was able to return to his original IFC home, this placement was disrupted and Connor moved to another IFC home in May. Then again, this placement was also disrupted due to Connor’s behavioral needs and he was put in a residential program in June. Connor was then hospitalized again in July and was eventually placed in another residential program in October 2014. Connor resides in that facility today. It is a unique intensive treatment program for children under age 13.

Connor has an assigned Educational Surrogate Parent (ESP), who has an advocacy role thought by many legislators and educational professionals as
key to ensuring educational success for children in care. ESPs exist due to a federal special education law, the Individuals with Disabilities Education Act (IDEA), which mandates that states protect the rights of children who are in the custody of the state, and who have special education needs. These surrogates are required to be independent, and DCF social workers cannot be appointed as a child’s ESP (Roche, 2013). Connor also has a detailed Individual Education Plan (IEP), and although he attends school in his residential program, the IEP from a previous educational setting remains in place. IEPs are typically created by the child’s original school district where they resided with their family of origin and attended school. Funding for the child’s education comes from the district of origin. Failure to transfer or update IEPs as foster care children move to new placements and schools is an ever-increasing problem. Some foster parents are not aware of the existence of educational coordinators, and therefore, they do not access valuable educational resources nor advocate for a child in their care. Foster parents may not have an understanding of the sometimes unique educational needs of foster care children, the complexity of IEPs, and the policy and legislation on this topic.

In the classroom, Connor has a high level of need. He becomes overwhelmed in groups of more than three, displays aggressive behaviors in class, and requires two staff members with him during the school day. He is reported to be a full year behind in reading. Connor’s relative stability is noted as being “fragile.”

Connor’s case highlights many of the educational issues children in placement face. He has very complex educational and behavioral health needs. It was over a year before his educational and residential settings were stabilized and consistent, and he is currently at risk of being moved to a less costly public day school setting where the progress and stability he has achieved may be disrupted. Connor’s educational surrogate and other caseworkers are fighting for him to remain in his current placement. Although Connor is at the extreme end of the spectrum in terms of need, the barriers he has faced in educational stability and permanency are common to children in care.

CURRENT LEGISLATIVE EFFORTS FOR REFORM

In recent years, the Massachusetts Legislature has attempted to enact educational reform for foster care children. In 2009, Massachusetts Sen. Anthony Galluccio introduced Senate Bill 41 (S.41), titled “An act relative for
educational stability for foster children.” The bill called for the commissioner of DCF to work in conjunction with the Office of the Child Advocate and the Secretary of Education to develop a statewide approach to ensure educational stability for foster care children. The bill had seven provisions, including calling for federal, state, and local funding for student transportation; the necessity to assign an educational advocate to each child in placement; the implementation of procedures which would ensure prompt transfer of student records; and other measures to promote educational stability. These measures were intended as a direct intervention on the poor educational outcomes for foster care children in this state.

One additional benefit to the bill was that it would have extended the McKinney-Vento Homeless Act to apply to children in foster care. Included in this federal act was a provision providing transportation to the child’s school of origin regardless of the location of the new school. Although this section of the act is intended to cover only children awaiting placement, it has been utilized in some states, including Massachusetts, to include those already in placement. The act was funded on the state level by federal grants, which were disbursed after certain conditions were met.

The next substantial legislative attempt at reform came in a Massachusetts House Bill 85 titled “An act relative to children in the care, protection, and custody of the Commonwealth.” House Bill 85 replicated much of the material in S.41, but was more expansive and called for a significant list of reforms. These included making DCF children under age 3 eligible for early intervention services, assurance that school days missed by children for court or meetings regarding their placement would not be counted against the child, and a two-day timeline assigned for transfer of school records. The bill also called for a special curriculum with an emphasis on culturally relevant life and interpersonal skills (Commonwealth of Massachusetts, 2016). Neither S.41 nor House Bill 85 were passed (Commonwealth of Massachusetts, 2016). It should be noted, however, that despite the lack of legislative changes, DCF instituted reforms that include automatic referrals for early intervention services, and extensions of McKinney-Vento.

ADDITIONAL ATTEMPTS AT POLICY REFORM

In addition to Fostering Media Connections (FMC), there are other groups working to call attention to the issue of educational stability for foster care children and attempting to influence legislators. In 2014, the Treehouse
Foundation, a nonprofit advocacy group located in Massachusetts, held its annual meeting titled, “Re-Envisioning Foster Care in America,” with a focus on the educational needs of foster care children. The conference was attended by social workers, representatives from DCF, politicians, and community activists. Members of the Treehouse Foundation continue to advocate and lobby for the educational interests of foster care children because, in their words, “It is our collective responsibility to reduce the number of children who will end up homeless and jobless because they did not have a family available to them to provide the guidance and support necessary to succeed” (Treehouse Foundation, 2014).

The Home for Little Wanderers in Boston is another organization dedicated to policy work involving foster care and at-risk children. The Home for Little Wanderers tracks statistics about the educational experience of foster care children. For example, they noted that while 24 percent of the general population holds a four-year college degree by age 26, in comparison, only 2.5 percent of foster care children who have aged out of care hold a four-year degree (The Home for Little Wanderers, 2014). Organizations such as FMC, the Treehouse Foundation, and the Home for Little Wanderers continue to work diligently to influence policy and improve the state of education for foster care youth in Massachusetts.

AUTHOR’S REFLECTIONS ON PUBLIC POLICY

My proposed educational reforms mirror the previous policy work undertaken by others; however, I would suggest more aggressive and widespread measures be taken. My first proposed reform would be the appointment of independent regional staff to act as educational advocates for foster care children instead of hiring in-house staff members to serve in this role. For example, in one Massachusetts town, 6 percent of children in the school district are in foster care. A Huffington Post article described the work of an educational advocate who was hired using state grants. She worked as a school-to-home liaison, ensuring children in care had a stable environment in both their school and home placements (Heimpel, 2011). She fulfilled a role that would be beneficial for every school.

My next suggestions require funding from DCF, the local child welfare agency. In order to better guarantee educational success for foster children, stability in placement should first be achieved. Kinship placements with family are often a foster child’s best chance at permanency. Additional state
money for DCF could be used to increase foster care stipends, ultimately promoting the success of kinship placements. This financial assistance could also benefit non-kinship placements as well. If children have permanency in placement they can remain in the same school, a key factor to academic success.

Older children are perhaps the most overlooked in the system. They frequently age-out, never having achieved permanency. As noted previously, only half of foster care children in the state graduate from high school. A very small number are able to complete college. By helping with college applications for this group of children, an educational advocate could make an enormous difference in their achieving success. Increased training of social workers with adolescent clients in DCF on the educational needs of older children would also be beneficial for teens and young adults in care.

CONCLUSION

The Council on Social Work Education (CSWE) lists as core competencies the advancement of human rights and social and economic justice, as well as engagement in policy practice to advance social and economic well-being, and to deliver effective social work services (CSWE, 2016). Both on the national and state level there is not enough being done to facilitate well-being for foster care children, particularly in terms of education. Even in the state of Massachusetts, typically a state in which students perform better compared to other students across the country, foster children are performing poorly. High school graduation rates have reached an all-time high of 80 percent nationally, but only 46 percent of foster kids in this state will earn their diploma. The statistics frame the problem.

An educated populace is in the best interest of society, and I would argue that we have a greater duty to make certain foster care children are educated. These children are removed from their families, often times for neglect or abuse, and then frequently shuffled from placement to placement. Most repeatedly transfer from school to school where records are lost and IEPs are not consistent from school to school. Foster children miss school due to moves, court, lack of transportation, and other issues. Education may be the only chance these children have to break cycles of poverty and abuse, and we are failing them.
References


The purpose of this study was to explore the experience of working with survivors of domestic minor sex trafficking (DMST). According to the Victims of Trafficking and Violence Protection Act of 2000, sex trafficking is the “recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” (United States Department of State, 2000, p. 8). Furthermore, sex trafficking of a minor has occurred when the “commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such acts has not attained 18-years-of-age” (p. 8). The exchange of sexual services is exploitation of the minor due to the power differential. Traditionally, much attention is given to human rights violations in other countries; however, child trafficking occurs in the United States at an alarmingly high rate. In the United States, there are between 100,000 and 300,000 underage girls being sold for sex each year. The average age of entry is approximately 13 years old (Trafficking, n.d.).

As social workers serving today’s youth, the odds of working with a survivor of sex trafficking is high. The exploitation of minors is widespread in society, and domestic sex trafficking is prevalent across the nation affecting different types of communities. Any child may be at risk. However, it is important to note that perpetrators of sex trafficking tend to target the most vulnerable populations, the same disadvantaged populations with whom those in the social work profession traditionally work. When providing services to children who have been trafficked, social workers come into contact with
children who are most likely distressed and attempting to cope with multiple trauma symptoms. There are two foci when working with these youth: child protection and recovery/empowerment, both of which will be explored as a part of this study. Additionally, the issue of secondary trauma and the importance of self-care will be discussed.

I became interested in this problem based on my work with adolescent females who have been adjudicated. My work takes place in a residential treatment facility for girls who have been placed on parole. Recently, I have noticed there are greater numbers of young women who are entering the residential care facility with a history of sex trafficking. However, it is essential to note this is not due to an increase in the numbers of youth being trafficked, but a shift in awareness about trafficked children.

As I move forward to focus on clinical work with this population, I find myself struggling to understand how best to work with these youth, and how working with victims of sex trafficking might affect my own well-being. By examining others’ experiences with this population, I hoped to gain a better understanding of how this work might inform my career as a practitioner. In completing this study, I knew that there were many people who enter the field of social work who may never have encountered this issue before and who may have found themselves questioning how to proceed. I also knew that the issue of child sex exploitation was very difficult to comprehend. I hoped this study would inform future practitioners who work with survivors to be aware of how to work with survivors, and how to develop an awareness of their personal feelings towards these clients.

**REVIEW OF THE LITERATURE**

Research into the number of cases of domestic minor sex trafficking in the United States highlights some challenges which may be attributed to a lack of awareness and terminology needed to properly identify and investigate such cases (Salisbury and Dabney, 2011). Mitchell, Finkelhor, and Wolak (2010) wrote about the challenge of defining the problem. The authors conducted a quantitative study focused on the incidence and characteristics of juvenile prostitution. They estimated in a one-year period that there were 1,450 arrests in the United States. In cases of juveniles being arrested for prostitution, they found that 53 percent of cases met criteria to be considered victims. This conclusion highlighted the importance of language, especially the discrepancy between the meanings of “prostitution” versus “trafficking.”
This has negative implications as data collected from police records indicated that 31 percent of youth were still labeled “delinquent” rather than as victims. In this regard, the way the problem is defined legally has the potential to lead to different adjudications. The conclusion, therefore, is that misnaming the problem may be a result of poor training and awareness.

Importantly, the language used by service providers on the issue of minor sex trafficking can easily lead to limited preparedness to respond to needs of the victims. (Hardy, Compton, & McPatter, 2013; Rand, 2009). When children are described as prostitutes this leads to a misconception that they are not victims. It is vital that exploited children be viewed as victims and be treated as such. When talking about minors who have been trafficked for sexual exploitation their “choice” to commit prostitution can be viewed as “voluntary slavery.” There may be the illusion of choice, but in fact there is an overwhelming level of coercion behind their entry into prostitution. Salisbury and Dabney (2011) advise that “regardless of the name...it comes about in a relationship of unequal economic, cognitive, and psycho-social power” (p. 6). Such a relationship makes the exchange between the trafficker and the trafficked child an exploitive relationship and should be viewed as such.

Rand (2009) also notes the importance of providing services to these young women that builds on their strengths, and addresses their mental, physical, and emotional health. She urges that practitioners realize the resilience of these young children and understand that they can be the strongest advocates for legal and systemic reform. Such reform must include trauma-specific work with survivors, empowerment, and a focus on survivors’ recovery. In Hardy, Compton and McPatter’s (2013) qualitative study, they highlight that trauma-specific work is a necessary component of treatment as survivors of sex trafficking typically develop symptoms of trauma as a result of forced subjugation and separation. The trauma is compounded with isolation and dynamics of captivity that create a unique set of needs for these young children. Highlighted, as well, was the notion of misidentification as a major barrier to treatment.

Also essential to effective treatment is noting the importance of looking at the overall functioning of individuals who have been trafficked. Wilson and Butler (2013) have identified many general characteristics of people who may have been trafficked. They note that they typically lack financial resources, have limited education or alternate skills, and have few family or friends for support. Many of these children lack educational qualifications and job skills. Even if attempts are made to return to school or secure alternate employment,
maintaining this new life may be difficult due to the physical and psychological problems associated with previous victimizations. If such needs are not sufficiently addressed, trafficked youth may fail in their efforts to achieve a life free of exploitation. There is an overwhelming need to focus on the circumstances that draw youth into commercial sexual exploitation. Wilson and Butler (2013) noted the most common circumstances that trafficked youth find themselves in is homelessness and having a history of maltreatment. Mitchell, Finkelhor, & Wolak (2010) explored how many children who are victims of trafficking have either distanced themselves from conventional supports, or more often than not, the perpetrator has created this distance.

Current research related to domestic minor sex trafficking focuses primarily on risk factors and the pathways to becoming a victim. There are gaps in the literature about effective practice with trafficked children as well as how interventions with this population impact service providers. The voices of service providers working with these children has the potential to inform future practice.

**METHODOLOGY**

**Procedures**

This study was implemented using a heuristic approach where there is a “process of internal search through which one discovers the nature and meaning of experience” (Moustakas, 1990, p. 9). The study sample size was five. Convenience sampling was used for recruitment due to time constraints. The sample consisted of two administrators from the state of Connecticut Department of Children and Families, two advocates working for not-for-profit organizations targeting domestic minor sex trafficking, and a registered psychiatric nurse. Interviews took place at convenient locations for the co-researchers in order to promote comfort. The interviews lasted approximately 30 minutes each.

For this study, the term “co-researchers” is used for people who were interviewed. At the beginning of the interview, co-researchers were provided with consent forms to inform them that their participation was voluntary and, as such, they could decline to answer any questions with which they were uncomfortable. They could also end the interview at any point. As part of the heuristic process, the first phase of the study consisted of identifying the focus of the inquiry and then coming to an understanding of the issue of domestic minor sex trafficking. The interviews were semi-structured in order to stay true
to the heuristic method. Co-researchers were asked one demographic question about the length of time they had worked with survivors of sex trafficking. They were each asked four core questions:

- How do you view your role of child protection when working with survivors of sex trafficking?
- What are your suggestions on how providers can help the recovery and empowerment process?
- How does this work impact you?
- How do you take care of yourself?

The semi-structured approach was intended to facilitate an open conversation flow and provide the opportunity for the co-researchers to ask follow-up questions. In this heuristic approach, “one is encouraged to permit ideas, thoughts, feelings, and images to unfold and be expressed naturally” (Moustakas, 1990, p. 39). Once interviews were completed, there was a time period of incubation, which according to Moustakas “allows (the researcher) to continue to clarify and extend understanding” (1990, p. 29) of the role of service providers with victims of sex trafficking. Such an understanding allowed for themes to be identified. This led to the development of the presentation of data.

Sample

Five co-researchers were interviewed for the purpose of this study. All five co-researchers were women who work in the area of domestic minor sex trafficking. Four co-researchers were employed in the state of Connecticut and one was employed in the state of Massachusetts. Of the five co-researchers, two worked with the Department of Children and Families and served as trainers on the issue of domestic minor sex trafficking to area providers. Another two co-researchers worked as advocates and mentors, and in this capacity coordinated “My Life, My Choice Groups” to area school-age children to whom they provide education about sex trafficking to participants. The fifth co-researcher was a psychiatric nurse working in a residential facility for adolescent girls. In her capacity she completed assessments as well as facilitated a “My Life, My Choice Group” with residents. The following table depicts the demographic information obtained from each co-researcher. However, it is important to note that a majority of co-researchers (four out of five) stated that they had worked with minors who had been trafficked as long as they had worked in the social welfare field. However, the time noted below is the length of time they had worked in the field with an awareness of the issue.
Five themes were identified after the period of incubation. These included: language, support and empowerment, individualized treatment, awareness, and self-care. The following sections reflect the main points made by the co-researchers.

**Language**

The importance of appropriate language, such as using the term “trafficking” versus “prostitution,” or “victim” rather than “prostitute,” was evident in all five interviews. Co-researcher E discussed the importance of providers being careful of the language they use when working with children who have been trafficked. The use of appropriate language is important to create a level of awareness as well as to “shift the lens” to view children as victims in need of services rather than delinquents who need to be remanded for their crimes. Co-researcher A described how before there was a level of awareness of domestic minor sex trafficking, children who exchanged sex for material goods were not seen as victims. Instead, they were described as “engaged in hypersexual behaviors” or they were “acting fresh” and “grown.” As a result, providers were not seeing that these children were “being used as a commodity,” and were not treating the trauma they had endured.

The use of non-stigmatizing language when working with children who have been trafficked may also help the children themselves understand they have been victimized and subsequently seek help. Some children do not realize that they have been trafficked “because they don’t have the language” (co-researcher E). They may not realize the level of coercion behind their “choice” to prostitute as a result of the grooming process that many traffickers use. Typically, children are trafficked by someone they know and trust. When a child is identified as a victim of trafficking, it is not unusual for the child
to not understand or believe they have been victimized. Typically, victims demonstrate a sense of shame, low self-worth, and are eager to feel loved and accepted (Goldblatt-Grace, 2009).

Many children who are lured into the world of sex trafficking are seen as the “throw away kids” (co-researcher C). They have been preyed upon by pimps, most commonly through measures of seduction. This process leads to many children feeling a sense of loyalty to their captor, and as such, cannot see themselves as victims. Additionally, victims may lash out at providers attempting to help them and be insistent that they are fine in their current situation. This response from victims stems from their identification with their captor as a means of emotional and physical survival. However, once they begin to learn the common terminology they may begin to realize they have, in fact, been victimized and can begin the healing process.

Support and Empowerment

There was a general consensus among the co-researchers that when working with children who have been trafficked one of the most important components of the healing process was providing the child with a consistent helping relationship. Co-researcher D described the necessity of building a trusting relationship with the child, as many children who have been victims of sex trafficking have “never had anyone to trust.” The overwhelming themes of abandonment, abuse, and neglect result in these children feeling isolated and lacking in connections with others. These children present with a need to develop a sense of belonging. This can be successfully accomplished simply by being present and available for the child. The co-researchers agreed that it was necessary when working with trafficked children for the provider to take an active role in helping that child to establish and build self-esteem.

Children who have been exploited need a supportive response from providers who are non-judgmental (Goldblatt-Grace, 2009). “Working with these young women, it’s important to realize they don’t need to be rescued, appreciate their resilience” (co-researcher D). These children have typically overcome several instances of being victimized, but have survived and should be seen as the survivors they are. Co-researcher A described the importance of empowering children who have been trafficked, and that to do so, providers must “learn and explore the strengths” of the child with whom they are working.

It is important not to lose sight of the fact that children who have been victimized still overwhelmingly “know what’s right for them” (co-researcher D). In order to feel supported and help these children become empowered to take
their life back, they must be offered choices and given the opportunity to make their own decisions. This may be difficult in cases where children choose to “stay in the life.” This can also be described, as it was by co-researcher A, as “forcing people into a box of what’s appropriate or not.” Although there may be intense feelings on the part of the provider working with these children, it is necessary to set feelings aside and work with the children “where they are at.”

**Individualized Treatment**

According to co-researcher B, “treatment must vary at the stage the child is at.” Co-researcher D explained that providers must understand that “when working with children who have been trafficked, most are out by force, not by choice.” That is, many of these children did not leave “the life” willingly, but as a result of circumstances, such as their trafficker being incarcerated, being placed in residential services, or parents becoming aware that their child is being trafficked, and taking precautions for the child not to return to “the life.” It is important for providers to understand this and not move too fast.

It is necessary to keep treatment individualized. As co-researcher A analogized “you don’t treat an addict purely for substance use.” Trafficking victims, just as with any person, are parts of multiple systems, and all these systems must be addressed. Effective treatment consists of wraparound treatment, including, but not limited to, family work, group work, skill building (social and life skills), and employment services.

**Awareness**

Until recently, domestic minor sex trafficking prevention programs and approaches were limited. A majority of service providers were working with children who had been trafficked; however, there was not much awareness of the problem. Co-researcher E explained “we’re all working with trafficking victims. You just don’t know it until someone sheds the light on it. Then it’s kind of all you see.” The lack of awareness extends to emergency department personnel and police officers. Co-researcher C said that providers now are “using the lens” of sex trafficking to increase awareness. She also explained that the notable increase in referrals is not due to the actual rise in the number of children being trafficked, but rather to “how it is being seen.”

**Self-Care**

Each co-researcher spoke about the importance of secondary trauma and the role of effective self-care. It was clear in each discussion that working with children who are victims of trafficking can take an emotional toll on a provider and prove difficult to “leave work at home” (co-researcher B). Just as it is im-

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important for survivors of sex trafficking to build a supportive network in the healing process, it is just as important for those working with survivors to build their own supportive network. Co-researcher A noted the importance of having a support group in the form of a “sisterhood of people in the field” in which providers can “normalize their anger” by having “open conversations” with one another. These open conversations included allowing one’s self and others to have “revenge fantasies” towards the perpetrator without judging, and realizing this was a normal response when hearing what children have endured.

It was also clear how important is to take time for one’s self. Co-researcher E described the necessity of “giving the self enough time to process” in order to not feel the stinging effects of secondary trauma after hearing the victims’ stories and self-disclosures. Two of the co-researchers also described the notion of taking time for self-care to be of the upmost importance. Co-researchers B and D were employed by companies which encouraged providers to take time to care for themselves though sabbaticals and seeking their own therapeutic services.

Collectively, the co-researchers described working with survivors of domestic minor sex trafficking and hearing horrific stories as something “you will never get used to,” but at the same time, felt validated by the work they do. Co-researcher D continued to advise “it’s always hard, my heart hurts.” However, co-research E encouraged providers working with youth who have been trafficked to “celebrate the little wins, because the small wins become something big.”

**SUMMARY**

**Implications for Practice**

This study found that working with youth who have been trafficked is complex and multi-faceted. While there is little evidence on effective models of treatment for trafficked children, promising practices include early and accurate identification, empowerment, and recovery.

Many providers working in the field of social welfare often encounter victims of domestic minor sex trafficking in their work. If they are not aware of the prevalence of sex trafficking and do not know the appropriate language to describe the problem, victims may not be identified, and therefore, never receive needed services. It is important for providers to directly inquire about sex trafficking. Assessment should include questions about being paid for sex (Goldblatt-Grace, 2009).
Next, it is vital for providers to offer these children services based on underlying issues that lead to the child being trafficked. This might involve trauma-evidenced practice. This individualized treatment relies on service providers being able to meet the child “where they are at” and put any personal judgments aside. This may be difficult for service providers to effectively manage, especially if the children are actively being trafficked and/or do not view themselves as “victims.” However, such a non-judgmental approach is more likely to result in a successful outcome. Along with the use of a relational model that approach may provide the victim with the one thing he or she had always been missing: a secure and supportive connection with another.

**Implications for Policy**

Based on the interviews, it was apparent that there was an overall lack of awareness in the prevalence of sex trafficking. Still, it was noteworthy that in some situations children were receiving services. Continuing to develop policies mandating prevention education for providers in social welfare settings would serve to increase the overall level of awareness of domestic minor sex trafficking as well as the identification of victims. Recently, increased enforcement from federal and state agencies, the creation of human trafficking task forces, and campaigns to increase public awareness have served to bring attention to the issue of domestic minor sex trafficking. States should implement programs that train services providers in laws connected to sex trafficking and best practices connected to designing services.

Additionally, it would be beneficial for there to be mandated comprehensive services for trafficked victims, including rehabilitation, healthcare, and locating supports. These services should be more intentional in reconnecting trafficked youth with supportive adults who can continue to help them in the recovery process in the absence of the service providers. Such re-connections can be fostered by creating a “sisterhood” of survivors, linking youth to mentors and providing wraparound treatment, which includes the child’s family or primary caregivers.

**Further Research**

It is important to expand research efforts and look closely at service delivery and outcomes for victims of domestic minor sex trafficking. In-depth information on the early risk factors of trafficked children would serve to not only enhance professional knowledge, but also to further the development of preventative measures. Also beneficial to effective practice with victims of domestic minor sex trafficking would be the implementation of a longitudinal study on the outcome of services.
CONCLUSION

There are limitations to this study. Most importantly, it utilized a small sample size, and the co-researchers were all women and not demographically diverse. The lack of diversity among the co-researchers may have resulted in the inability to identify different perspectives in terms of working with trafficked youth. Nonetheless, this study adds the voices of providers to the discussion of effective practice with trafficked victims. In conclusion, the author’s view is that developing programs and effective practice with trafficked youth is not enough, but merely a stepping stone. To end domestic minor sex trafficking calls for a broad, societal movement.

References


Since the sexual revolution of the 1960s, sexuality has become a more accepted topic in society. Even with evolving norms, the concept of sexuality remains complicated by differing cultural notions of acceptability, particularly with individuals who have cognitive and/or physical disabilities (Yau, Ng, Lau, Chan, & Chan, 2009). “Developmental Disability” (DD) is an umbrella term used to describe a variety of cognitive or physical disabilities. “Intellectual Disability” (ID) refers specifically to individuals with limitations in intellectual functioning and adaptive behaviors. This is now the preferred term to describe persons formerly identified as having “mental retardation” (American Association on Intellectual and Developmental Disabilities, 2013). Individuals with ID often have a co-occurring DD diagnosis, such as fetal alcohol syndrome or Down syndrome (American Association on Intellectual and Developmental Disabilities, 2013). It is important to note that the same professional groups work with people who have both ID and DD diagnoses.

Given the evolving role of providers and their responsibility to support individuals with ID/DD to live healthy and productive lives, it is important to ensure that professionals know how to help clients obtain a healthy sexuality. Providers often serve as advocates for the rights of these individuals and are integral to ensuring quality of life. Sexuality is a complex human experience for all people, but specifically for individuals with ID/DD who are part of a marginalized group. Given the central role of providers in the lives of these individuals, it is important to understand their views. The purpose of this qualitative study is to describe provider perspectives on how to support ID/DD persons’ healthy sexuality.
LITERATURE REVIEW

Studies on the sexuality of individuals with ID/DD suggest that sexuality is important to their quality of life. Historically, individuals with ID/DD have been subjected to harsh societal responses to their sexuality, including sterilization, marital prohibition, and sexual segregation (Taylor Gomez, 2012; Coffman, 2007). While attitudes towards sexuality and individuals with ID/DD have evolved, social systems continue to reinforce asexual stereotypes that systematically exclude this population from receiving important learning opportunities. This has resulted in a lack of informed decision making (Swango-Wilson, 2010; Gill, 2010).

Sexual expression among individuals with ID/DD in the form of actively seeking out and engaging in intimate relations with another person is not often encouraged by caregivers/service providers, especially for those expressing interest in same-sex relationships (Bedard, Zhang, & Zucker, 2010; McClelland et. al, 2012; McGuire & Bayley, 2011; Hingsburger, 1993). Self-pleasuring and masturbation as a form of sexual expression has been more widely accepted by caregivers/service providers; however, practical approaches to providing education on this topic continues to be a challenge (Hingsburger, 1994; Gill, 2012). When the opportunity for sexual expression is limited, individuals with ID/DD are at risk for engaging in unsafe sexual behavior or being victimized (McClelland et al., 2012). Formal sex education programs and materials for individuals with ID/DD tend to minimize sexual choices, sometimes based on the values of the provider. This is more noticeable when comparing materials given to individuals without ID/DD, which promote healthy sexual expression with those with ID/DD (Gill, 2010).

There are a number of studies examining attitudes of sexuality and individuals with ID/DD from provider perspectives (McGuire & Bayley 2011; Sax & Flannegan, 2013; Franco, Cardoso, & Neto., 2012; Van Dyke, McBrien & Mattheis, 1996; Hingsburger, 1993). Studies indicate that provider perspectives on sexuality reflect acceptance and recognition of sexuality as an integral part of the human experience for individuals with ID/DD (McGuire & Bayley, 2011; 2012; Sax & Flannegan, 2013; Van Dyke, McBrien & Mattheis, 1996). While providers recognize the importance of sexuality in persons with ID/DD, systems designed to implement services remain restrictive in supporting individuals to express their sexuality in a way that is meaningful (McClelland et al., 2012; McGuire & Bayley, 2011; Walker-Hirsch, 2007).
METHODOLOGY

Rationale

Having worked in the field of providing services to individuals with ID/DD, I have been surrounded by service providers who appear to be socially liberated in discussing the topic of sexuality; however, when discussing this topic in the context of the ID/DD population, these professionals seemed perplexed. There exists a common theme of not knowing how to integrate sexuality into services for persons with ID/DD. Based on this perception, I decided to identify a small number of ID/DD professionals and discuss sexuality.

The underlying purpose of the study is to examine providers’ perspectives on the sexuality of individuals with ID/DD. More specifically, the study aimed to understand the reasons why addressing sexuality with this population is difficult.

Research Design and Procedure

This study was designed from a qualitative-heuristic approach. The first task of the study was to identify a sample of providers working in the field. Following approval from Springfield College’s Human Subject Review and completion of specific training around ethical research, the identification process began. Convenience sampling was used to identify the first two participants in the study. The following four participants were identified through snowball sampling whereby the first two participants identified relevant contacts.

Next, questions were developed based on a review of the literature and my own real work experience. Semi-structured interviews were conducted, with general questions being asked first to ensure participants felt comfortable, and more in-depth questions asked later in the interview. Two sessions were conducted to carry out interviews: one session was a one-one interview that lasted 40 minutes; the second session involved five participants in a group discussion format that lasted 60 minutes. Participants were given a small token of appreciation for their participation in the interview in the form of a $10 gift card. Each session was recorded using a digital voice recorder and field notes taken during the course of the interview. Participants signed a consent form ensuring confidentiality in reporting this study. Their names and work locations were also changed for the purposes of confidentiality.

Following the completion of the interview, the data was analyzed. All interviews were assessed for content. Important themes and quotes were
identified through field notes and interviews through a vertical and horizontal coding process. Themes supported by quotations were then outlined in the findings section followed by discussion.

Participants

All participants were professionals providing services to individuals with ID/DD. In total, six participants provided interviews for this study. One participant was retired, while the other five were working in the field. Three participants worked for the state providing services, while the remaining three participants worked in private, nonprofit settings providing services. All were Caucasian women. One participant was over age 60, and the other five participants were under age 32. Each participant had at least a bachelor’s-level degree of education from various backgrounds, including liberal arts, nursing, and social work.

RESULTS

Limits on sexual expression and a heteronormative society

Most participants stated they felt unable to openly explore issues connected to the sexuality of their clients. One participant specifically said that exploring sexuality is a “rare” event. Another pointed out that sexuality, regardless of who you are, is not discussed: “The only thing society can do is blast sex all over the place and then systematically refuse to talk about it.” She went on to say specifically of people with ID/DD:

“People with disabilities are only talked about in regard to their sexuality with negatives...society feels more comfortable talking about sexuality and individuals with disabilities in regards to abuse rather than being sexually active.”

The first participant provided further insight into the barriers that individuals with ID/DD face in expressing their sexuality, as it is prohibited in the physical space where people live their lives. Individuals with ID/DD are under constant supervision with rules that discourage sexual expression.

“Participants indicated that the idea of heterosexual relationships is much more accepted for this population, while same-sex relationships are mostly unrecognized by providers.”

One participant theorized that identifying as gay or lesbian might be difficult because of stereotyping from a heteronormative society:
“I think a lot of people we work with, they often already feel like they are on the outside and they want in so anything that will push them out even further is not good to them...people with disabilities know everyone gets excited when someone gets married, they know that is the next step when you’re in relationships...to be able to do something like come out would further stigmatize you to someone. Do they want to be more stigmatized?”

**Limits on sexual expression from families and guardians**

When dealing with the sexuality of people with ID/DD, all participants spoke of the complexities around working with families and guardians. Sexuality is seen differently by families and guardians. One participant said:

“A huge number of families I work with think their kids with disabilities should not get education. They (the kids) don’t have the same feelings, don’t understand sex, and shouldn’t learn about it. I think that’s the overwhelming majority of families that feel that way. It’s a huge issue because the kids do have these feelings and don’t understand them and do something incredibly inappropriate and then we all freak out about it and we put them in other services as a result, like mental health services and we’re not getting at the core of the problem...a lack of education.”

The “risk” of a bad sexual decision leads families to simply not discuss the subject whatsoever.

According to participants, guardianship further complicates the issue of sexuality. Guardianship is put in place for individuals who are deemed incompetent to make decisions by a court. In some cases, court-appointed guardians are assigned to individuals and serve as decision makers. One participant commented that this type of guardian often doesn’t know the individual stating: “Guardians are often robots that sign paperwork and don’t have contact.” When working with guardians around their client’s sexuality, “We have to ask the guardian, when is this okay and when is it not”? All participants agreed that: “99 percent of the time if the guardian says don’t talk about it, then it won’t be talked about.” Guardians appear to make these decisions based on their own morals and values rather than the values and preferences of their client.
Limits on formal and informal sexual education including training for service providers

Formal and informal sexual education for individuals with ID/DD is not always available. In some cases, participants pointed to families excluding their children from educational opportunities at school. It appeared to the participants that behaviors are often inappropriate because there had simply been a lack of education and discussion about sexuality.

None of the participants interviewed had received training on the subject of sexuality of individuals with ID/DD. They recognized such training exists, but it was not offered frequently and not required in their positions. All agreed more training around this topic should be offered. One participant spoke about the importance of training for staff and the implications for services saying, “Everything is as good as the workers on the front line...some people are really interested in helping people know about sexuality and information, others say ‘no way.’” There is no consistency among direct care staff in supporting someone to explore their sexuality.

“Think about all the stuff we train people on...just like if you’re a CNA, you learn how to transfer people in a certain way through training, you learn how to use a gait belt in a certain way, and this is the same. You need to learn how to approach people and how to assess them with where they’re at.”

Sexual education is low as a service priority.

There seemed to be a consensus among participants that sexuality is important in their client’s lives and it should be more actively integrated into their work. There was, however, an overwhelming feeling that it’s just not seen as a priority.

“We have a long, long, long way to go; there are so many other issues that are deemed a bigger priority that this is not ever going to be in the forefront...I would say the department is slower than society in general. I don’t see it leading the charge, and there are a lot other ‘safer’ issues to take on other than sexuality.”

Formal education programs do not prioritize this subject according to two participants. One participant, who specialized in ID/DD studies for her bachelor’s degree, echoed this sentiment: “My degree had a specialization in
intellectual disabilities and we never discussed this. All I know is from my own values and beliefs.”

**DISCUSSION**

Results of this study are similar to previous studies on sexuality and individuals with ID/DD. Participants in this study, as well as previous studies (McGuire & Bayley, 2011; Sax & Flannegan, 2013; Van Dyke, McBrien & Mattheis, 1996), support the idea that sexuality is an important part of the human experience and individuals with ID/DD should be able to express this in some way. There was a particular focus in this study around the diverse ways that people can express themselves sexually (e.g., same-sex relationships). This further supports results of previous studies on relationships that contend that providers tend to be accepting of their clients, but services remain restrictive (McClelland et al., 2012; McGuire & Bayley, 2011; Walker-Hirsch, 2007). Finally, a lack of sexuality education for individuals with ID/DD and a lack of training professionals in the field were sentiments spoken by all participants, none of whom received formal training on the topic.

The idea of risk and fear by parents and caregivers was an unexpected theme in interviews. Whether it was families wanting to protect their child, a guardian wanting to ensure safety, or a service provider trying to balance the needs of the individuals with the fears of their families, fear was a common thread. One participant went so far as to use the word “petrified” to describe families thinking about their adult child with ID/DD and sexuality. This brings to light the conundrum providers find themselves in protecting individuals from harm, while allowing them to live a life of dignity.

The “dignity of risk” was a term coined by Perske (1972) in the early 1970s, and is still used in the field of providing services to individuals with ID/DD. It is the idea that individuals with ID/DD should live in a world with appropriate risks that any person would have regardless of a disability. He says that deleting risk from an individual’s life hinders his or her personal development and human dignity. It further stigmatizes and “diminishes” this population in the eyes of society by enhancing their socially perceived difference (Perske, 1972). Sexuality is a risk in many ways, with families and care providers feeling they want to protect the individual from exploitation or harm; however, diminishing the risk of sexual expression further diminishes the dignity of the person. Based on the idea of the “dignity of risk,” a lack of focus on supporting individuals to explore their sexuality only reinforces societal stereotypes.
Setting priorities is an important task in the delivery of social services. All participants unfortunately thought that while promoting sexuality was important to take on, their jobs required them to attend to other priorities, including obtaining essential services for the client and his or her family.

**IMPLICATIONS FOR ADVANCED GENERALIST SOCIAL WORK**

For the last 30 years, advocates have pushed for services for individuals with ID/DD that included positive connections to the community. Currently, people with ID/DD are given employment support, and in some cases, live independently. These improvements have been monumental, but social service providers have yet to universally embrace sexual expression among individuals with ID/DD. On a macro-level, educational institutions that prepare professionals should address this issue. Job training should be provided more universally to professionals who work with this population.

On a micro-level, professionals need to incorporate the idea of dignity when working with this population. While the expression of sexuality for this population will continue to challenge families and guardians, professionals in the field should support the person with ID/DD in making independent choices.

**Limitations**

The sample was small, limiting generalizability. Due to time constraints, the snowball/convenience method of sampling was used, which resulted in a lack of diversity among the participants. More specifically, the participants were all Caucasian females from a similar age group. The sample did not include providers with diverse sexual identities. In addition, two of the participants had a personal relationship with the author that may have influenced the results.

Another potential limitation was connected to the use of semi-structured interviews. Pre-established questions were asked during both sessions, but ultimately, the content of each interview varied based on follow-up questions. It is important to note that researcher bias could be a factor in interviews, though efforts were taken to avoid leading interviewees to answer questions according to the researchers own beliefs.

While limitations exist, it is important to remember the purpose of the study was not to make findings generalizable; rather, the purpose was to explore provider perspectives on sexuality utilizing in-depth narratives and potentially inform future practice, research, and policy development for service delivery to individuals with ID/DD.
CONCLUSION

This exploratory study supported the finding from prior research, but also raised other important questions. How well have current services done in prompting “dignity of risk” in terms of sexuality? Why do service providers feel guardians have the final say when it comes to someone expressing sexuality? Why do professional educational programs leave sexuality out of their curriculum? Do families and service providers treat individuals with ID/DD differently based on gender in regards to their sexuality? The sample size in this study was small and lacked diversity in occupation, gender, and age; however, the same sentiment of not knowing what to do about this issue remained. Further study, utilizing a variety of providers and family members, should be completed to inform current policy around service delivery for individuals with ID/DD.

References


Mandatory Minimums: How Drug Sentencing is Impacting America Today

Brooke Simpson

The purpose of this paper is to present a discussion on mandatory sentencing of people convicted of drug crimes as an issue of social justice. The “War on Drugs” began in the 1970s with the presidency of Richard Nixon. This would later evolve into the “get tough on crime” approach of the Reagan administration (1981-1989), which was highly influenced by the crack/cocaine epidemic (Gross, 2008). In fact, the way we perceive the use of recreational drugs today has been highly influenced by the events of the last 30 years. Not only were drug dealers and associates severely punished, but recreational drug users also received punitive mandatory minimum sentences (Thirty Years of America’s Drug War, n.d.; Graham, 2010). The visibility of substance abuse and drug-related violence during the 1970s and 1980s brought about far-reaching policy changes with respect to the illegal use of drugs, including minimum mandatory jail time (Gross, 2008).

Prior to the establishment of strict mandatory minimum sentencing, there was no uniformity in sentencing or public policy. For example, in 1984 the Sentencing Reform Act was implemented as part of the Comprehensive Crime Control Act. Essentially, the Sentencing Reform Act was initiated to help bring fairness to the sentencing process since judges were doling out sentences at their discretion. An example of this can be found in a study by the U.S. Department of Justice. In this study, more than 200 judges were given identical cases with an assignment to fictitiously determine appropriate sentences. Results demonstrated the depth of inequality in American sentencing. The study revealed that judges across the country agreed on sentencing duration for only three out of 16 case studies (Gross, 2008).
While a judge may hand down a heavy sentence, the Department of Parole had the final say, often cutting down individual sentences by 40 percent, 50 percent, or 70 percent depending on the length of time to which an individual was sentenced (Gross, 2008). The range of possible sentences, with the role that the Department of Parole played, demonstrates why a fair and consistent method was needed in determining and distributing sentences.

Following the Sentencing Reform Act, the United States Sentencing Commission was about to establish a policy to promote equality in sentencing (Gross, 2008). Instead, the Anti-Drug Abuse Act of 1986 was passed, which created minimum penalties for those who sold drugs to individuals under age 21, hired individuals under age 18 to sell drugs, and/or utilized firearms during an offense (Albonetti, 2011). Finally, the Omnibus Anti-Drug Act of 1988 was passed. This policy is operative today (Albonetti, 2011). The Omnibus Anti-Drug Act introduced mandatory minimum sentencing of five years imprisonment for possessing more than five grams of crack cocaine and a mandatory minimum sentence of 20 years for offenders who were directly involved in drug operations (Albonetti, 2011).

When mandatory minimum sentencing was first established, it was viewed as a positive addition to the judicial system that would eradicate the disparities in the sentencing practices of individual judges, and dissuade American citizens from getting involved with drugs for fear of severe repercussions (Albonetti, 2011; Gross, 2008; Mazza, 2004). Prior to the establishment of mandatory minimums, it was reported that extralegal factors such as race, ethnicity, socioeconomic status, and gender played a significant role in the sentences handed down by judges (Albonetti, 2011). Mandatory minimums, however, had the opposite effect and, in fact, these disparities became even more evident with the tripling of drug convictions since the 1980s (Inciardi, 2004).

David Gil, a policy theorist, writes about the way societal oppression by persons in power leads to violence. Based on this, it might be said that there is an association among a person’s economic and social status, drug sentencing, and incarceration. Individuals sentenced to mandatory minimum drug sentences are frequently from oppressed groups in society. They often come from a background where their basic needs have not been met (Gil, 1996). In turn, this leads to destructive, and sometimes violent, behavior. Instead of lashing out at those in power, individuals may engage in self-destructive behaviors, such as committing crimes and abusing drugs (Gil, 1996). This is commonly the case for individuals who are incarcerated for nonviolent crimes.
related to illegal substances, and where many come from impoverished backgrounds in which they were not provided the same opportunities as others.

WHO IS AFFECTED?

Mandatory minimum sentencing is a far-reaching policy that affects a very large and disproportionate number of persons from minority groups. In 2012, 23,000 people were sent to federal prison for a drug-related offense (Sentences That Fit, 2014.), and most were first-time, nonviolent drug offenders (Inciardi, 2004). This means that prisons are being filled and American taxpayers are paying for punishment instead of treatment that could help rehabilitate individuals in need. In one report, it was noted that 38 percent of offenders were Hispanic, 33 percent were African-American, 27 percent were Caucasian, and 3 percent are other minorities (Sentences That Fit, 2014). Furthermore, in reality, Caucasians frequently do not receive mandatory minimum sentences, whereas members of the African-American and Hispanic communities almost always receive mandatory minimum sentences (Vincent & Hofer, 1994). The lifetime chance of minority persons being incarcerated also supports this perspective, with a 1-in-3 chance of African-American men, as opposed to 1-in-17 Caucasian men being incarcerated in their lifetime (The Sentencing Project, 2014). This is strong evidence that members of minority groups are greatly affected by the mandatory minimum sentencing policy.

How does mandatory minimum sentencing impact families? For one, over two-thirds of incarcerated women are serving time for nonviolent drug offenses and three-fourths of incarcerated women are mothers. As a result of mandatory minimums, these women are unable to care for and support their children (Women and Gender, 2014). Additionally, children of incarcerated parents are more likely to end up in foster care, drop out of school, and enter the criminal justice system. This demonstrates how incarcerating a parent on a mandatory minimum sentence damages more than just the incarcerated individual, but affects the lives of his or her children as well. Once a parent is freed from prison, he or she still faces many barriers to adequately providing for his or her family. For example, a formerly incarcerated individual may encounter difficulties in obtaining housing and in receiving public services (Women and Gender, 2014).

The entire country is affected by mandatory minimum sentencing with state spending on prisons and jails increasing over 300 percent since the 1990s, and taxpayers spending approximately $600 billion to support the
correctional system in 2012 (Sentences That Fit, 2014). Maintaining an inmate in a correctional institution costs about $31,286 per year on average, but this ranges from $14,603 in the least expensive institution to $60,076 in the most expensive (Henrichson & Delaney, 2012). On average, it costs approximately $86 per day to house an inmate in prison, not including outside costs, such as medical bills or visits to the hospital. In addition, it has been reported that costs for federal prisons are expected to increase 30 percent by the year 2020 (Klien & Soltas, 2013). One hopeful sign is that if political figures, such as the current attorney general, advocate for decreased sentences then the projected increase may not come to fruition (Rhodan, 2014).

PUBLIC PERCEPTION OF THE PROBLEM AND POLITICAL DEBATE

Mandatory minimum sentencing was once popular and seen as a necessary addition to public policy, but today it has fallen out of favor. According to The Mellman Group (2012), 60 percent of the population looked unfavorably on mandatory minimum sentencing for nonviolent drug offenses, and 84 percent of Americans felt the money spent on incarcerating nonviolent drug offenders would be better spent on strengthening programs like parole and probation (Sentences That Fit, 2014). It now appears that public opinion is leaning away from mandatory minimum sentencing. Regarding the current political debate, there is more agreement than disagreement on the issue of mandatory minimum drug sentencing. Conservatives and liberals have declared that mandatory minimum drug sentencing for nonviolent offenders should be changed (Moore, 2014; Bernick & Larkin, 2014). The main selling point for conservatives appears to be centered on the high cost of keeping nonviolent offenders incarcerated, with particular attention to the fact that the U.S. Department of Justice requested $8.5 billion in total funding in 2015 for its prison and detention budget.

Both parties agree that the mandatory minimum sentencing policy is out-of-date. Conservatives are opposed based on monetary considerations, and liberals are against it because of the inequitable impact it has on minorities and the poor (Moore, 2014). In conclusion, our political parties appear to be ready to work together to establish a mutual goal that will be agreeable to both.
Massachusetts has made strides in its effort to address the problem of mandatory minimum sentences for nonviolent drug offenders. Progress has been made in helping individuals incarcerated for nonviolent offenses become eligible for parole and work release sooner (Sentences That Fit, 2014). The law regarding drug-free school zones was also changed, leading to fewer persons being incarcerated.

In January 2014, Congress passed the Smarter Sentencing Act (USDOJ, 2014). This act gives discretion back to judges in sentencing offenders, helps eliminate overcrowding in prisons, and ultimately saves money by not providing excessive sentencing to nonviolent offenders (USDOJ, 2014). The underlying values of this act include promoting human rights, helping to rectify racial disparities in the prison system, and managing resources more efficiently. This act brings focus to the plight of nonviolent offenders serving long sentences (Stone, 2012).

These changes in policies are significant when considering the high value Americans place on liberty. Not only do long-term sentences disproportionally imprison minorities, they also undermine liberty values. Eliminating mandatory minimums can reinforce the value of liberty in America. As Stone says, “To realize one’s goals, it helps to belong to a community that provides the basic capabilities to live freely” (Stone, 2012, p. 116).

I would like to describe a political cartoon (Cagle Post, 2013), which I believe is an accurate representation of the “War on Drugs.” It depicts a large, mechanical-looking figure with a gun and club labeled “War on Drugs.” The figure is tossing small individuals into a pen labeled “Nonviolent Offenders.” By examining something as simple as the size of individuals in the cartoon, the reader understands the artist believes the war on drugs is a focal point in American politics; one that has taken many prisoners. The large, menacing figure is dropping individuals into a cage of offenders, demonstrating that the artist thinks the U.S. government has little regard for whom it imprisons in this war on drugs. Finally, the depiction of the figure with a gun and club conveys the idea that we as a society are willing to utilize brute force against nonviolent offenders. President Barack Obama has worked to make changes, such as lowering some of the mandatory minimums,
but overall, these have only had a minor impact on the correctional and judicial systems.

Mandatory minimums are not in accordance with the United Nations’ Declaration of Human Rights (UDHR, 1948). This declaration contains key concepts, including human dignity, civil and political rights, economic, social and cultural rights (Wronka, 2004). Excessive sentencing strips away human dignity, making individuals feel inferior. In addition, civil and political rights are violated as this policy unfairly affects minorities. In turn, there is a detrimental impact on their economic, social, and cultural rights. When considering the Universal Declaration of Human Rights, the second article of nondiscrimination really stands out. The reason is because prison systems are filled with minority individuals and it is no surprise that individuals incarcerated for nonviolent drug offenses also fall into this demographic. If we value nondiscrimination, I find it hard to understand that we accept polices that discriminate. Additionally, it is easy for people in power to consider criminals as society’s lowest denominator instead of human beings. This thought process keeps individuals as “less than,” and it essentially takes human beings and turns them into objects instead of finding their individual human value (Wronka, 2008). Finally, relative to the declaration, mandatory minimums violate civil and political rights.

SUMMARY

In conclusion, I believe that the efforts currently set forth in both the Massachusetts state government and federal government have been productive. Mandatory minimum sentencing is now an open topic for legislators, and it appears that people are beginning to view addiction as a disease instead of simply criminal behavior, leading to a greater emphasis on finding help for individuals with an addiction instead of merely punishment for wrongful behavior. Major politicians, including the president of the United States, are adding their voices in seeking policy changes. Collaboration between the two major political parties in the U.S. now have the power to bring changes to this policy in the long run.
References


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