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GROUP TREATMENT FOR MALE SEX OFFENDERS WITH AN INTELLECTUAL DISABILITY

Section A: A systematic review of group psychological treatment for male sex offenders with an intellectual disability

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Section B: Understanding important aspects to treatment for intellectually disabled sex offenders – can existing models be applied to this group?

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Summary of the MRP portfolio

Section A is a systematic literature review exploring the impact of sex offender treatment on cognitions associated with sex offending and on sexual re-offending, for male sex offenders with an intellectual disability (ID). Considerable methodological limitations in the existing literature prevented firm conclusions from being drawn, however the main conclusion was that changes in cognitions associated with sex offending do not necessarily prevent further sex offending behaviour. More rigor is needed in research using higher quality studies to be able to draw conclusions about the effectiveness of ID sex offender treatment.

Section B aimed to provide an understanding of how ID sex offenders perceive group sex offender treatment, and their efforts to not re-offend. A qualitative thematic analysis study is presented where ID sex offenders completed a semi-structured interview. Three main themes were identified as being important in gaining this understanding: connecting with others, possible factors influencing re-offending behaviour, and progression in reducing risk of re-offending. The results supported some aspects of existing models of sex offending, but highlighted a need for the development of a specific model of sex offending for the ID population.

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Section A

A systematic review of group psychological treatment for male sex offenders with an intellectual disability

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Abstract

There are no specific models of sex offending for intellectually disabled sex offenders. Current treatment is adapted from sex offender treatment in the general population. There is a lack of clarity as to the effectiveness of these treatments for intellectually disabled sex offenders and whether the models that underpin these treatments are applicable to an intellectually disabled population.

A systematic review was conducted using 12 relevant studies. They were reviewed according to guidelines recommended by the Enhancing the Quality and Transparency of Health Research Network, with a focus on study design and methodology.

This review concludes that changes in cognitions do not always prevent re-offending behaviour within an intellectually disabled population. Availability of methodologically sound studies has prevented being able to draw other firm conclusions about the impact of group treatment on cognitions and behaviour associated with sex offending in the intellectually disabled population. Higher quality studies are required.

A discussion of the methodological limitations of the studies highlighted clinical implications of risk, treatment planning and delivery, with a consideration for future research.

Keywords: intellectual disability, sex offender, group treatment

Introduction

Research into sex offender treatment programmes (SOTPs) has focussed on sex offenders in the general population, without an intellectual disability (ID). Before this is elaborated on, definitions used in this review will be provided.

Intellectual disability definition. The definition of ID is taken from the document *'Learning Disability: Definitions and Contexts'* (The British Psychological Society, 2000), which defines ID as "significant impairment of intellectual functioning; significant impairment of adaptive/social functioning; age of onset before adulthood. All three criteria must be met for a person to be considered to have a learning disability" (The British Psychological Society, 2000, p. 4). This review will use the term 'intellectual disability' throughout as identified in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-V; American Psychiatric Association; 2013) as it is more up to date and can be used interchangeably with the term 'learning disability' as it uses the same definition as identified above.

Sex offender definition. The definition of 'sex offender' is taken from the Sexual Offences Act (2003) used in the UK criminal justice system. This definition has been used as sex offences are classified differently across countries, whereas this review is only concerned with sex offences in the UK. A sex offender is someone who has been convicted of any of the sexual offences outlined in this Act (Appendix A).

Prevalence of sex offending in the general population

As of 2015 there were 11,490 sentenced sex offenders in the UK which was a 10% increase compared to the previous year (Ministry of Justice, 2015). The Office for National Statistics (2015) reported that sex offences account for 2-3% of total recorded crime. A meta-analysis

of 61 studies reported sex offence recidivism rates of 13.4% over 4-5 years (Hanson & Bussière, 1998) and 13.7% over 5 years (Hanson & Morton-Bourgon, 2004), with lower recidivism rates for those who completed treatment compared to those who did not (Hanson & Bussière, 1998). These statistics are likely to be lower than actual rates of re-offending due to under reporting by victims, with approximately only one in four sexual assaults reported to authority (Bachman, 1998).

Prevalence of sex offending in an ID population

A number of researchers have commented on the high incidence rate of sex offending in men with ID. Gross (1984) stated that between 21% and 50% of offenders with an ID had committed a sex offence, which is higher compared to non-ID sex offenders (Hanson & Bussière, 1998). Despite these statistics, it is difficult to draw firm conclusions about the prevalence of sexual offending among an ID population due to limited research and differences in methodology between studies.

Evidence suggests there are higher rates of offence recidivism in ID sex offenders, with 34% of sex offence recidivism occurring within 12 months of discharge (Day, 1993; 1994; Klimecki, Jenkinson, & Wilson, 1994; Scorzelli & Reinke-Scorzelli, 1979). Another study found 4% re-offended within 12 months and 21% within 4 years of treatment (Lindsay et al., 2002). Re-conviction rates are 6.8 times higher at 2 years and 3.5 times higher at 4 years post treatment compared to non-ID sex offenders (Craig & Hutchinson, 2005). These differences could be due to offending being less sophisticated in an ID population and more likely to be detected (Craig & Hutchinson, 2005), and treatment potentially not preventing re-offending for this group.

Are ID sex offenders a different group?

Research suggests that ID sex offenders are similar to non-ID sex offenders on factors such as poor treatment response, denial of offence, anti-social attitude (Lindsay, Elliot, & Astell, 2004), impulsivity (Lindsay & Parry, 2003), educational history, contact with psychiatric services or previous charges for sex offending (Glaser & Deane, 1999). There are however differences between the two groups; ID sex offenders have more adult male victims (Blanchard et al., 1999; Gilby, Wolf, & Goldberg, 1989) and are less likely to commit violent or penetrative offences (Murrey, Briggs, & Davis, 1992).

Sex offenders with ID are typically much less likely to be offered sex offender treatment compared to non-ID sex offenders (Murphy, Powell, Guzman, & Hays, 2007). It is important however both ethically and financially, that treatment is offered to ID sex offenders, as too frequently they are hospitalised indefinitely and diverted away from the criminal justice system (Green, Gray, & Willner, 2002; Holland, 2004; Lindsay, 2002). Recommendations for treatment, state that hospital stays should be as short as possible and the least restrictive (Royal College of Psychiatrists, 2013).

Difficulties faced by those with an ID

Individuals with an ID face numerous additional challenges compared to non-ID sex offenders. Difficulties reading body language can lead to negative experiences in relationships (Spafford & Grosser, 1993). They may experience differences in opportunities to develop relationships; for example, many people with ID live with their parents for longer (Mencap, 2012) or live in supported accommodation, making it more difficult to express their sexuality appropriately.

Deficits in language competence have been linked to both underlying language deficits (Lapadat, 1991) and insufficient social knowledge (Bryan, Burstein, & Ergul, 2004). People with ID are likely to have impaired intellectual functioning and information processing, particularly of complex information, with additional memory difficulties (Swanson & Zheng, 2013). This needs to be taken into account when considering treatment, as they are likely to impact on formulating offending behaviour, treatment content and delivery. Simply adapting a treatment that is typically used in the non-ID population with language suitable for someone with ID, may not be sufficient given the difficulties mentioned above.

Theories of sex offending

A number of theoretical models seek to explain sex offending, although none are specific to an ID population. Only the two most dominant theories within the literature will be discussed and their applicability to ID sex offenders will be considered.

Finkelhor's 'pre-condition model of child sex abuse' (Finkelhor, 1984). Finkelhor developed a multi-factorial model to understand sex offending against children, where four pre-conditions were deemed necessary for sex offending to occur. He said there has to be a sexual motivation to offend against children, such as emotional congruence or sexual arousal. Although an individual may be motivated to have sex with a child, to do so would require overcoming internal inhibitors that prevent such an act, such as their conscience. External stressors, alcohol, impulsiveness may all impact on an individual's internal inhibitors, but entrenched beliefs that this behaviour is acceptable in the form of distorted cognitions, may also facilitate sex offending against a child. In addition to this, there are also external inhibitors as part of the situational context that prevents sex offences from occurring. Clear planning may also be involved in overcoming these external inhibitors. Overcoming the

victim's resistance, for example through blackmail, is also necessary according to this model for a sex offence to take place.

Some men with ID may have a genuine sexual interest towards children due to emotional congruence (Ward & Hudson, 2001). In relation to the second pre-condition, research has suggested that ID sex offenders may have distorted cognitions about sex and relationships (Craig & Hutchinson, 2005; Langdon & Talbot, 2006; Murphy, 1990) and are also likely to have had less sex education, and may not have the same internal inhibitors compared to someone without an ID. External inhibitors such as appropriate sexual expression (e.g. via intimate relationships, access to pornography) may be less available for those with ID, particularly those in restricted settings (Brown, 1994). This may increase the likelihood of a sex offence occurring. The literature suggests ID sex offenders overcome victim resistance in the same way as non-ID sex offenders for example, by using bribes and emotional blackmail (Lindsay, 2009).

This model therefore demonstrates applicability for ID sex offenders due to all of the preconditions potentially being met for this group. Due to difficulties in intellectual functioning, there may be less of an emphasis on internal inhibitors within treatment due to the difficulties faced by people with ID in processing complex information.

If treatment was based on this model it may include education about sex and relationships, developing appropriate relationships, understanding the law to prevent over-coming victim resistance, and identifying and challenging cognitions associated with sex offending.

Ward and Hudson's 'self-regulation pathways model' (Ward & Hudson, 1998).

Ward and Hudson (1998) proposed four pathways of offending to obtain gratification of sexual desires, using either an active (referred to as 'approach') or passive (referred to as 'avoidant') style of self-regulation. The first pathway is the approach/explicit pathway in

which the individual is motivated to sexually offend. The second pathway is the approach/automatic pathway, which sees the individual displaying learned behaviour consistent with sex offending. The third pathway, avoidant/active, is where the individual tries to manage thoughts and behaviour that lead to sex offending. The fourth pathway, avoidant/passive, is where the individual wants to avoid sex offending but does not have the coping skills to manage this.

This model is likely to be applicable to ID sex offenders. They are more likely to adopt a more passive pathway to offending due to poor coping skills (Lindsay, Steptoe, & Beech, 2008) and/or learned behaviour in relationships (Lindsay, 2002; Lindsay, Law, Quinn, Smart, & Smith, 2001). Ideas from this model are used in treatment for ID and non-ID groups (Ward, Yates, & Lang, 2006), particularly in developing coping skills and altering cognitions consistent with sex offending.

Other models of sex offending. There are other models of sex offending behaviour such as Marshall and Barbaree's (1990) integrated theory of sex offending, and the Good Lives Model (Ward & Stewart, 2003), although they will not be discussed as they are not featured in the studies included in this review.

Treatment for non-ID sex offenders

A number of meta-analytic reviews have sought to provide information and clinical guidance about the effectiveness of treatment for sex offenders in the general population. Systematic reviews could not conclude how effective sex offender treatment was on offence recidivism due to limited methodologically robust studies (Craig, Browne, & Stringer, 2003; Furby, Weinrott, & Blackshaw, 1989). The Cochrane Collaboration (White, Bradley, Ferriter, & Hatzipetrou, 1998) highlighted the need for randomised control trials (RCTs) to draw firmer conclusions. More recent reviews have shown that recidivism rates for sex offenders are

lower when they are in treatment compared to controls (Loesel & Schmucker, 2005; Hanson, Bourgon, Helmus, & Hodgson, 2009), with lower recidivism rates when receiving cognitive behaviour therapy (CBT) and systemic treatments (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson et al., 2002).

Treatments have been developed for sex offenders based on both of the models of sex offending discussed previously. Existing sex offender treatment programmes tend to be underpinned by more than one theoretical model and include more generic understandings of sex offending such as the 'cycle of offending'. This may explain why some theories do not seem to clearly underpin existing treatment programmes, and why there is not one approach to sex offender treatment.

That said most sex offender treatment programmes with non-ID sex offenders adopt a group therapy format (Knopp, 1984; MacFarlane, 1983). Research suggests that some of the most effective treatments for non-ID sex offenders has been group based (Beckett, Beech, Fisher, & Fordham, 1994), possibly due to the additional interpersonal support from other group members (Ware, Mann, & Wakeling, 2009) that are absent in individual treatment.

Current treatment for ID sex offenders

In the last 30 years there has been an increased focus on ID sex offender treatment, however there are no models specifically developed to help understand the routes to problematic sexualised behaviour within an ID group. Despite this, sex offender treatment for those with an ID have been implemented based on models of sexual offending in the general population, with adaptations for the ID population. Adaptations have included simplification of language, using visual images and emphasising the importance of generalising skills (Lambrick & Glaser, 2004). It is unclear whether these treatments are as effective in an ID group and whether adapting treatments designed for a non-ID group is effective.

Aim of this review

The aim is to systematically review the literature, to provide an account of the efficacy of a range of group psychological treatments for male ID sex offenders, with a focus on cognitions associated with sex offending and sexual re-offending. It also considers more broadly the applicability of existing models of sex offending for an ID population.

This review focusses on group interventions as they are considered to be the most effective treatment format for non-ID sex offenders (Beckett, Beech, Fisher, & Fordham, 1994). Only research using male participants is included, due to the higher proportion of ID sex offenders being male (Riding, Swann, & Swann, 2005). Study summaries are presented with potential clinical implications in terms of treatment approaches moving forward. Future research will be discussed.

For the purposes of this review, an effective treatment would lead to reductions in attitudes consistent with sex offending, and no further re-offending. Although the papers included in this review often use a number of different measures of victim empathy or locus of control, this review will only be concerned with attitudes consistent with offending due to this being looked into more consistently across the literature, in addition to re-offending behaviour.

Methodology

A systematic review of the literature (Booth, Papaioannou, & Sutton, 2012) involved using specific search terms on electronic databases, and searching reference lists of relevant papers.

Search terms

Search terms were specific to this review and included terms used in related research. These terms were combined using the 'AND' boolean operator in the title field on electronic databases. All search terms can be seen in Table 1.

Table 1. *Details of search terms.*

Criteria	**Search terms**
Intellectually disabled	"learning disability" OR "learning disabled" OR "intellectual disability" OR "intellectually disabled" OR "intellectually impaired" OR "intellectually handicapped" OR "mental retardation" OR "mentally disabled" OR "mentally handicapped"
Treatment	"treatment" OR "treating" OR "treat" OR "intervention" OR "treatment programme" OR "psychological treatment" OR "psychological intervention" ("group treatment" yielded no papers, so search terms were broadened)
Sex offender	"sex offender" OR "sex offending" OR "sexual offender" OR "sexually offending" OR "sexually offend"

Additional terms relating to attitudes ("attitudes", "cognitions") and offence recidivism ("offence recidivism", "re-offending", "offending") were initially included in the search, but were removed as they did not yield any papers.

Search strategy

The following electronic databases were searched from their earliest entries up to 31st July 2016: PsycINFO, Cochrane Database of Systematic Reviews, Medline, Database of Abstracts of Reviews of Effects and Web of Science. Searches were limited to journal publications in English, and duplicates were removed. See flowchart in *Figure 1* for details of search results.

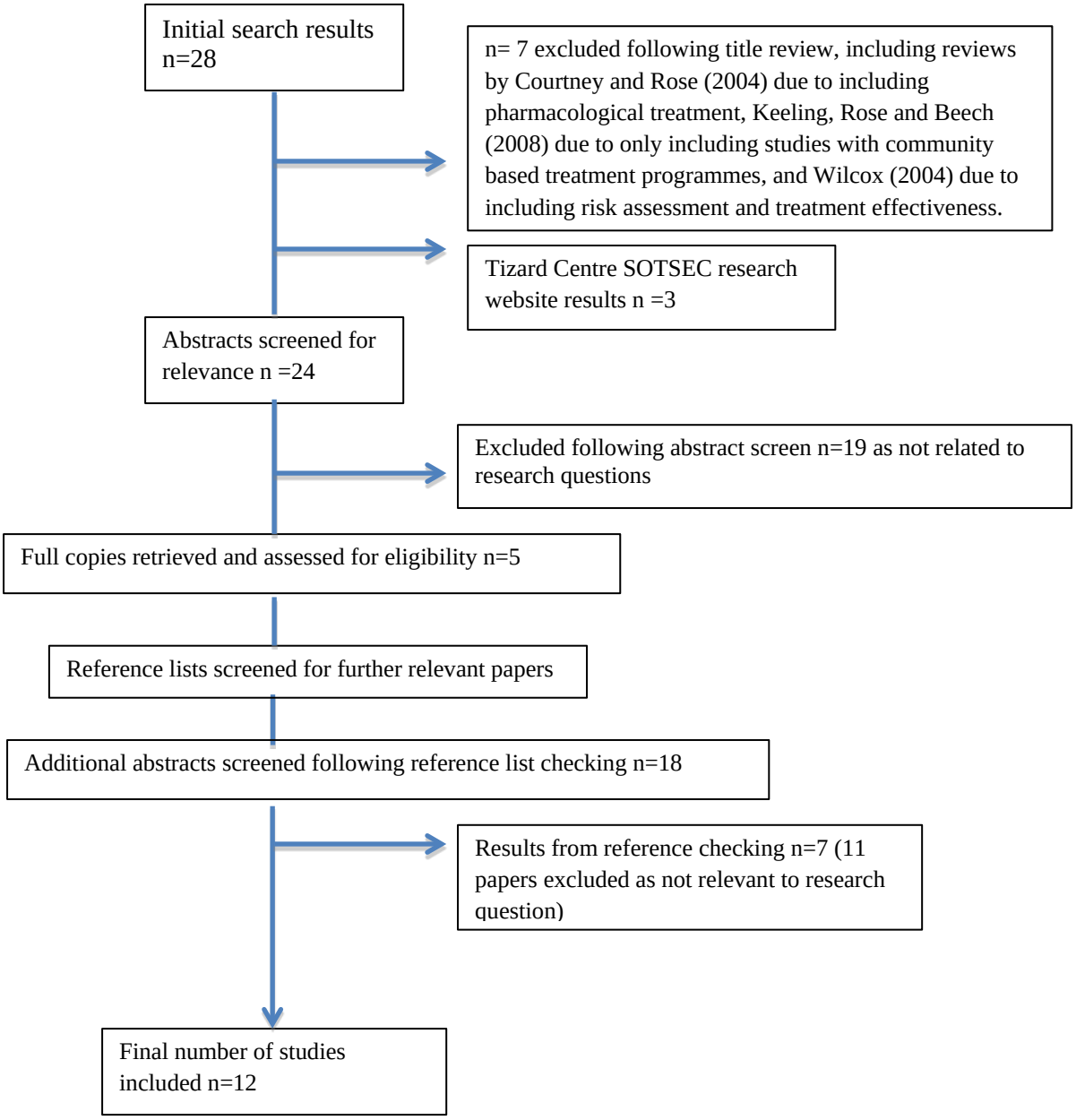

Figure 1. Flowchart of search procedure and results.

Study inclusion criteria

Papers were included in the review if they met the following criteria:

- Participants with ID
- Participants aged 18 and over
- Male participants

- Participants have sexually offended (may or may not have been convicted of a sexual offence but have demonstrated sexually inappropriate behaviour)
- Considers the effectiveness of a group psychological treatment
- Due to the high prevalence of mental health difficulties amongst the ID population (Deb, Thomas, & Bright, 2001), studies were not excluded where participants had mental health difficulties.

Study exclusion criteria

Papers were excluded from the review if they met any of the following criteria:

- Children or adolescents as participants due to developmental differences between these age groups
- Participants over the age of 60 due to additional potential age-related cognitive decline affecting outcome of treatment.
- Included pharmacological treatment
- Female sex offenders

Quality assessment

The quality of the studies that were included were evaluated using checklists as recommended by the Enhancing the Quality and Transparency of Health Research (EQUATOR) Network. Four case studies were assessed on quality using the Single Case Reporting Guideline in Behavioural Interventions (SCRIBE, Tate et al., 2016) checklist, and eight cohort studies were evaluated using the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE, von Elm et al., 2007) statement which are guidelines for reporting observational studies. Data extraction forms were specifically devised using these checklists (Appendix B). See Table 2 for a list of all studies included in this review.

Results

Although many studies identified the treatment programmes as aligning with a particular approach such as a cognitive or a CBT approach, the description of the treatments provided have sometimes indicated a more integrated treatment approach. The studies included in this review (see Table 2) will be discussed according to the type of treatment approach indicated by the treatment descriptions in each study.

Table 2. *Study summaries.*

Study	Details of intervention	Sample size / Design	Measures	Findings	Quality assessment
Craig, Stringer, and Moss (2006)	Integrative treatment group programme based in the community for 2 hours once a week for 7 months. Treatment included sex education, the law, cognitive distortions, cycle of offending.	n=6 Case study design Included a 12 month follow up period.	-Multiphasic Sex Inventory (MSI[1]) -Coping Response Inventory (CRI[2]) - Psychiatric Assessment for Adults with a Developmental Disability (mini PAS-ADD[3]) -Vineland Adaptive Behaviour Scales (VABS[4])	- No further incidents of sexual offending in 12 month follow-up period. - No significant difference in attitudes toward sexual offending post group. - Significant difference on scores of socialisation play and leisure on VABS post treatment. - Improvement in admitting sexual interests and sexual knowledge on MSI.	**Strengths:** Definition of ID provided, aims and hypotheses clear, clear rationale, participant characteristics described, discussion of study limitations. **Weaknesses:** Case study design, small sample with variation of offences, inclusion and exclusion criteria of participants not provided, measures used not standardised for use with ID, reliability and validity of measures not provided, treatment not described in detail to enable replication, clinically significant change not reported on those measures which produced a significant difference at different time points.
Rose, Jenkins, O'Connor , Jones, and Felce (2002)	Not identified by authors but seems to be an integrative group treatment approach, for 2 hours over 16 weeks. Treatment included altering cognitive distortions, sex education, self-control strategies	n=5 mixed methods – cohort study with additional participant interviews. A 3 and 6 month follow-up period.	-QACSO[8] -Nowicki-Strickland scale[5] -Sexual Behaviour and the Law scale (SBL; developed by research team) -Victim Empathy Scale [6]	-Attitudes consistent with offending reduced for most but increased to baseline levels 6 months post treatment. -External locus of control increased over time (opposite to predictions). -Sexual knowledge increased after the group. -No offending behaviour reported during group or during follow-up period.	**Strengths:** Aims and hypotheses clear, background and rationale relevant, appropriate t-tests to analyse data and analysis clear, most missing data addressed, participant characteristics provided, provides additional qualitative component. **Weaknesses:** Most measures not standardised for ID (only the QACSO was standardised for ID), small sample size, cohort study with no control group, clinically significant change not reported, diverse participant group, group facilitator also supported participants in

	and offending cycle.			-Interview data found the group found it useful.	completing measures (demand characteristics), lack of treatment detail provided, not all confounding variables discussed.
Murphy et al. (2010)	SOTSEC-ID a manualised integrative treatment approach for 2 hours a week for 12 months. Treatment included sex education, identifying and challenging distorted cognitions, increasing victim empathy, applying four step model of offending, relapse prevention.	n=46 (92% completed). Not all convicted but engaged in sexually abusive behaviour. Cohort study with 6 month follow up.	-Sexual Attitudes and Knowledge (SAK[7]) -QACSO[8] -Sexual offenders self-appraisal scale (SOSAS[9]) -Victim Empathy Scale[6]	-Significant improvements in cognitive distortions, and significant increases in sexual knowledge and victim empathy. -Seven re-offended during treatment or follow-up.	**Strengths:** Background and rationale clear, hypotheses clear, larger sample size than other studies in review, manualised treatment, treatment delivery training provided, multi-site, participant inclusion criteria provided, participant characteristics provided, acknowledge need for control (planned to use waiting list control but lack of data obtained), descriptions of analysis and explained missing data, acknowledgement that not all variables related to offending are accounted for, authors acknowledge study strengths and limitations, explain that due to a lack of funding the follow up period could not be extended. **Weaknesses:** Cohort study design with no control group, variation in offence type, no power calculations so unclear whether sample size adequate to detect effects, clinically significant change not reported.
Lindsay, Neilson, Morrison, and Smith (1998a)	Cognitive behavioural treatment for 2.5 hours a week for duration of probation period. Treatment	n=6 Case study design with 4 year follow-up. All received 1-3 years	Authors devised an assessment of beliefs consistent with sexually offending behaviour – not referenced.	-All had changes in attitudes consistent with offending, but pattern of changes varied with some aspects changing more than others, and attitudes such as blame and harm being more	**Strengths:** Multiple baseline to enable within subjects control for treatment effects, participants only completed the treatment outlined, long term follow up period of 4 years, participant characteristics provided, re-test reliability of measure used was high, acknowledge variation in offences.

	included identifying and challenging distorted cognitions, increasing victim empathy and relapse prevention.	probation. 2 groups – offences against girls, offences against boys.		resistant to change. -No offence recidivism although not confident with one case.	**Weaknesses:** Case study design, small sample size with a variation of offences, differences in length of time of follow up period, lack of detail about treatment, patient selection criteria and treatment setting, participants completed occupational placement which may interfere with treatment effects, no clinical cut offs for data provided, clinically significant change not reported.
Lindsay, Marshall, Neilson, Quinn, and Smith (1998b)	CBT group delivered for 2 hours a week for 12 months for participants residing in the community, in a low secure provision and medium secure provision (24%). Treatment included accepting responsibility for the offence, identifying other cognitions and challenging them, increasing victim empathy and	n=4 AB case design. Four year follow-up period.	- Attitudes toward exhibitionism questionnaire devised by researchers (not referenced).	-Improvements in attitudes consistent with indecent exposure being fun, and it not causing harm to women. -Least amenable to change are beliefs where the perpetrator feels the victim shares responsibility for the offence and that women may take a long time to recover from the incident.	**Strengths:** Rationale provided, participant characteristics provided, coding reliability presented and is high, results summary clear, acknowledge limited generalisability to population, an attempt for participants to have similar offences. **Weaknesses:** Aims not clear, case study design, analyses not stated, clinically significant change not provided, participant selection criteria not stated nor treatment setting, measure used not standardised and validity/reliability data not provided, effect sizes not reported, treatment not provided in enough detail for exact replication, no mention of treatment effects on re-offending rates.

	behaviour consistent with offending.				
Heaton and Murphy (2013)	SOTSEC-ID manualised integrative treatment programme for 2 hours a week for 12 months for participants residing in the community, low secure provision and medium secure provision. Treatment was the same as that identified in Murphy et al. (2010).	n=34 Cohort study with follow-up ranging from 15-106 months (mean length was 44 months) depending on when group ended.	-Sexual Attitudes and Knowledge Questionnaire (SAK[7]). -QACSO[8] -Sexual Offenders Self Appraisal Scale (SOSAS[9]) -Victim Empathy Scale – Adapted (VES-A[10])	-Improvements in sexual knowledge, empathy and cognitive distortions post group with only sexual knowledge showing further improvement at follow-up. -11 out of 34 men showed sexually abusive behaviour at follow-up (32%). -SOSAS no significant changes.	**Strengths:** Aims clear, participant exclusion criteria provided, larger sample compared to other studies, authors acknowledge confounding variables, statistical methods clear. **Weaknesses:** Power calculations not provided, clinically significant change not reported, broad definition of sex offending behaviour to include convicted offences and behaviours indicative of sex offending, variation in range of offences, variation in follow up depending on when the group ended, study co-ordinator was also the group facilitator (demand characteristics), no control group, many participants have received further therapy since attending the group.
Keeling, Rose, and Beech (2006)	Integrative treatment programme for participants in custody. Treatment provided for 2.5 hours, 4 days a week for 12 months. Treatment	n=11 (7 additional were discharged prior to completing treatment). Cohort study.	-UCLA Loneliness Scale-Revised (UCLA-R[11]) -The Criminal Sentiments Scale (CSS[12]) -The Miller Social Intimacy Scale (MSIS[13]) -Modified Abel and Becker Cognition	-Significant differences post treatment on victim empathy, self-control and attitudes consistent with sexual offending. -No significant changes on social intimacy, emotional loneliness and criminal attitudes. -No mention of offence recidivism.	**Strengths:** Rationale, aims and hypotheses clear, reliable change calculated, two measures used were validated for use with ID, reliable change index and effect sizes were reported on acknowledging the type 1 error present in small scale studies when using t-tests, a deception scale was used to decipher genuineness of responses. **Weaknesses:** Small sample size with a variation of offences, cohort study with no

	included sex education, problem solving, victim awareness, understanding emotions, identifying distorted cognitions, relationships, the offence cycle and relapse prevention.		Scale (M-ABCS[14]) -Victim Empathy Distortion Scale (QVES[6]) -QACSO[8] -Self Control Rating Scale (SCRS[15]) -Paulhus Deception Scale (PDS[16])	-Large effect sizes on victim empathy scale, M-ABCS[14], SCRS[15], QACSO[8] and UCLA-R[11].	control group, no follow up data, not clear of time points that measures were administered, lack of detail in treatment outline, some measures not validated for ID use, broad definition of 'special needs', re-offending rates not provided.
Lindsay and Smith (1998)	Cognitive behavioural treatment programme for participants on probation, for 2.5 hours a week for 1 or 2 years depending on length of probation.	n=7 in each group. Cohort study – group comparison with follow-up at least 2 years post probation.	-Authors developed a standard assessment that measured beliefs consistent with sex offences against children and indecent exposure (not referenced).	-Significant differences between groups on attitudes consistent with offending (particularly denial and minimisation of offence), with 2 year probation group showing more improvements. -2 patients with 1 year probation re-offended whereas none re-offended who were on 2 year probation period.	**Strengths:** Within subjects control group, comparison groups, follow up period provided, authors acknowledge some limitations of the study, aims clear. **Weaknesses:** Small sample size, cohort study without control group, background information brief, lack of discussion of confounding variables, broad types of offences, treatment not described in detail, not enough time to deal with denial and minimisation in one group so group treatment differed, measure used not validated, clinically significant change not reported.
Swanson and Garwick (1990)	Outpatient integrative treatment group incorporating sex education,	n=15 Open cohort study.	-Goal Attainment Scale[17]	-2 were re-convicted of sex offences. -4 involved with police for sexual offences. -group members barely	**Strengths:** Clear background information, defined recidivism and ID, mentions goal of the group, mentions participant inclusion criteria. **Weaknesses:** Aims are unclear other than not

	developing a support system and emotion regulation. Goal based treatment over 1.5 hours a week. Open ended group (mean length of treatment 14 months).			achieving goals that were identified at the start of treatment.	re-offend for two years, variation of offences, lack of discussion about limitations of the study, no discussion of confounding variables, lack of detail for treatment, procedure and participant characteristics, no statistical analysis and therefore clinically significant change not reported.
Murphy, Powell, Guzman, and Hays (2007)	Integrative treatment (inpatient and community clients) for 2 hours a week for over a year.	n=8. Cohort study with 6 month follow-up.	-Sexual Attitudes and Knowledge Scale (SAKS[7]) -QACSO[8] -Sex Offenders Self Appraisal Scale (SOSAS[9]) -Victim Empathy Scale-Adapted (VES-A[10])	-Sexual knowledge and attitudes and victim empathy improved significantly. -No significant differences on QACSO and SOSAS for cognitive distortions. -One group member who did group twice re-offended. -At 6 month follow up 3 had re-offended but were not re-convicted.	**Strengths:** Exclusion criteria provided, rationale clear, clearly identified where participants were recruited from, most measures developed for use with ID. **Weaknesses:** No control group, small sample size with variation of offences, lack of clear aims, no hypotheses, no definition of ID, two participants completed group twice, lack of treatment detail provided, very focussed on ASD and offending behaviour but not mentioned in abstract, clinically significant change not reported on those measures with significant improvements.
Keating (2000)	'RESPECT' integrative treatment with weekly or	n=24 Open cohort study.	None.	-3 re-offended during treatment.	**Strengths:** Lots of background information describing the model of treatment. **Weaknesses:** No justifiable rationale provided,

	monthly attendance depending in progress.				the paper is generally unclear, lack of information about participants in the study, length of treatment unclear, no information about types of offences participants had committed, not written as a clear research study, limitations not discussed, cohort study with no control group, no statistical analysis provided and therefore also no clinically significant change reported.
Lindsay, Olley, Jack, Morrison, and Smith (1998)	Integrative treatment programme for participants on probation. Treatments lasted 2.5 hours a week. One participant completed treatment individually over 9 months and other had treatment for 2 years in a group. First hour involved general issues and events related to each individual, including information about	n=2 Case study design (1 in group treatment compared 1 in individual therapy). Methods used and the cognitions that were challenged were the same.	Author devised assessment of beliefs consistent with sexually offending behaviour – not referenced (initial stages of QACSO)	-Further reductions made for the participant in the group. -For the participant in the group the reductions were consistent at a 60 month follow-up. -Participant who received individual treatment re-offended 9 months into treatment and imprisoned. -The participant who completed individual treatment improved on 3 scales (Rape, voyeurism and exhibitionism) but dating abuse remained the same at the end of treatment.	**Strengths:** Multiple baseline design providing within subjects control, raw data provided, and participant characteristics provided, attempt for participants to have similar offence type. **Weaknesses:** Rationale and aims unclear, case study design, the participant who was provided with individual treatment was seen by the author, no clinically significant change reported on, group vs individual treatment likely to differ in their application, no selection criteria provided, stalking not conceptualised at the start of the study.

	concerning behaviour that may lead to offending. Thirty mins spent on general talking so group facilitators could observe interpersonal behaviour. Last hour focussed on specific techniques, reviewing offending and cognitions. Offending cognitions were established and challenged using socratic questioning, encouraging to adopt a realistic attitude and then reinforced.

[1] Nichols & Molinder (1984)
[2] Moos (1993)
[3] Prosser, Moss, Costello, Simpson, & Patel (1997)
[4] Sparrow, Bella, & Chichetti (1984)
[5] Nowicki (1976)
[6] Beckett & Fisher (1994)

[7] Heighway & Webster (2007)
[8] Broxholme & Lindsay (2003)
[9] Bray & Forshaw (1996)
[10] Beckett & Fisher (1994)
[11] Russell (1996)
[12] Gendreau, Grant, Leipciger, & Collins (1979)
[13] Miller & Lefcourt (1982)
[14] Kolton, Boer, & Boer (2001)
[15] Kendall & Wilcox (1979)
[16] Paulhus (1991)
[17] Kiresuk & Sherman (1968)

Integrative treatment approaches

Integrative treatment approaches use a combination of models to provide comprehensive and person centred treatment (Dallos, Wright, Stedmon, & Johnstone, 2006). The integrated treatment approaches used in these studies combine cognitive treatment with more generic understandings of sex offending, which aim to increase victim empathy, develop alternative coping strategies, sex education, exploring the cycle of offending and relapse prevention.

Six studies (one case study and five cohort studies) used an integrative group treatment approach, and another two cohort studies used a manualised integrative treatment approach. These will be reviewed separately.

Case studies. Craig, Stringer, and Moss (2006) conducted a case study (n=6) which reviewed the impact of an integrative group sex offender treatment on attitudes consistent with offending and re-offending for ID sex offenders in the community. No improvements were found in attitudes consistent with sex offending, but there were no further incidents of re-offending during the 12 month follow-up period.

This study had a number of strengths despite also having limitations and lack of generalisability of using a case study design. A definition of ID was provided and the study aims were clear. Participant characteristics were clearly described and the authors acknowledged the study limitations, unlike some other studies discussed in this review. However a number of weaknesses reduced the quality of the study. It was unclear how valid and reliable the measures were as this information was neglected and measures were not standardised for use with an ID population. It is unclear whether the measures were understood by participants, potentially limiting the validity of the study. The exclusion criteria for participants were not stated and there was a wide variation of sex offences within the sample. Details of the treatment were lacking, preventing accurate study replication.

Cohort studies. Five studies used an integrative treatment approach within a cohort design. Each will be discussed separately due to differences in the treatments provided.

Keating (2000) described the 'RESPECT' intervention that consisted of seven steps – acceptance, victim empathy, self-esteem, developing a plan for the problematic behaviour, choice of action and self-trust. Treatment consisted of an open group where participants attended weekly or monthly, for the length of their probation. The programme was described in detail, enhancing study replication. It provided offence recidivism data for 24 paedophiles that had completed the programme whilst being in hospital or in the community. Three participants (12.5%) re-offended during treatment, which is lower than other reports (Hanson & Bussierè, 1998; Hanson & Morton-Bourgon, 2004). The study aims were unclear and no measures were described, which leaves outcomes other than re-offending behaviour unclear. No additional statistical analyses were completed and therefore no clinically significant change can be reported. As the treatment used an open group format, the group dynamics may have changed depending on who attended, possibly affecting outcomes.

Although this was a novel treatment for ID sex offenders, there was a lack of information about the study design, which limits the conclusions that can be drawn, and identifies this study as being of poor quality.

Rose, Jenkins, O'Connor, Jones, and Felce (2002) reviewed a treatment programme for ID sex offenders (n=5) on attitudes consistent with sex offending and re-offending. This study included a qualitative component about participant experiences of the group. No incidents of sex offending were reported up to 12 months post treatment and there were improvements in cognitions consistent with sex offending. These scores did reduce to baseline six months post treatment potentially showing a limited length of treatment impact.

Participants reported they found the group useful, but it is not clear why or how. A number of study limitations means the results have to be interpreted with caution. The same individual who delivered the treatment completed outcome measures with participants, possibly leading to distorted responses due to demand characteristics. Only one measure was standardised for use with the ID population. There were no reliable change calculations made on measures that showed improvements following treatment. Participants had also received individual counselling and so we cannot be sure of the true effect of group treatment on outcome.

A 12 month treatment study by Keeling, Rose, and Beech (2006) recruited 18 ID sex offenders in custody with a range of sex offences. The authors were interested in the impact of treatment on attitudes consistent with offending and victim empathy. There was no reporting of offence recidivism, but improvements were made across all measures.

Two measures were validated for use with an ID population, and a deception scale was used to detect attempts at response distortion. Type I errors in using statistical analyses with a small sample size were discussed. Reliable change was calculated and effect size reported, which no other study in this review has provided. Other limitations that were acknowledged was the lack of follow-up data, lack of treatment detail and the implications of using a broad definition of ‘special needs’. The authors seemed to make a real attempt to highlight the methodological limitations in comparison to other studies.

Murphy, Powell, Guzman, and Hays (2007) also conducted a cohort study (n=8) with a six month follow up period exploring the impact of group treatment on sexual knowledge, attitudes consistent with sex offending, self-appraisal, victim empathy and on offence recidivism. No improvements were found in attitudes consistent with offending. During the six month follow up three participants (38%) re-offended but were not reconvicted.

There are significant strengths and weaknesses of this study which impact on the reliability of its findings and overall study quality. A definition of sexually abusive behaviour was provided, and there was detailed information about the participants. Three out of the four measures were adapted for use within an ID population, making the responses more reliable. Multiple baseline measures provided a within subjects control for treatment effects. Limitations of the study were a small sample size and no definition of ID. Two participants completed the treatment twice which limits the conclusions about the effectiveness of this particular treatment. Although an outline of the topics covered in the treatment was provided, there was no information about how these topics were delivered.

Swanson and Garwick (1990) also conducted a cohort study (n=15) which involved an open-ended treatment group. The group met for 90 minutes on a weekly basis, and the average length of time in treatment was 14 months. The aim of the treatment was to prevent further sex offending for a period of two years, although it is not clear why only two years. During treatment two participants (13%) were re-convicted of sex offences and four (27%) were involved with the police for sex offences, totalling 40% of the study sample. The authors gave a definition of ID and recidivism in relation to their study, and also provided the inclusion criteria, but did not offer information about group members' characteristics. The treatment philosophy was outlined but details of the treatment programme was not provided, and therefore it is unclear what the treatment consisted of and how this was implemented. The study used a goal attainment scale to inform the overall results of the study, which enhanced the person centred nature of the treatment, but limits generalisability.

This study is limited in terms of the information it can provide for treatment of ID sex offenders due to a lack of methodological robustness. There is no control group or within subject measures, and the results suggest a lack of impact of treatment on sex offending

behaviour, as almost half of the sample were identified as behaving in a sexually inappropriate manner after starting treatment. There were no additional statistical analyses and therefore the reliable change index following treatment cannot be reported. The authors also did not address the study's limitations and seemed overly positive in regards to their conclusions.

To summarise, there is variability in terms of the group treatments offered for ID sex offenders, how they are evaluated, and the outcomes of these studies. There are a number of confounding variables in each study, which the authors have failed to acknowledge in most cases.

Manualised integrative treatment programmes

The Sex Offender Treatment Services Collaborative – Intellectual Disability (SOTSEC-ID; Sinclair, Booth, & Murphy, 2002) is a group of professionals involved in the development of treatment for ID sex offenders. This manualised programme has been employed in a number of healthcare trusts and provides a more standardised approach to treatment, involving sex education, interpersonal skills, identifying and changing distorted cognitions related to sexual behaviour, victim empathy, cycle of offending and relapse prevention.

Two studies were retrieved as part of this review that have used this approach. The authors have described the treatment approach as using 'CBT', however the descriptions of treatment provided by the authors suggest a more integrative manualised approach as other lifestyle factors and extended support are also included in the programme. Both studies used this 12 month weekly SOTSEC-ID treatment programme but one study included an extended follow-up period. This follow up study used some of the same participants, but there were also additional participants included, which is why both studies are reported in this review.

Murphy et al. (2010) conducted the largest cohort study in this review with 46 participants with a six month follow up period, and Heaton & Murphy (2013) conducted a similar study (n=34) with an extended follow up period of 15-106 months. The aim of the studies was to provide treatment for ID sex offenders and evaluate treatment effectiveness based on changes in sexual knowledge, attitudes consistent with sex offending and re-offending rates. Measures were completed in both studies at baseline, at the end of treatment and at a 6 month follow up. The participants in Heaton and Murphy's (2013) study also completed measures at longer term follow up.

Both studies found significant improvements in attitudes consistent with re-offending. Both studies also reported sexual re-offending during the study period, with Murphy et al. (2010) reporting a lower re-offending rate of 15% compared to Heaton and Murphy (2013) at 32%. Both of these rates are higher than previously reported in meta-analytic reviews (Hanson & Bussierè, 1998; Hanson & Morton-Bourgon, 2004). This could be due to Heaton and Murphy (2013) having a shorter follow up period, possibly indicating a lack of continued impact of treatment. This of course has to be treated tentatively due to some methodological limitations.

These studies are the most methodologically robust in this review due to the detailed information provided to enable replication, and both having used the same manualised treatment. Only one of the measures (SOSAS; Bray & Forshaw, 1996) was not validated for use with the ID population. These studies provided clear aims and hypotheses, definitions of sexually abusive behaviour and study inclusion criteria. Where details were omitted from these papers about treatment and details of the measures, the authors made reference to locations where this information could be retrieved. All staff working with these participants were trained in the treatment approach which provided consistency in treatment delivery. Despite these strengths, the authors mentioned that there was a control waiting list but did not

provide details of this in the write up. Although these studies have larger sample sizes than in other studies reviewed, there is no mention of power calculations. Neither a clinically significant change score nor an effect size was provided, despite both studies identifying significant improvements on measures. This leaves us unclear about the strength of the study and the true effect of treatment. In addition to this, there was also a wide variation in the sample in terms of offence type.

CBT based treatment programmes

CBT is based on the assumption that cognitions affect behaviour and emotions, and by changing cognitions, behaviour can be modified. A CBT therapist assumes that psychological difficulties are partly caused by cognitive dysfunction and through learning, cognitions can be changed (Sternfert-Kroese, 1997) which can result in changes to behaviour.

Three case studies and one cohort study used CBT treatment for ID sex offenders.

Case studies. All of the case studies looked at the impact of CBT based group treatment programmes on attitudes consistent with sex offending and on sexual re-offending (Lindsay, Neilson, Morrison, & Smith, 1998a; Lindsay, Marshall, Neilson, Quinn, & Smith, 1998b; Lindsay, Olley, Jack, Morrison, & Smith, 1998c). All studies had varying follow-up periods of four years (Lindsay et al., 1998a), five years (Lindsay et al., 1998c) and at least six years (Lindsay et al., 1998b). Lindsay et al. (1998a) compared treatment over a 1 or 2 year probation period with six ID sex offenders. Lindsay et al. (1998b) compared treatment in a group versus an individual setting specifically for four exhibitionists and Lindsay et al. (1998c) for two stalking offenders, but the treatment in all studies was the same. The treatment involved offence acceptance, altering distorted cognitions and reviewing behaviour. Altering cognitions involved showing slides of men engaging in indecent exposure (Lindsay et al. 1998a) or discussing various scenarios including showing a picture of a man reading a

story to a young girl sat on his knee. If the cognition consistent with offending had been elicited, the session would focus on challenging this belief.

The findings of all studies reported a significant improvement in attitudes consistent with sex offending following treatment, with those on two year probation sentences improving more than those on a one year probation period (Lindsay et al., 1998a). Those in group treatment improved more than those in individual treatment, which was also consistent at a 60 month follow up (Lindsay et al., 1998c). Specific beliefs around acceptance of behaviour were easier to change, and beliefs around blame and harm were the most difficult to change (Lindsay et al. 1998a). For the exhibitionist group, beliefs around indecent exposure being fun or not causing women any harm were the most open to change (Lindsay et al., 1998b). One participant's exhibitionist attitudes returned to baseline levels at follow up, which was 25% of the sample (Lindsay et al., 1998b). Lindsay et al. (1998a & b) reported no further re-offending during follow up, but the participant in Lindsay et al. (1998c) re-offended and was subsequently imprisoned.

Due to the nature of these studies using a case study design, we cannot draw firm conclusions about specific treatment effectiveness, due to the absence of any control group or a reliable change index on measures demonstrating significant improvements following treatment. A lack of methodological rigour also effects the quality of the studies and the ability to replicate on a larger scale. Small sample sizes limits generalisability of the study. The use of one measure of attitudes consistent with sex offending, and the fact that this has not been validated for use with an ID population limited the reliability of the reports of altered cognitions. The studies did however provide descriptions of patient characteristics, and while there was a lack of detail about the treatment as a whole, there was a clear description of how distorted cognitions were elicited and challenged within the group. In Lindsay et al. (1998c)

participants in the group treatment condition are likely to have been challenged about their cognitive distortions in a different way compared to the participant who received treatment individually, which limits the comparability of these approaches in this study.

Due to the significant methodological limitations and limits of the study design, the results have to be treated with great caution.

Cohort study. A cohort study (n=7) by Lindsay and Smith (1998) used the same treatment as identified in the case study designs by Lindsay et al. (1998 a, b & c) and similarly assessed the impact of this treatment on attitudes consistent with sex offending, with participants who were on either a one or two year probation period. Participants were split into different treatment groups based on the duration of their probation, which occurred weekly for 150 minutes. Participants completed a measure designed to assess attitudes consistent with sex offending at four time points before treatment, which allowed for a within subjects control group design. The authors found significant improvements in both groups after treatment on attitudes consistent with sex offending, particularly denial and minimisation of the offence, with those who were on two year probation period showing more improvements than those on a one year probation period. No incidents of re-offending were reported from those on a two year probation period, whereas two participants re-offended who were on a one year probation, during the study period.

The within subjects control group design strengthens this study's methodology to some extent, but still prevents the ability to draw firm conclusions about treatment effectiveness on sex offending due to other methodological weaknesses. The authors clearly provide the aim of the study and justify the lack of a control group by discussing the ethical issues around doing so. Details of participant characteristics and treatment were provided which increases the likelihood that the study can be replicated. The authors highlighted that there was not

always sufficient time to deal with denial and minimisation in the group with participants on one year of probation, which indicates that there were differences in the way the treatment was administered, or that these beliefs are resistant to change and therefore longer treatment may be needed. This may have led to the differences in sex offending behaviour between groups during the study period. The authors have acknowledged some of the study limitations, but do not discuss the confounding variables which may have influenced the study results or clinically significant change, which ultimately lead to a reduction in study quality.

Discussion

Summary of findings

This review comprises 12 studies that have sought to measure the impact of group treatment for ID sex offenders on cognitions consistent with sex offending, and on preventing sexual re-offending. Across the studies 168 participants completed group based sex offender treatment programmes. The studies are difficult to compare due to various theoretical underpinnings, and methodological and treatment differences.

The review demonstrates a variation of the impact of sex offender treatment on positively altering cognitions associated with sex offending. At this time we cannot conclude that treatment does or does not impact on these cognitions, due to the methodological differences and lack of methodologically robust studies and differences in study outcomes. There was also a variation in reported re-offending behaviour across the studies, meaning that no firm conclusions can be drawn about the effectiveness of treatment on preventing re-offending.

Although many studies in this area reported significant improvements on various measures following treatment, these improvements were mostly inconsistent with reported re-offending behaviour. The most consistent finding in this review is that changes in cognitions do not always lead to no further re-offending. In some cases, group members reported a reduction in cognitive distortions but still went on to commit further sexual offences (Heaton & Murphy, 2013; Lindsay & Smith, 1998; Murphy et al., 2010), and in some other cases worsened or mixed outcomes on cognitions have resulted in further re-offending (Craig, Stringer, & Moss, 2006; Lindsay et al., 1998a; Rose et al., 2002). Perhaps the variation in outcomes can be attributed to the heterogeneous group that are being researched, which makes it difficult to conduct large scale, methodologically robust studies.

It is important to consider whether existing treatments are indeed useful in preventing re-offending and whether the existing models upon which this treatment is based, are applicable to an ID group in preventing sex offending behaviour.

The findings in this review suggest there may be less positive results for sex offender treatment for ID sex offenders, compared to non-ID sex offenders. Re-offending rates in ID sex offenders in this review are consistent with meta-analytic reviews (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004), suggesting that current treatment programmes may not be effective in preventing further re-offending. This may be due to treatment not being adapted in an applicable way for ID sex offenders and/or models not being specific for ID sex offending. The models described earlier (Finkelhor, 1984; Ward & Hudson, 1998) do not incorporate specific factors related to ID sex offending, such as a lack of opportunity to develop appropriate sexual relationships and having less social support, and therefore may not be as applicable as initially thought to ID sex offenders. A model incorporating these

specific factors is likely to be more applicable to ID sex offenders, which may in turn lead to the development of more effective treatments to prevent sex offending.

Methodological limitations of existing research prevent firm conclusions from being drawn about treatment effectiveness. Many studies included in this review were overly positive in their results and conclusions of ID sex offender treatment, and many failed to acknowledge the methodological limitations of their studies. It is important to note that none of the studies included in this review have used an RCT design limiting conclusions about treatment effectiveness, although it would be unethical to employ an RCT design with this population due to having to with-hold treatment for the control group. Only studies using a case study or cohort design (without a control group) have been used. These study designs sit at the bottom of the hierarchy of effectiveness (National Health and Medical Research Council, 2009), indicating low quality evidence.

Methodological limitations need to be addressed to produce more robust crucial research in this area. A wide variation of participant characteristics and offence type may explain some variation in results. Treatment content, treatment length and session length differed across studies, which may have led to some variation in the results. This could be due to longer programmes reinforcing learning leading to a longer period of treatment impact. This supports other research that has shown a decrease in offence recidivism when intensive treatment is delivered to high risk offenders (Bonta, Wallace-Capretta, & Rooney, 2000).

Self-report measures often lead to socially desirable responses and acquiescence (Clare & Gudjonsson, 1993) which may affect the validity and reliability of the studies. Only one study included a deception scale to gauge socially desirable responding. Also of importance is to establish whether the measures used across the studies were valid for use with an ID sample,

as Rose et al. (2002) pointed out that some of their sample could not complete the measures due to the severity of their ID.

For those studies that demonstrated improvements on measures, sufficient evidence of individual change using the reliable change index (Jacobson & Truax, 1991) was not presented in any of the case studies and only provided in one of the cohort studies. Effect sizes were also not presented for the larger cohort studies. This is a significant element of being able to provide conclusions about treatment effectiveness, and thus the conclusions about treatment effectiveness for this group are limited.

There has not been any consideration of the role of mental health on treatment effectiveness, despite mental health problems presenting in 32% of the ID sex offending population (Day, 1994; Lindsay et al., 2002). These statistics suggest that some individuals in the studies are likely to have mental health difficulties, which may have affected their engagement with treatment, and/or may have been part of the formulation of their offending behaviour in the first place.

Surprisingly all of the studies fail to mention the impact of differences in severity of ID on treatment outcome. There are likely to have been differences in levels of understanding and ability, which may explain some of the variation in treatment outcomes. Perhaps a narrower range of IQ in studies would help to eliminate this as a confounding variable.

It is important for this population to have made significant improvements in offending behaviour in order to be considered of less of a risk to society, and considered for discharge or release into the community, which may lead to socially desirable responses on measures. It is therefore essential that re-offending behaviour be considered when evaluating treatment effectiveness as this may more accurately identify level of risk to others.

It is important to recognise the widely varied sex offences captured within these studies (for example indecent exposure, accessing child pornography, rape of a child, rape of an adult etc.), and the difficulty in separating offences to understand more about whether some offences respond better than others to treatment.

It is unclear whether positive outcomes can be attributed to the treatment itself, or whether other factors such as being supported on probation and their wider care team can account for some of these changes (especially for those in inpatient settings as they are likely to be receiving other forms of treatment). This may be more supportive of the Good Lives Model (GLM; Ward & Stewart, 2003) of sex offending, which emphasises the need for individuals to adopt a fulfilling lifestyle by supporting wellbeing, including developing relationships. Without a control group, the effectiveness of such treatment is unclear.

It is worth noting that the effectiveness of sex offender treatment seems to be considered differently to other psychological treatment, in that it is only considered effective if there has been no re-offending (Lindsay, 2009). If an individual has committed one further sexual offence the treatment is deemed to have been ineffective, whereas this is considered a relapse in treatment of other conditions such as alcohol or drug addiction. It is likely that this is due to the seriousness of sex offending behaviour and the risks that it poses to society.

Strengths and limitations

This review adds to the understanding of sex offender treatments for an ID population, and has significant clinical implications.

The majority of studies were found following bibliography searches indicating that the initial search strategy may have had some gaps, and that future reviews should consider looking at a larger set of databases.

Although this review used quality checklists as outlined by the EQUATOR guidelines, the STROBE (von Elm et al., 2007) checklist did not consider different elements of treatment or give an indication of how to evaluate the quality of information provided about treatment. This is therefore not quality assessed as well as other areas identified by this checklist.

The study in this review that includes a qualitative component may have benefitted from using a quality checklist more suited to a mixed method design, to ensure the quality was evaluated accurately.

The review may have also benefitted from a quality rating for each study based on the checklists that were used. This may have increased the accuracy of the review.

Clinical implications

The potential clinical implications of this review focus on the types of treatment offered for ID sex offenders. It is possible that this population benefits from sex offender group treatment, but the lack of good quality research only allows us to conclude that changes in cognitions do not necessarily prevent re-offending. The review has important implications for assessing risk, treatment planning, measuring treatment outcomes and also in thinking about the applicability of existing models of sex offending to an ID population. Are current treatments for ID sex offenders relying too heavily on modifying cognitions consistent with sex offending, and are they missing other key contributors to sex offending for this population not currently incorporated into non-ID models of sex offending? Are current models of sex offending not as applicable to this population as initially thought?

It is essential that treatment has clear theoretical underpinnings which the treatment presented in this review do not. Simply adapting treatments used for the non-ID sex offending population, for ID sex offenders may not be sufficient. If existing models are adapted it

misses the ID part of the formulation of offending behaviour, and perhaps this needs to be incorporated, for example they are likely to have more difficulty establishing appropriate relationships, less coping strategies for stress and smaller support networks. Perhaps there is more to understand about ID sex offending behaviour, which may include developing a specific ID sex offending model. Interventions may also need to be much wider than just psychological therapy, for example developing a person's support networks, and providing opportunities for appropriate sexual expression.

Longer follow-up periods are necessary given the limits to treatment effectiveness over time and thought needs to be given to ensure that any positive changes can be maintained. There are of course financial implications to this, but perhaps there needs to be more investment in this client group so there is less re-offending, as risk would then be reduced and the long term costs of hospital admission or imprisonment would be reduced.

In more manualised approaches, there may be less of a need for clinical psychologists to be involved in programme delivery if in depth training is provided. If manualised approaches are implemented more often, it leaves us to question whether there is a role for clinical and forensic psychologists in the delivery of such offender treatment. Contrary to this, if other health professionals are able to deliver manualised treatment it could make this type of treatment more readily available to those that require it.

Clinical psychologists could be key in helping staff in secure provisions to understand the current treatment limitations and emphasise the need for ongoing individual support post sex offender treatment. This could be in providing support around key strategies and in further understanding their offending behaviour, based on more individualised biopsychosocial formulations of an individual's offending behaviour. Clinical psychologists can also provide supervision for group facilitators and treatment evaluation.

Research implications

Research in this area is at a very early stage using small and diverse samples in various contexts. More work is needed to develop theories of sex offending in an ID population to help understand sex offending behaviour better within this group which can then inform treatment. More individual case studies may also be interesting as offenders with ID are such an heterogeneous group in terms of offending, type and severity of ID and treatment context. Such case studies may lead to preliminary hypotheses about certain groups of individuals or certain types of offences, but this would need to lead to larger scale studies with control groups to examine treatment effectiveness. Further work also needs to be done to aid our understanding of the processes of change, to ensure that treatment includes aspects that are key in the behaviour change process. Due to many participants re-offending it is essential that this is understood. Therefore research examining ID sex offender perceptions of why they do to not re-offend and how they are supported to do so is of interest. This may lead to an understanding of whether ID sex offenders are aware of their level of risk to others and how they make attempts to stop re-offending.

Although there are considerable methodological limitations in the studies reviewed, it is possible that ID sex offenders may benefit from group treatment, but further exploration is needed to see if group treatment is more effective than individual treatment. Most of the studies reviewed treatment programmes that were 12 months and longer. Further research could explore whether shortened interventions could have the same impact on reducing sex offending behaviour. This would reduce the cost of treatment for services.

A limitation to a lot of research within this field is that the data may not be reliable due to not all participants being able to complete all measures due to severity of their ID. Existing measures used in this research need to be modified and validated with this group so all

participants are able to complete. In addition to self-report measures, it may be useful to include more objective/informant based measures to gain an alternative view.

Conclusion

This review considered the impact of group based treatment programmes for ID sex offenders on cognitions associated with sex offending and on re-offending behaviour, with a broader consideration for the applicability of existing sex offending models for ID sex offenders. Design and methodological limitations across the studies have been highlighted, and have prevented being able to draw many firm conclusions. The most consistent finding was that changes in cognitions associated with sex offending do not necessarily lead to changes in offending behaviour for this group.

This review highlighted the need for higher quality research with methodological rigour in order to be able to understand the true effectiveness of ID sex offender treatment.

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Section B: Understanding important aspects to treatment for intellectually disabled sex offenders – can existing models be applied to this group?

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Abstract

Background – Existing research shows that sex offender treatment programmes for intellectually disabled sex offenders are not always effective in preventing further re-offending. Research to understand what this group find important in the treatment process is essential in understanding the applicability of existing treatment for this group.

Method – Thematic analyses were used to analyse 14 interviews with intellectually disabled male sex offenders, who had completed a group sex offender treatment programme.

Results – The results supported some aspects of existing models of sex offending, and identified other aspects considered important in treatment for this group. Three main themes were identified: connecting with others, possible factors influencing offending behaviour, and progress in risk reduction.

Conclusions – Existing models of sex offending may not be applicable for intellectually disabled sex offenders in preventing further sex offending. Consideration of developing a new model of sex offending specifically for intellectually disabled sex offenders may be required, which may lead to a potential review of existing intellectually disabled sex offender treatment.

Keywords: intellectual disability, sex offender, group treatment

Introduction

Prevalence of sex offending

As of 2015 there were 11,490 sentenced sex offenders in the United Kingdom. This was a 10% increase compared to 2014 (Ministry of Justice, 2015). In a meta-analysis of 61 studies, Hanson and Bussière (1998) found rates of sex offence recidivism to be 13.4% over five years, indicating a high proportion of sex offenders continue to re-offend following treatment.

The prevalence of sex offending within the intellectually disabled (ID) population appears to be higher than that of non-ID sex offenders (Lindsay, 2002), although a variation in prevalence rates has been reported (Gross, 1984). Evidence suggests higher rates of offence recidivism in ID sex offenders (Craig & Hutchinson, 2005), with 34% of re-offending taking place within 12 months of release from prison (Klimecki, Jenkinson, & Wilson, 1994). This could be due to sex offending being less sophisticated in the ID population and more likely to be detected (Craig & Hutchinson, 2005). These statistics indicate a need for effective treatment for ID sex offenders.

Models of sex offending

There are no specific models to understand sex offending in an ID population. The two most dominant models of sex offending within the general population are described below.

Finkelhor's 'pre-condition model of child sex abuse' (Finkelhor, 1984). This multi-factorial model suggests four pre-conditions are necessary for sex offending to occur:

1. Motivation to offend
2. Overcoming internal inhibitors to offend
3. Overcoming external inhibitors (such as restrictions in environment)
4. Overcoming victim resistance

According to this model, sex offending is unlikely to occur if any one of the pre-conditions is unsatisfied. Treatment therefore needs to prevent these conditions from being met, and is usually achieved by increasing internal inhibitors and ensuring plentiful external inhibitors such as support from professionals, and avoiding situations where sex offending is more likely to occur.

Ward and Hudson's 'self-regulation pathways model' (Ward & Hudson, 1998). This model proposes that there are four pathways to offending which are determined by either an active or passive style of self-regulation. The first pathway is the approach/explicit pathway in which it assumes a motivation to sexually offend. This is adapting an active style of self-regulation. The second pathway is the approach/automatic pathway in which the individual displays learned behaviour consistent with sex offending, using passive self-regulation. The third is the avoidant/active pathway in which attempts are made to manage the thoughts and behaviours that lead to sex offending. The fourth is the avoidant/passive pathway where the individual does not have the coping skills to prevent sex offending, even though they may not necessarily want to sexually offend.

Similarities between these models. These models overlap in some areas. Both assume that an individual can be motivated to offend, and that distorted cognitions play a role in sex offending. They also both assume that sex offending is learned by experience of exposure to abusive relationships. Any further relationships are therefore guided by this knowledge and experience of relationships.

Other models of sex offending. Other models that have been used to explain sex offending, but are less dominant within the literature exploring sex offender treatment effectiveness for the ID population include the Good Lives Model (Ward & Stewart, 2003). This relies on facilitating a more fulfilling life and integration into society. Marshall and

Barbaree's (1990) integrated theory of sex offending has also been used to explain sex offending which considers biological, childhood experiences and socio-cultural factors, presenting a more intrinsic explanation of offending. This model may be used when formulating sex offending to include their ID and other factors that may influence offending behaviour for this group. This model may highlight key differences between sex offenders in the general population and ID sex offenders.

Sex offender treatment

Meta-analytic reviews have sought to provide information and clinical guidance about the treatment effectiveness for non-ID sex offenders. These reviews tell us that due to a lack of methodologically sounds studies, firm conclusions about the effectiveness of sex offender treatment cannot be provided (Furby, Weinrott, & Blackshaw, 1989), with a need for randomised control trials (RCTs) to be able to draw firmer conclusions (White, Bradley, Ferriter, & Hatzipetrou, 1998). However, there are reviews that suggest recidivism rates are lower for those in treatment compared to those who are not (Loesel & Schmucker, 2005; Hanson, Bourgon, Helmus, & Hodgson, 2009). Most sex offender treatment programmes with non-ID sex offenders also adopt a group format (Knopp, 1984; MacFarlane, 1983).

Difficulties faced by individuals with ID

People with ID are likely to face difficulties in reading non-verbal communication (Spafford & Grosser, 1993) and understanding emotions (Arthur, 2003). They are also likely to have differences in cognitive processing (Kolligian & Sternberg, 1987), may be more likely to live with their parents for longer and may have more limited access to sex education. These factors need to be considered in models of sex offending, in planning treatment and delivery compared to treatment for non-ID sex offenders.

Applicability of sex offender treatment models to ID sex offenders

Due to a higher prevalence of sex offending within the ID population, it is crucial that treatment is provided for this group. To date, sex offender treatments for those with an ID have been based on models of sex offending in the general population. Adaptations have included simplification of language, using visual information and emphasising the importance of generalising skills (Lambrick & Glaser, 2004) to ensure a level of understanding for this group. However, it is unclear whether existing models of sex offending are applicable to an ID group, if treatments are effective and whether current adaptations made to treatment are sufficient to prevent future re-offending. This is due to a variation in treatment outcomes and high re-offending rates. There may be other key differences between ID sex offenders and non-ID sex offenders that are not considered in the adaptation of treatment due to existing sex offending models not incorporating specific factors involved in ID sex offending.

Although there is a paucity of research exploring the effectiveness of ID sex offender treatment on re-offending, that which does exist is inconclusive due to methodological weaknesses. The most consistent finding across the literature is that improvements in distorted cognitions such as blaming the victim, do not necessarily prevent further sex offending behaviour (Craig, Stringer, & Moss, 2006; Heaton & Murphy, 2013; Lindsay, Neilson, Morrison, & Smith, 1998; Murphy, Powell, Guzman, & Hays, 2007; Murphy et al., 2010; Rose, Jenkins, O'Connor, Jones, & Felce, 2002). A better understanding of sex offending behaviour for this group, and understanding what is considered helpful to prevent re-offending is necessary to determine the applicability of existing sex offending models.

Research rationale

Treatment for ID sex offenders has not been hugely successful in preventing further sexual re-offending. It is therefore important to understand how ID sex offenders perceive sex offender treatment and what they consider to be important in this process. This will help to understand how much of existing sex offending models are applicable to ID sex offenders and will offer insight into what may be important to prevent ID sex offenders from re-offending after completing treatment.

The present study

By using first hand experiences of individuals who have completed sex offender treatment in a group setting, a qualitative analysis aimed to address the following research questions:

1. How do ID sex offenders who have completed sex offender treatment understand their on-going risk?
2. What do ID sex offenders who have completed sex offender treatment do to help prevent them from re-offending?
3. How applicable are current models of sex offending for an ID population?

Method

Design

Methodology. A qualitative non-experimental design was used to address the research aims.

A semi-structured interview schedule (Appendix E) was developed based on the guidance by Smith, Harré, and Langenhove (2003), to avoid jargon and use open ended rather than closed questions. Interviewing people with ID is challenging and suggestions to overcome these

challenges (Booth & Booth, 1996) were incorporated into the interview schedule, such as using more direct questioning and prompting if necessary.

A qualitative methodology was deemed the best approach to obtain a deep and rich understanding (Miles, 1979) that could not be achieved from a quantitative design. Thematic analysis was considered more suited to this exploration than grounded theory which aims to build a theoretical model (Corbin & Strauss, 2015) or interpretive phenomenological analysis (IPA) which is concerned solely with subjective experiences. This study was not only concerned with how the participants made sense of their experiences, so thematic analysis was considered more appropriate to answer the full range of research questions. The analysis followed the guidelines by Braun and Clarke (2006).

Both deductive and an inductive approaches to thematic analysis were used to identify patterns within the data. A deductive approach is driven by theory, producing pre-determined codes. An inductive approach on the other hand is data driven as it comes directly from the data, without any theoretical influences.

Codes for the deductive component were generated prior to analysis from the overlapping components of both Finkelhor's (1984) model and Ward and Hudson's (1998) model, as they are the most dominant models of sex offending in the literature (Appendix K).

A deductive approach was important in identifying similarities in the data between ID and non-ID sex offenders, and determining the level of applicability of existing sex offending models. An inductive analysis was also essential to understanding ID sex offenders and their efforts not to re-offend, adding to the existing evidence base. These approaches have been demonstrated together in Fereday and Muir-Cochrane (2006), where the authors reported it enhanced the rigor of their data analysis.

Epistemology. The researcher held a critical realist position (Sullivan, 2010) as the interviewing procedure took on a construction of reality as opposed to a more objective reality.

Participants

Participants were recruited from NHS organisations from October 2015 to February 2016 and again at a second time point in August 2016 following a review of existing data. Participants came from a range of settings: secure hospital provision, probation and in the community. Individuals were approached about the study if they met the following inclusion criteria:

- Identified as having an ID by the service they were attached to at the time of recruitment
- Over age 18
- Able to provide informed consent
- Committed a sex offence (may or may not be convicted)
- Completed a sex offender treatment programme in a group

Individuals were excluded from the study if they met any of the following criteria:

- Unable to provide informed consent
- Acutely distressed and/or too distracted by ongoing symptomology to participate

At time point one 18 individuals were approached and 13 agreed to take part in the study. One individual was excluded from the study following consenting due to concerns about his capacity to participate further, and another was initially excluded due to not adequately meeting the study criteria. After a review of the data at time point one, it was decided that an

additional interview would more clearly address the study aims. This second interview asked more questions about efforts they have made to prevent them re-offending and additional support (Appendix E). Five participants who consented and completed an interview at time point one consented to take part in an additional interview at time point two. An individual who was previously excluded, was included at time point two due to these protocol changes. A further two participants provided their consent at this point. The study had a total of 14 participants, and no further participants were sought due to no new themes arising from the data. No other participants recruited at time point one gave their consent to a second interview at time point two.

A summary of the participant demographics is presented in Table 3. The sample had an age range of 24-57 years and an IQ range of 51-79. A more detailed description of two participants, one who was residing in a secure hospital and one who was living in the community is provided below to give a sense of the participants who took part in this study.

Participant 5. Mark* was a 57 year old living in a secure hospital for people with ID. His IQ measured 67 on the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999), which is in the 'Extremely Low' range.

No information was available about his early developmental history. However, he did attend a mainstream school, although his attendance was inconsistent due to truanting. At age 8 he was sexually abused. He became sexually active at a young age, promiscuous during his teenage years with voyeuristic behaviour throughout his life. He was convicted of rape aged 17, and imprisoned in a young offender's institution. Upon release he married and had two children. He lived independently in the community with his family, until he divorced.

He committed a number of other sex offences primarily directed towards women, consisting of inappropriate sexual behaviour, inappropriate touching, exhibitionism and frotteurism.

During sex offender treatment his mental state fluctuated, and spoke about doing the treatment to prevent him going to prison. He tended to minimise other group members sex offending behaviour. He also had poor recall of the treatment despite a great deal of repetition. He functioned fairly independently on the ward, and received support when on leave in the community due to his continued risk to others.

Participant 8. Brian* was aged 49 and had a mild ID. He was living in the community and attended a relapse prevention group programme on a monthly basis.

He attended a mainstream school but his attendance was inconsistent due to physical health problems. He moved to a school for children with ID due to struggling to achieve academically. When he left school he attended a day centre for people with ID, but was excluded from this and one further day centre due to having sexual intercourse with women at the centre. One woman reported this as rape and he received a police caution.

He received anti-libidinal medication for a short time but this was terminated due to the side effects he experienced. He attended a group sex offender treatment programme (SOTP) and demonstrated a good memory for the material but did not show empathy for his victims. He seemed unashamed of his offences and talked about them in a straightforward manner. Following this treatment programme, he continued to have one to one psychology sessions, and during this time he did not re-offend. When these sessions ended he re-offended.

He was supported by his mother with daily living such as managing finances.

Table 3. *Participant demographics*

Participant Number	Number of interviews	Time point recruited	Age	IQ (as documented in their medical records)	Mental health diagnosis	Index offence	Setting of group completion	Current location	How long ago completed SOTP	Re-offence information
1	2	1	35	76	ASD	ABH due to fetishism	Inpatient secure hospital	Inpatient secure hospital	8 years	Sexually inappropriate behaviour but no re-offence / conviction.
2	2	1	37	66	ASPD	AOABH and exhibitionism (intent to perform sexual act)	Inpatient secure hospital	Inpatient secure hospital	3 years	Sexually inappropriate behaviour but no reconvictions.
3	1	1	24	70	None	Rape on a minor	Inpatient secure hospital	Inpatient secure hospital	3 years	Exposed himself to another patient.
4	2	1	30	51	ASD, depression, GAD	Rape on service user	Inpatient secure hospital	Inpatient secure hospital	3 years	Sexually inappropriate behaviours but no reconvictions.
5	1	2	57	67	Paranoid schizophrenia	Rape	Inpatient secure hospital	Inpatient secure hospital	3 years	Frotteurism, sexually inappropriate to ward staff.
6	2	1	36	61	ASD	Sexually motivated attempted abduction	Inpatient secure hospital	Inpatient secure hospital	5 years	Sexual indecent assault but no reconvictions.
7	2	1	35	79	ASD	Indecent assault of a minor	Inpatient secure hospital	Inpatient secure hospital	Unknown	Reconviction of indecent images of children.
8	1	1	49	Unknown	None	Rape, indecent assault, exhibitionism	Community	Community	4 years	None.
9	1	1	47	69	Autism	Obscene phone calls	Community	Community	7 years	Taken sisters underwear.
10	1	1	28	54	None	Exhibitionism	Community	Community	6 years	Exhibitionism.
11	1	1	39	60	Schizophrenia	Indecent exposure	Inpatient secure hospital	Community	11 years	None.
12	1	1	24	Unknown	ASD	Inappropriate sexual and violent behaviour towards female adults and children.	Probation	Community	18 months	None.
13	1	2	34	62	None	Rape of a minor	Medium secure hospital	Medium secure hospital	8 months	None.
14	1	1	45	68	None	Rape	Inpatient secure hospital	Inpatient secure hospital	2 years	Sexual indecent assault but no reconvictions.

Note. ASD is autism spectrum disorder. ABH is actual bodily harm. ASPD is anti-social personality disorder. AOABH is assault occasioning actual bodily harm. GAD is generalised anxiety disorder.

Procedure

Consent was sought to obtain demographic information and to take part in an interview about the group sex offender treatment programme they had completed. A copy of the consent form (Appendix F) was uploaded to all electronic records.

Ethical Considerations. Due to this study requiring participants from NHS sites, ethical approval was sought and granted from NHS ethics in December 2015 (Appendix C). Research and development departments were contacted for the NHS host trusts and approval gained. Two amendments also received approval (one of these was due to substantial changes to the protocol including new research questions and change in type of data analysis, see Appendix C) from the ethical board on 26th September 2016, and from relevant research and development departments on 27th September 2016 (Appendix D). The researcher followed the Code of Ethics (The British Psychological Society, 2009) outlined by The British Psychological Society for the duration.

This study was of a sensitive nature due to participants being identified as sex offenders. This, in addition to the limits of confidentiality, was explained during the information giving stage, consenting, and at the start of the interview. Capacity was assessed at the point of consent and again at the start of the interview by checking understanding of the research and what was involved, due to possible changes in capacity.

Although the study did not require participants to discuss their sex offences, it was important to consider how disclosures of sex offences would be dealt with should they arise. All participants were informed at the start of the interview that if they mentioned any offences that staff were unaware of, it would be reported to staff. Although some participants did talk about their sex offending behaviour, no participants disclosed any new sex offending that was not already known about.

Sampling. Purposeful sampling identified further participants on probation and in the community. Potential participants meeting the inclusion criteria were given information about the study. Four individuals declined to meet with the researcher following a brief outline of the study given by a member of staff.

The sample was homogeneous in that all participants were male, had ID and had committed a sex offence. The sample was also heterogeneous as participants had committed different types of sex offences, had different levels of ID severity, and differences in time since completing sex offender treatment. Some participants continued to be treated in a hospital setting whereas others received treatment in the community.

Informed consent. Due to all participants having an ID, it was particularly important to consider acquiescence and capacity to consent, to ensure that the consenting process was ethical. Guidance was sought about checking capacity to consent from the research supervisor, who had a great deal of clinical experience with this population.

A service user from Salomons Advisory Group of Experts (SAGE) was involved in the design of the information sheet and consent form, which led to slight changes in language used to assist in participant's understanding.

All participants were given information sheets and consent forms, and given an opportunity to go through the information sheet with the researcher. All participants were given at least 48 hours to decide if they wanted to take part. All participants who took part in a second interview at time point two were re-consented into the study.

Interviews. The semi-structured interview schedule was developed by the researcher based on the following areas:

- Understanding and experiences of relationships
- Use of techniques and understanding of risky situations

The initial interview schedule was piloted on a service user from a Community Learning Disability Team (CLDT) who met the criteria for the study, which helped to ensure the questions were relevant to the research question, and to gauge how forthcoming participants would be during the interview. The questions were amended and interview schedule re-structured to aid understanding.

Following a review of data at time point one, changes were made to the interview schedule to ensure the study aims were met. Changes to the interview schedule included the following additional areas (see Appendix E for the revised schedule used at time point 2):

- Asking participants about their efforts to bring about changes in their behaviour
- Ongoing sources of support

Individual interviews lasted between 20 and 65 minutes (in the interview lasting 20 minutes, the participant was reluctant to answer some questions), and were recorded and transcribed verbatim (Appendix J).

Methodological rigour. The research integrity was improved by discussing the thinking behind the initial coding and theme development with supervisors, as recommended by Braun and Clarke (2006). A research diary was kept for the whole process (Appendix I). Bracketing interviews were completed to prevent the researcher's own assumptions and beliefs from influencing the data. They were completed on two occasions during data collection, before the first interview and part way through data collection. They were conducted with colleagues in line with the procedure outlined by Ahern (1999). Reflective notes were also made (Appendix H).

Data analysis. Based on Braun and Clarke's (2006) recommendations, the following stages were followed in analysing the data:

1. Codes were identified based on existing models of sex offending by Finkelhor (1984) and Ward and Hudson (1998). These two models were chosen as they are the main models of sex offending contained within the literature. These two models also overlap in places, and these overlaps formed the codes used as part of the deductive analysis. The codes were:

- Motivation to offend
- Distorted cognitions
- Experience of abusive relationships

See Appendix K for further details.

2. Recordings were listened to and transcripts read several times.
3. Initial codes and ideas were generated.
4. Deductive coding of transcripts using codes identified from the literature.
5. Additional inductive coding of the data relevant to the research questions.
6. Grouping of codes based on similar themes – started generating thematic maps to show links between themes.
7. Identifying themes based on grouping of codes – further generation of thematic maps (Appendix L).
8. Reviewing the themes and re-naming based on sub-themes.

Once the data had been analysed a summary of the findings was produced and provided for all participants in the study (Appendix M) and the ethics board (Appendix N and O).

Results

Participant demographics

Table 3 shows there were 14 participants recruited into the study from secure hospital provision, probation or from the community. Participants had a range of index offences

against adults and children, and ten participants (71%) displayed behaviour consistent with sex offending since completing treatment, which is higher than reported in the literature (Klimecki, Jenkinson, & Wilson, 1994; Lindsay et al. 2002). There was also a variation in length of time since completing the SOTP, ranging from 8 months to 11 years.

Interviews

A deductive and inductive approach to thematic analysis of 14 transcripts generated three main themes and 13 subthemes. These themes demonstrated how ID sex offenders understood their on-going risk and what they did to help prevent them from re-offending. This also facilitated discussion about the applicability of current models of sex offending for an ID population.

Participants felt that ‘connecting with others’ was important in their experience of treatment. Trust, relationship knowledge, relationship development and feeling supported were all key areas identified as being significant in being able to connect with others.

The second main theme of ‘possible factors influencing offending behaviour’ were important to participants which to some extent helped to understand how they perceived their current situation. Distorted cognitions, stressful situations, negative relationship experiences, not feeling supported and memory difficulties were identified as important, however not all of these areas were directly linked by participants as influencing offending behaviour. Participants did however make a direct link between stressful situations leading to re-offending behaviour and to some extent external management from staff as reducing risk of re-offending.

Participants perceived there to be a ‘progression towards risk reduction’. They believed they had made some improvements in their behaviour by moving to a less secure ward or having

less supervised support when in the community, although there was no direct link made between these and risk of re-offending. Self-management, external management of risk, understanding risk and indicators of remorse were shown by participants to be key factors in helping to understand their current situation, but again were not directly linked by participants to offending behaviour.

The overall analysis is presented with interview extracts. Sub-themes are identified as to whether they emerged using deductive or inductive thematic analysis. If codes were identified by four or more participants it was considered a sub-theme. Identifying information is replaced with X.

Theme 1 – Connecting with others (n=14; inductive)

All participants identified 'connecting with others' as significant in their experience of treatment. Trusting others, including other members of the group, developing relationships, feeling supported by both staff and other group members and learning more about relationships helped participants to connect with others.

Subtheme 1 – Trust (n=5; inductive). Trust was identified as a key aspect of being able to develop relationships, particularly with other group members. Trust is likely to have been particularly important during treatment due to the nature of the group's offences. Participants mentioned how trusting the group led them to being more open within the group, possibly because they felt more comfortable. This may have been due to knowing that others were in the group for committing similar offences and therefore were less likely to be judged by others. The extract below from participant three (P3) demonstrated how trust led him to be more open:

> *P3:* Erm, you had to talk about your offence…a month down the line I think it was…Just had to get everyone's trust first.

Interviewer: Sure yeah.

P3: Then we can talk about it.

Participants also identified trust as being important in relationships more generally. This is shown in this extract from participant 13 (P13):

Interviewer: Do you think it [Trust] affects relationships you have?

P13: Might do yeah…might be harder to get a relationship as well

It is possible that trust is so important for this group as they may have had previous negative experiences that may have led them to not trust other people.

Subtheme 2 – Relationship knowledge (n=12; inductive). Participants said they had limited understanding of sex education and relationships prior to starting treatment, as can be seen in this extract from participant 14 (P14):

Interviewer: Mmm so did you learn more about relationships from the group as well?

P14: Yeah I've learned I've probably learned more about it from that than I have in the past…cause it's like even when at school I didn't really do sex education and that

The data suggested participants had some knowledge of appropriate relationships. Participants did not explicitly identify learning about relationships, but showed some understanding about consenting in a relationship and the law surrounding this, including how they would ensure that a person is over the age of 16 in order to have a sexual relationship. This is shown in this extract from participant six (P6):

Interviewer: Was there anything that you learned from the group about that?

P6: Yeah just keep away from young ones …and things like that, sixteens, don't mix with young ones that's all

Participants have shown that they understand there are other aspects to relationships than having sexual intercourse, as shown in this extract from participant five (P5):

P5: Just a nice lovable, what's the word, erm companionship

Interviewer: Yeah

P5: Companionship with that other female lady

Interviewer: Yeah, so that's more important to you than a sexual relationship?

P5: Yeah especially if she was religious like me as well…we'd get on like a house on fire then

Subtheme 3 – Relationship development (n=9; inductive). Participants identified relationship development as being an important part of treatment and support. Some of these relationships developed within the group as identified by participant nine (P9):

P9: I still like seeing the folks here you know…cause we've all become good friends…we can have a laugh you know. We all know things about the past when we've been in prison…and we can talk about it.

Relationships outside the group have also developed as a result of being in treatment, which may be due to developing more social skills by being in treatment with other people. This is identified by participant 12 (P12):

Interviewer: Has the group changed your life in any way?...

P12: In what way is I've got new friends here

Developing relationships with staff have also been identified as being important to participants, as identified by participant two (P2) which may help in feeling supported:

P2: I've got a really good relationship with my care team, my keyworkers and co-key workers.

Subtheme 4 – Feeling supported (n=12; inductive). Feeling supported within the group and by members of staff has been identified as an important part of treatment by 12 participants. Participants identified receiving support from staff when in the community (and/or on the ward) as being helpful, as shown in this extract by participant two (P2):

Interviewer: What support do you get in the community?

> *P2:* I'm shadowed…It means I've got shadowed community leave it means the staff member doesn't stay right alongside me, they stay behind me… it means that I've got staff behind me but gives me a chance for me to be on my own

Participants also identified that staff being available by being able to speak to them when they needed to, helped in them feeling supported as shown in this extract from participant four (P4):

> *P4:* I could talk to some staff on the ward … X is the team leader… I could talk to her I suppose … cause she's one of the staff… or I could talk to any of the staff really

Participants also identified support from other group members as important in treatment, as identified in this extract from participant one (P1):

> *P1:* Yeah, wanted had thoughts, we talk about it we help each other aswell [group members]

Theme 2 – Possible factors influencing offending behaviour (n=13; deductive and inductive)

It is important to be aware of some of the factors that may influence further sex offending, as this awareness could lead to situations being managed differently or lead to further support being provided to ID sex offenders.

Participants attributed some of their offending behaviour to situational factors and identified other sub-themes such as distorted cognitions, stressful situations, negative experiences in relationships, not feeling supported and memory difficulties, as being important to them. This led to the development of the main theme 'possible factors influencing offending behaviour'. Participants identified stressful situations as having a direct link to re-offending behaviour.

Subtheme 1 – Distorted cognitions (n=5; deductive). This subtheme evolved from existing models of sex offending, and supports existing literature to some extent in that distorted cognitions may be related to sex offending behaviour. It is important to note that none of the participants explicitly identified distorted cognitions as being linked to their offending behaviour, but the content of the interviews demonstrated some distorted cognitions.

Minimisation of the offence was the most common distorted cognition identified in the data amongst this sample, which alludes to the lack of importance that is placed on the offence. This could be due to not understanding the seriousness of the offence, or intentionally denying the seriousness. This is demonstrated in the following extract from participant five (P5):

> *P5:* Yeah I was there for 15 years, it was a nightmare down there, it was like hell down there, it was hell I tell ya. I was on the same ward as XXX the great gangster in XXX and his bodyguard XXX and there was 2 murderers, and there were a lot of lifers there were a lot of people doing a lot of time…I shouldn't have been on the ward really
>
> *Interviewer:* Why do you think you were on the ward?
>
> *P5:* Well I don't know really, I don't know, they just put me on there

Blaming the victim for the offence, which can be identified as a distorted cognition, appeared to be present in other participant's responses as shown in this extract by participant two (P2):

> *Interviewer:* And did you know about consent before?
>
> *P2:* I did ask her, and she kept saying to me she wanted to have a relationship. She kept eyeing me up when I was working, kept coming up and getting my attention when I was working with heavy machinery… and I'm like I can't keep looking at you if I'm working on something that has very sharp blades on it. She kept on and on.

Subtheme 2 – Stressful situations (n=6; inductive). The data showed various situations in their current contexts which participants found stressful. This is important to understanding risk of re-offending, as participants suggested that stressful situations may be a risk factor for further re-offending as shown in this extract from participant seven (P7):

P7: I knew I was wrong at the time [about offence]…

Interviewer: What made you carry on?

*P7:*All the things in my head, I had my dad and my family in my head, I couldn't get rid of them really in my head…I think it led me to do it [offence]

This may have been due to having difficulties in managing stressful situations and in applying coping strategies learned in treatment to other situations. This is something that individuals with ID are likely to find difficult without external support.

Participant one (P1) identified the possible frustration, anger or fear of delays in moving as being difficult to manage, potentially contributing to re-offending:

Interviewer: Yeah, ok. Alright. Erm, has there ever been a time when using this hasn't worked?

P1: Ermmm.

Interviewer: In stopping risky behaviours?

P1: Kind of next door.

Interviewer: Mmhmm

P1: Because that actually bugged out.

Interviewer: What do you mean?

P1: Part of it was, part of me, I found out I was moving and I mucked up.

Interviewer: Okay

P1: Part of it could be it was taking so long to…for me to move on

Subtheme 3 – Negative relationship experiences (n=6; deductive and inductive).

The data making up this subtheme supports the existing literature to some extent in that participants reported having negative experiences in relationships, but not experiencing abuse exclusively. The data does not tell us however that negative experiences in relationships are directly linked to offending behaviour. This subtheme is supported by this extract from participant eight (P8):

P8: Feels good, cause before I met this one I hadn't had a girlfriend for about 3 months…cause they were always, pardon me, they were taking the P out of me. … and er, all they wanted was the money and sex and I wasn't up for all that

One participant did however mention that he had been a victim of sexual abuse as can be seen in this extract from participant ten (P10):

P10: I had a girlfriend and she forced herself on me

Interviewer: Did you want that?

P10: No I didn't want no sex.

Subtheme 4 - Not feeling supported (n=4; inductive). This subtheme consisted of participants feeling unable to speak to others about their difficulties. Participant six (P6) highlighted new staff as preventing him from feeling supported, as he found it difficult to talk to new staff:

Interviewer: Do you feel able to talk to the staff here?

P6: Sometimes, sometimes I find it difficult

Interviewer: What makes it difficult?

P6: When you get new staff in

Interviewer: Yeah

P6: Like new employees, and you just don't know how to take it

This indicates that feeling supported is important to participants, and they feel less supported when staff are unfamiliar to them, due to finding it more difficult to talk to them. Participants also identified that the demand from other patients interfered with their ability to approach staff for support, and that this can influence whether they continue to seek staff support. This can be seen in this extract from participant two (P2):

Interviewer: What makes it difficult to talk to staff?

P2: Erm, like other patients when the alarm goes off and sometimes they talk over you, and want to talk to staff but XXX will talk over you.

Interviewer: So you feel you get interrupted when you talk to staff?

P2: Yeah

Interviewer: Does that put you off talking to them or not?

P2: Sometimes not all the time.

It is important to note that there was no direct link made by participants of whether this was a contributor to offending behaviour.

Subtheme 5 – Memory difficulties (n=5; inductive). Five participants said they had difficulty remembering some aspect of the treatment. It is possible that participants used memory as a reason to prevent being asked further questions about an area that they may have been finding difficult to talk about during the interview, potentially giving rise to difficult feelings. This sub-theme may be a combination of real memory difficulties and also as a method of preventing further questioning. It is very difficult to tease apart whether there is genuineness to memory difficulties or not. An extract from participant one (P1) demonstrates how limiting his memory difficulties can be:

Interviewer: Okay. Are there any bits of the group that you didn't like. Whether it was the content of it

P1: I can't remember.

Interviewer: Or just being the group. Okay erm. Were there any activities you didn't like in the group

P1: Laugh – I can't remember much.

Participant 13 (P13) tells of how his memory difficulties limited his ability to talk about his offence during the group in the following extract:

Interviewer: Ok yeah. Is it that you didn't want to talk about it in the group?

P13: No I just didn't have the memory, memory is bad really

Participants did not direct link memory difficulties to re-offending behaviour.

Theme 3 – Progression of risk reduction (n=14; inductive)

All participants identified themselves as either having made changes to their thinking, behaviour or both following treatment, which was considered as progress in working towards not re-offending. The data fell into four subthemes of self- management, external management, understanding risk and indicators of remorse.

Subtheme 1 – Self management (n=14; inductive). This was the largest subtheme that developed from the dataset. All participants identified using either cognitive or behavioural strategies such as distraction or thinking about the consequences of offending. The extract below from participant 11 (P11) demonstrates the nature of this subtheme and that keeping busy kept his mind focussed:

P11: That's why I keep myself busy, so I don't think about it…I just keep myself busy

…and then you don't think about the future…

Participant two (P2) demonstrates how he manages his risky thoughts:

Interviewer: And you said you manage them [risky thoughts] how?

P2: Self-talk and switch. I can switch like I'm on a desert island enjoying myself.

There was no direct link made between self-management and risk of re-offending.

Subtheme 2 – External management (n=9; inductive). External management refers to the support that is provided by staff and other health professionals, and includes relapse prevention and other treatments in any other form.

Participants identified external support as being helpful in helping them move forward, with seven out of nine participants using this as a treatment memory aid of material covered in treatment. This is shown in an extract from participant 13 (P13):

Interviewer: And when you go out do you have anything then that you use. Some people have said that they have relapse prevention

P13: Yeah I've got that…it helps with memory, what's the worst thing that can happen, how you can keep safe and things like that.

Participants also identified staff support more generally as being helpful to them, as can be seen in this extract from participant 14 (P14):

Interviewer: But what do you use to help you reduce the risk?

P14: It depends where I am, if I'm outside I talk to staff and that

This participant has made a direct link between staff support and a reduction of his risk, although wider claims are limited as this was not the case for all participants.

Subtheme 3 – Understanding risk (n=11; inductive). Eleven participants showed an understanding of situations that they identified as 'risky'. Participants alluded to this being linked to offending behaviour, but this was not made explicit. Despite this participants did

make attempts to avoid certain situations that were deemed to be 'risky'. The extract from participant three (P3) shows that he has an understanding of risky situations:

> *Interviewer:* Yeah, ok. So do you know what your risky situations are?
>
> *P3:* Yeah
>
> *Interviewer:* What are they?
>
> *P3:* Err, parks, schools, swimming pools at certain times and beaches …People that are younger than me.

The next extract from participant 2 (P2) shows that he also tries to avoid situations where children are present:

> *P2:* … one time I was on community leave was just about to get on the bus, and I said no I'm not getting on the bus
>
> *Interviewer:* Why's that?
>
> *P2:* Staff said why and I said look at the bus, packed with kids
>
> *Interviewer:* Ok
>
> *P2:*And you can understand children or young adults can easily make themselves look a lot older than they are…and I said no I'm not going on the bus with the kids, and I walked back

Subtheme 4 – Indicators of remorse (n=6; inductive). This subtheme consists of participants demonstrating a level of remorse about committing their offence. This was in the form of finding it difficult to talk about their offence in treatment or a reluctance to talk about it, possibly due to feeling ashamed. This was demonstrated in this extract from participant 13 (P13):

> *Interviewer:* What was it like talking to people about your offence in the group?
>
> *P13:* It wasn't easy…cause it erm, you feel ashamed you feel like you've done something wrong

Participant 12 (P12) shows how he reacted to thinking about specific stages of his offence, possibly due to experiencing shame and possibly feeling guilty about his offence:

P12: What's it called, the 4 steps to offending

Interviewer: Yeah

P12: That's the one I hated the most

Interviewer: Why did you hate that the most?

P12: Because it was just hurting, I wrote it down…and it just hurts me when I write it down and things

Interviewer: Hurts you inside?

P12: Yeah I've got butterflies in my stomach

Despite enough data being present to represent this as a sub-theme, it is important to emphasise that less than half of all participants showed some signs of remorse during the interviews or alluded to it, and therefore there is only limited evidence of this as a sub-theme.

Discussion

This study used both deductive and inductive approaches to thematic analysis in order to understand how ID sex offenders perceive sex offender treatment, and their efforts not to re-offend. More broadly, this study considered the applicability of existing treatment models for ID sex offenders.

The findings highlighted the following main areas as important to ID sex offenders: connecting with others, possible factors which may influence offending and progression towards risk reduction. Specifically, this was seen in the form of how supported they felt, development of relationships, relationship knowledge, stressful situations, negative relationship experiences, self-management strategies, external management and having an

understanding of their risk to others. Despite some participants potentially using their memory difficulties as a protective strategy to prevent further questioning during the interview (as discussed earlier), it is possible that genuine memory difficulties influenced their efforts not to re-offend due to not being able to remember treatment. It is important however to be realistic and understand that ID sex offenders are not likely to be able to remember all of the treatment programme, especially when treatment has been conducted over a 12 month time period, or was completed a long time ago due to a natural decline in retention ability over time. This means it is important that group members are reminded of what was covered in the group and that group members who are deemed to remain at risk continue to receive ongoing support.

Participants identified that learning about relationships thus increasing their knowledge and developing more positive relationships was important to them. It could be argued that this may be associated with a reduced re-offending rate, as it may give them an increased knowledge of what is appropriate and inappropriate in relationships. For example, an increased understanding of the law around relationships, such as the need for consenting to sexual intercourse. The existing data cannot provide this information, although this is an area that is discussed in the GLM (Ward, 2002), and is an area for future research to explore.

Participants identified some situations which may be linked to an increased risk of re-offending. The data showed stressful situations and some aspects of external management to be directly linked to risk of re-offending behaviour. Other arguments are made about the likelihood of other factors influencing re-offending behaviour based on the existing evidence base, even though there were no direct links made within the data.

Although distorted cognitions were not directly linked to risk of re-offending in this study, it could be argued that they do increase risk of re-offending. This based on existing literature

that suggests distorted cognitions may be linked to inappropriate sexual expression (Broxholme & Lindsay, 2003).

Existing literature has highlighted that many sex offenders have experienced previous abuse which may influence the likelihood of sex offending behaviour (Jespersen, Lalumière, & Seto, 2009), which may extend to more general negative experiences in relationships. Similarly, a lack of trust within relationships could prevent communication. It could be argued that a lack of trust may increase the likelihood of re-offending due to feeling isolated, which can be common in individuals with ID (Estell et al., 2008). Developing trust within a relationship may be important to reducing feelings of isolation, and is important in terms of accessing support.

Participants believed they had made some progression by using relapse prevention plans when in the community, and developing positive relationships. It was not clear what their understanding of this was in relation to their risk of re-offending, as this link was not explicitly made. However despite not being discharged from hospital or supervision not being reduced in the community, they still felt that had made improvements to their behaviour. They understood that continued improvements were required for less supervision and discharge where relevant.

Self-management could be argued to reduce the risk of re-offending, as if individuals have strategies that help manage risky thoughts or help them to manage emotions, they may be less likely to offend. Despite participants identifying strategies they use themselves to manage their risk to others, this appears to be mostly in combination with external management strategies such as relapse prevention, which prevents over relying on self-management. Due to having an ID, it may mean that at times this group are unable to rely on self-management to reduce risk. Applying skills to new and different situations may be particularly problematic

for this group, which may be why external management and support has been identified as important.

Although a direct link was not made within the data about whether a lack of remorse is linked to risk of re-offending, existing literature suggests that lack of remorse can be a strong predictor of re-offending behaviour in the general population (Quinsey, Coleman, Jones, & Altrows, 1997). It could therefore be argued that a lack of remorse may increase the risk of re-offending for ID sex offenders too, although this needs to be explored further.

This study shows that existing sex offending models may not be as applicable to ID sex offenders as originally thought. The results support the inclusion of some aspects of treatment from models of non-ID sex offending, such as identifying and challenging cognitive distortions and that negative experiences of relationships can lead to re-offending, but the data did not support other assumptions such motivation to offend, which was not referred to by the participants in this study.

There were other newly identified areas not mentioned in existing models, which participants considered to be an important part of treatment. These were connecting with other people, particularly trusting others, developing relationships and feeling supported. It is important in treatment to consider those who do not feel supported, and that stressful situations can potentially lead to re-offending. A consideration of the implications of memory difficulties, the extent of being able to manage thoughts and emotions, other external support, and understanding their risk to others is also necessary. Current models do not include these factors and so may be less applicable to understanding ID sex offending.

This study suggests other factors may be contributing to offending behaviour, that have not been identified in the general population, for example the data in this study shows that individuals found feeling supported and connecting with others as important. It is possible

that by enhancing support networks there may be a reduction in re-offending. This is not substantiated in this data, but the literature suggests that increased support is related to a reduction in crime rates in the general population (Cullen, Wright, & Chamlin, 1999).

The inclusion of concepts such as 'consent' in existing treatment may need to be adapted so there is an increased focus on practical strategies, which may be easier to grasp. This demonstrates a potential need for a specific model of sex offending for ID sex offenders.

New treatment programmes for ID sex offenders would need to ensure that consideration is made for developing positive relationships, that ID sex offenders feel supported, and staff are aware of situations that may lead to re-offending. This may need to be contained within an individual relapse prevention plan due to the heterogeneity in this group. Consideration is also needed of the limitations of self-management strategies to manage thoughts and emotions related to risk, and that an increased understanding of risk and external support may help prevent re-offending.

Despite positive responses from participants about their efforts to stop offending, there continues to be high rates of re-offending following treatment. In part this is because existing treatment approaches aren't working. However, fears about release/discharge and a subsequent reduction in support may also increase people's risk of offending, as this may be particularly stressful and anxiety provoking. This suggests that discharge from hospital or coming to the end of a period of probation needs to be carefully planned, and individuals need to be well supported.

Strengths and limitations

The deductive approach demonstrated to some extent whether the main models of sex offending are applicable to ID sex offenders. The inductive approach provided further

understanding of the additional areas that are considered important to ID sex offenders in preventing re-offending. The results would not have been as comprehensive and would tell us less about ID sex offenders had only one of these approaches been used.

Whilst efforts were made to maintain a high quality of research by using reflexivity, there were a number of limitations affecting the overall study quality. Guidelines for qualitative research by Elliott, Fischer and Rennie (1999) were used to evaluate the quality of this study. The study's strengths were situating the sample and checking the credibility of themes with another colleague, although the credibility could have been improved by also checking with participants. By having a range of participants from different contexts with a variation of sex offences, they are representative of the heterogeneous group of ID sex offenders.

Despite the aims changing, and the data being re-analysed from a previous project, the findings may have been influenced by the previous project, leading to some assumptions in the data analysis. This project may have benefitted from further discussion of this as part of a bracketing interview.

Completing interviews on such a sensitive subject with individuals who have an ID was difficult. Participants were sometimes reluctant to answer questions or may have been overly positive, possibly due to feeling uncomfortable or to present themselves in a favourable light. Participants who were interviewed twice revealed more information suggesting that future studies may benefit from building gradual rapport, using multiple interviews.

Even though the interview schedule was designed to take into account the challenges identified by Booth and Booth (1996) in interviewing people with an ID, the interview process was difficult and not always fruitful in eliciting information. Communicating thoughts may be more challenging in this group, which resulted in using more direct questioning (and sometimes leading questions) than planned, due to some difficulties

participants had in answering open-ended questions. This may have influenced responses somewhat.

There were also limitations to the design of the study as a whole as it did rely on participants' memory of the treatment. Despite this, it was clear that participants were able to say when they were unable to remember, but the majority of participants demonstrated a reasonable memory for most of the areas they were interviewed about.

Clinical implications

The most significant implication for working clinically with this group is that treatment may not be effective in preventing re-offending. Research shows that just because a person has offended and has completed sex offender treatment, it does not mean their risk is lower (in this sample 70% re-offended or displayed behaviour consistent with sex offending following treatment).

A connection with others, both with group treatment members and staff outside of the group, was considered important. This supports existing research for the use of group treatment with ID sex offenders (Beckett, Beech, Fisher, & Fordham, 1994) compared to individual treatment, but also highlights that more emphasis may need to be placed on this in treatment with this group. There are some areas that are likely to require individual work, due to a wide variety of offending histories and presenting problems; such as individual formulation of their ID, offending behaviour and risk assessment with a clinical or forensic psychologist.

Treatment for this group is also not just about sex offending treatment, as there is a need for ongoing support. There needs to be opportunities to develop meaningful relationships, and have opportunities for appropriate sexual expression, as sex offending may be as a result of internalising difficult feelings, as identified in the general population (Hart-Kerkhoffs,

Doreleijers, Jansen, van Wijk, & Bullens, 2009). Consistency within staff teams so ID sex offenders feel supported, and a recognition that at times of stress risk of re-offending may be increased. A non-judgemental stance is also important so that individuals feel more able to disclose if they feel at risk of re-offending. Group treatment should also consider longer treatment so that group members can develop trust with others and develop peer relationships in helping them to build support networks. Education about healthy relationships is important to understanding relationships and developing other support systems.

Underlying models of sexual offending are likely to be slightly different in this group, and therefore simply adapting treatment from the general sex offending population may not be the best approach. Sex offender treatment needs to be adapted further to include other areas that were identified in this study specific to an ID population, although this study on its own cannot produce firm recommendations for an ID sex offending model. A more specific model may lead to more comprehensive treatment, which may result in improved re-offending rates.

Future research

There are clearly limits to the applicability of established models of sex offending with an ID population. There is no current model of sex offending in an ID population, and therefore efforts need to focus on this. Existing models of sex offending, based on this study, are unlikely to be comprehensive in understanding sex offending behaviour in an ID population, and so this needs to be researched further to ensure there is a sound theoretical base for treatments offered. Research exploring situations that may lead someone to re-offend and why, are also key in understanding continued risk to others.

Conclusion

This current study aimed to understand how ID sex offenders perceive their current situation and their efforts not to re-offend, with a broader consideration for the applicability of existing sex offending models to ID sex offenders. The findings show three main areas that are influential in understanding this: connecting with others, possible factors influencing offending behaviour and progression towards risk reduction. The results supported some parts of existing models of sex offending used in the non-ID population, but revealed other aspects that ID sex offenders perceived as important which are not in existing models of sex offending. This shows that current sex offending treatment may not be sufficient in preventing re-offending, and that a specific model of ID sex offending needs to be developed.

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Section C

Appendix of Supporting Material

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Appendix A: Sexual Offences Act (2003) – list of sex offences classified in the UK

Rape

1 Rape

Assault

8 Assault by penetration
9 Sexual assault

Causing sexual activity without consent

10 Causing a person to engage in sexual activity without consent

Rape and other offences against children under 13

11 Rape of a child under 13
12 Assault of a child under 13 by penetration
13 Sexual assault of a child under 13
14 Causing or inciting a child under 13 to engage in sexual activity

Child sex offences

15 Sexual activity with a child
16 Causing or inciting a child to engage in sexual activity
17 Engaging in sexual activity in the presence of a child
18 Causing a child to watch a sexual act
19 Child sex offences committed by children or young persons
20 Arranging or facilitating commission of a child sex offence
21 Meeting a child following sexual grooming etc.

Abuse of position of trust

22 Abuse of position of trust: sexual activity with a child
23 Abuse of position of trust: causing or inciting a child to engage in sexual activity
24 Abuse of position of trust: sexual activity in the presence of a child
25 Abuse of position of trust: causing a child to watch a sexual act
26 Abuse of position of trust: acts done in Scotland
27 Positions of trust
28 Positions of trust: interpretation 23
29 Sections 16 to 19: marriage exception
30 Sections 16 to 19: sexual relationships which pre-date position of trust

Familial child sex offences

31 Sexual activity with a child family member
32 Inciting a child family member to engage in sexual activity
33 Family relationships
34 Sections 25 and 26: marriage exception
35 Sections 25 and 26: sexual relationships which pre-date family relationships

Offences against persons with a mental disorder impeding choice

36 Sexual activity with a person with a mental disorder impeding choice
37 Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity
38 Engaging in sexual activity in the presence of a person with a mental disorder impeding choice
39 Causing a person, with a mental disorder impeding choice, to watch a sexual act

Inducements etc. to persons with a mental disorder

40 Inducement, threat or deception to procure sexual activity with a person with a mental disorder
41 Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception

42 Engaging in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder
43 Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception
Care workers for persons with a mental disorder
44 Care workers: sexual activity with a person with a mental disorder
45 Care workers: causing or inciting sexual activity
46 Care workers: sexual activity in the presence of a person with a mental disorder
47 Care workers: causing a person with a mental disorder to watch a sexual act
48 Care workers: interpretation
49 Sections 38 to 41: marriage exception
50 Sections 38 to 41: sexual relationships which pre-date care relationships
Indecent photographs of children
51 Indecent photographs of persons aged 16 or 17
52 Criminal proceedings, investigations etc.
Abuse of children through prostitution and pornography
53 Paying for sexual services of a child
54 Causing or inciting child prostitution or pornography
55 Controlling a child prostitute or a child involved in pornography
56 Arranging or facilitating child prostitution or pornography
57 Sections 48 to 50: interpretation
Exploitation of prostitution
58 Causing or inciting prostitution for gain
59 Controlling prostitution for gain
60 Sections 52 and 53: interpretation
Amendments relating to prostitution
61 Penalties for keeping a brothel used for prostitution
62 Extension of gender-specific prostitution offences
Trafficking
63 Trafficking into the UK for sexual exploitation
64 Trafficking within the UK for sexual exploitation
65 Trafficking out of the UK for sexual exploitation
66 Sections 57 to 59: interpretation and jurisdiction
Preparatory offences
67 Administering a substance with intent
68 Committing an offence with intent to commit a sexual offence
69 Trespass with intent to commit a sexual offence
Sex with an adult relative
70 Sex with an adult relative: penetration
71 Sex with an adult relative: consenting to penetration
Other offences
72 Exposure
73 Voyeurism
74 Voyeurism: interpretation
75 Intercourse with an animal
76 Sexual penetration of a corpse
77 Sexual activity in a public lavatory

Appendix B - Data extraction forms

Data extraction form for case study designs based on SCRIBE checklist (Tate et al. 2016)

Study: Author: Year:	
Title and abstract Title [1] Abstract [2]	
Introduction Scientific background [3] Aims [4]	
Methods ***Design –*** design [5], procedural changes [6], replication [7], randomisation [8], blinding [9] ***Participants –*** selection criteria [10], participant characteristics [11] ***Context –*** setting [12] ***Approvals –*** ethics [13] ***Measures and Materials –*** Measures [14], equipment [15] ***Interventions –*** Intervention [16], procedural fidelity [17] ***Analysis –*** Analyses [18]	
Results Sequence completed [19] Outcomes and estimation [20] Adverse events [21]	
Discussion Interpretation [22] Limitations [23] Applicability [24]	
Documentation Protocol [25] Funding [26]	

Data extraction form based on STROBE checklist (von Elm et al. 2007)

Study: Author: Year:	
Title and abstract Title Abstract	
Introduction Background Objectives	
Methods Study design Setting Participants Variables Data source Bias Study size Statistical methods	
Results Participants Descriptive data Outcome data Main results	
Discussion Key results Limitations Interpretations Generalisability	
Documentation Protocol [25] Funding [26]	

Appendix C: NHS Ethical Approval

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Appendix D - R&D Approvals

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Appendix E – Semi-structured interview schedule

Please note changes to the interview schedule following amendment 2 and significant revision of the schedule are highlighted using tracked changes.

Semi-structured Interview Schedule

Allow 1 hour.

Thank you for agreeing to take part in the interview for this research study. The interview should not last any longer than an hour, but this will depend on how much you want to say.

If there are any questions that you would prefer not to answer just let me know and we can move on to the next question.

I wanted to remind you that all of what you say will be kept confidential, however if you discuss any inappropriate sexual behaviour that you have not told other people before, then I will need to pass this information on.

It would be helpful if you did not mention any names of other group members during the interview.

If you would like a break that it fine, just let me know.

Do you have any questions before we start?

First I am going to ask you some questions about attending the group.

~~Usefulness of the Sex Offender Treatment Programme~~

1. What did you expect the group to be like?

Prompts: How did it feel starting the group? What was it like to do the group with other people?

2. What do you remember about the group?
Prompts: Do you remember anything else.

3. Do you remember what was covered in the group?
Prompts: What did you talk about in the group?

~~2.~~4. Which parts of the group did you like the most?
Prompts: Why did you like it?

~~3.~~5. Which parts of the group were the most helpful?
Prompts: Are there any sessions you remember more than others?

What was the session about?

Do you still think about that part of the group now?

Yes: When do you think about it/use it is your life?

Can you give me an example of when you have used it?

No: Why don't you think about it/use it?

If you did think about it/use it would it make your life different in any way?

What would make it easier to use?

~~4.~~6. Which parts of the group were unhelpful?
Prompts: What was it?

Why was it unhelpful?

Can you think of anything that would have made it better/more helpful?

7. How do you know if the group has been helpful or not?

Prompts: What has happened that makes you think you have made changes to your behaviour?

Now I am going to ask you some questions about relationships.

~~Changes~~

~~5.~~8. How did you think about relationships before the group?
Prompts: Tell me about a relationship between you and a friend at that time.

What was it like?

Tell me about a sexual relationship you had at that time.

Who was it with?

How long did it last?

What did you think about the relationship?

~~6.~~9. Is this how you always thought about these types of relationships?
Yes: did you ever think about anyone differently?

No: in what other ways did you think about relationships?

Ask for example

~~7.~~10. Did the group change the way you think about sex and relationships?
Prompts:

Yes: In what way do you feel differently about sex and relationships?

In what way do you interact differently with other people?

Ask for examples

No: why do you think this was?

What would have made you think about sex and relationships differently?

~~8.~~11. Have you had a relationship since finishing the group?
Yes: Has this relationship been the same as other relationships or different?

If same – ask how?

If different as in what way has it been different to other relationships?

Ask for example.

No: Would you like to have a relationship? Why do you think you haven't had a relationship since finishing the group?

~~9.~~12. Are there any things that you would have liked to talk about more in the group? Would this have been helpful to you making positive changes? How would it have been helpful?

Now I am going to ask you some questions about whether you have used parts of this group in risky situations.

~~10.~~13. Do you know what your risky situations are?
Ask to describe it

~~11.~~14. Do you do anything to help you in risky situations?
Prompts: Can you describe what it is?

How does it help?

How well does it work in stopping your risky behaviours?

Ask for examples of when this has been helpful

~~12.~~15. Has there been a time when using this strategy hasn't worked in stopping your risky thoughts?
Yes: Can you tell me what happened?

Why do you think it didn't work?

What did you do instead?

Ask for examples

~~13.~~16. Do you always do the same thing when you are in a risky situation or having risky thoughts?
Yes what is this? Why do you always do the same thing?
No: what else do you do?

17. What support do you have?
Prompts: What support do you have from staff?

How does your keyworker support you?

Do you attend any other groups? What are they for?

Do you have individual therapy?

18. What support do you have when you are in the community?
Prompts: How do you prepare to go out?

Do you have a relapse prevention plan? Can you tell me what is in it? Is it helpful?

Yes – How?

No – why don't you think it is helpful?

~~14.~~19. Has the group changed your life in any way?
Prompt:

Yes: In what way has it changed?

Ask for examples.

What affect has it had on your life?

How has this made you feel?

No: Why do you think this is the case?

Ask for examples if necessary.

How has this made you feel?

~~15.~~20. Can you tell me about a recent time when you used some of the things you learnt in the group, other than what you have previously talked about?
Prompt: What was the situation? What did you do? How did you do it? Ask about successful and unsuccessful attempts and what the differences were.

21. Why do you think you are still in hospital/still have contact with services?
Prompt: Have you got into trouble for sexual behaviour since doing the group?

22. Are you able to stop yourself from sex offending?
Prompt: How do you stop yourself from sex offending?

What helps you do this?

~~16.~~23. Would you change any part of the group if you had the chance?
Prompt:

Yes: What would you change?

Why would you change this?

Yes or No: are there any things that would have been helpful to learn about?

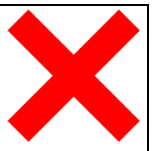
~~17.~~24. Is there anything else that you would like to say?

Thank you for taking part in this interview.

You will be given information about the results of this study at a later date.

Appendix F – Participant consent form

Research Consent Form

Please read each statement, and put a tick in the box if you agree or a cross in the box if you disagree.		
 I know what this student research is about.		
 I have read the sheet telling me about the research.		
 I am happy to take part in a recorded conversation about the men's group.		
 I am happy for my clinical notes to be looked at for the research.		

 I am happy to be contacted at a later date if the research needs me to answer more questions.		
 I have been able to ask questions.		
 I am happy with the answers to my questions.		
 I have had time to decide if I want to take part.		
 I know I can change my mind at any time but any information already collected will be kept for the study.		
 All information about me will be stored in a locked cabinet, and only looked at by Nikkita and her supervisors working on the study.		
 I would like to take part in the study.		

Name of participant:_____

Signature of participant:_____

Date:

Name of researcher:_____

Signature of researcher:_____

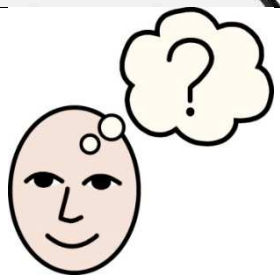
Date:

Appendix G – Participant information sheet

Information Sheet

My name is Nikkita

I am inviting you to take part in a student research study.



This research hopes to understand what helps or doesn't help people make changes in their lives after going to the men's group.

Who has reviewed this study?

The South Central Oxford C Research Ethics Committee has reviewed this study and have approved it.

What will happen to me?

I will use the scores from a questionnaire you completed before and after the group.

You will have a conversation with me about your experience of this group.

Our conversation will be recorded so that I can type out our conversation. The recording will be password protected. Only Janine and I will have access to the recording.

I will not type out your name or any other information that may identify you. Your information will be given a number. Once our interview is typed out I will delete the recording.

In hospital, you will have a file containing information about you e.g. age, offence history. I will need some of this information from your file.

A note will be made in your file that you are taking part in the study. No one will know any other information about you.

Your name will not be mentioned in the research.

Some quotes from the interview may be used in the write-up of the study, but no one will know this is you.

After the interview I might need to come back and ask you some more questions.

Who can I talk to about the study?

If you have any questions about the study you can talk to me (Nikkita) on 0333 011 7070. Please state that you are phoning for Nikkita. Or you can talk to my supervisor Dr Janine Blacker.

If you have any questions about research in general you can speak to your key worker.

The interview may make you have some negative thoughts or emotions. You can speak to your key worker or other staff on the ward about this.

What are the benefits of taking part?

You will help professionals to understand what helps people make positive changes or stops them from making changes during and after the group.

Will I find out the results of the study?

Yes, you will be given information about the results of the study overall. We cannot give you your individual results.

What if I change my mind?

You do not have to take part in the study, and it is ok for you to change your mind. Any information that has already been collected for the study will be kept. This information will also be kept if you lose your ability to make decisions.

Your medical care and any other care you receive will not be affected.

Do you have any questions about the study?

Appendix H – Reflective notes from bracketing interview

Interview 1

Sex offenders – anxiety about interviewing sex offenders and whether I will be safe enough despite all of the procedures in place to prevent this from happening. What draws me to this client group? 1. Curiosity of wanting to understand how they could offend 2. Is it a lack of understanding on their part? Always had an interest in forensic aspect of clinical psychology since under-graduate degree.

Difficulty in interviewing will be putting my own assumptions aside about what they are saying especially if they show no remorse or are graphic in their responses. None of the questions require someone to divulge their sex offence but this may come up, and need to think about how I may react to that, and the influence this may have on the interviewee's responses.

The publication of my findings may provide additional support for some types of treatment, or it may suggest the opposite. If it does suggest the opposite it could put me in a difficult situation given that my research supervisor delivers the SOTP in one of the host NHS Trusts. One of my other placement supervisors led me to other potential participants for the study, and who has been authored on some of the papers referenced. There could be the potential for conflict depending on the results of the study.

Learning disability – My main concern in working with this client group is the worry I have in being too patronising when talking and interviewing some participants. There is likely to be a variation in IQ level and levels of understanding, so this is something that I will have to gauge when with them. Also, I have a worry that the potential participants may agree to take part in the study despite me saying that they do not have to. They may see me as related to

my supervisor due to the study being about the group that she runs, and want to please us both.

Appendix I - Excerpt from research diary

24th October 2015	Completed bracketing interview with XXX and notes made on reflection of this.
26th October 2015	Interview 1 Started to look at interview 1 again and code line by line – keeping in mind the context and other analytic techniques that were not previously considered. I have so far only coded one chunk of text and using this approach has already elicited new thinking and information that is relevant. This shows the need to re-code all of my data that I have done so far at a slower pace. Started looking at the data. The words in a square are the words that have been thought about in terms of their meaning. The first word is 'okay' – this could mean in this context that it was not good or bad to start the group. Based on this idea it does mean that there may be some worries about starting the group but also some positives as otherwise this response may have been 'dreading it' or otherwise different. It is used again 4 lines later at line 12 – does this have the same meaning as in the first use? What is the client trying to tell us about his experience of starting the group – was not his choice and potentially reluctant to do group. If he did have a choice would he not have done the group? This is allowing me to think about what it would be like to have to start a group about sexual offending with men who I didn't know and which I felt I did not have a choice about doing. Would I have felt worried, scared, helpless, "intimidated"?
23rd October 2015	It's important to document my thinking at this stage. It seems that some of the participants are almost brainwashed by the system and this is important to be aware of. When participants say things like " I wouldn't do it again" I am finding that I do not believe them. I think this is due to it not sounding genuine and is almost sounding rehearsed.
5th November 2015	Started line by line coding of interview 1 rather than coding of chunks of text. Glad that I have gone back to the first interview to do it in this way as many more codes have been elicited by doing this. Am hoping that my coding is now much more analytical rather than descriptive which will provide richer theory.
6th November 2015	Coding transcript 1 am aware that my coding on page 5 about differences in relationships is a bit confusing. Have a number of codes about the same things and perhaps the code "experience of different types of relationships" is a higher code or even a category. Maybe this could be the name of the category. I don't think it matters if the name of a category is the same name as a code. The participant seemed to struggle to give a description of how the relationships he had experienced differed and the ways in which they different. Perhaps this reflects a lack of understanding about relationships. If he was able to understand or knew more about this, the data would be different and a richer account would probably be given.
13th November 2015	The participant seemed to change the topic at line 273 – could this be because he did not understand the question or he had more to say and there hadn't been any space for this in the interview so far? Line 305 – participant is saying that he is busy most of the time. I think this challenges my view of inpatient wards being dull and activity less. My ideas about inpatient wards was that people sat around all day and people didn't go out much,

	but he is saying the opposite of this. Even though this participant is saying that he does not want to hurt people any more I could not help feeling at risk during the interview as he was looking at my feet. So despite what he was telling me perhaps I did not believe him or feel confident in what he was saying. Having re-coded interview 1 I now have 127 codes compared with my initial 44. I think I have given much more thought to each line of text which has resulted in more codes and have used the analytic strategies better and more closely to the text. Some of the coding has been done in vivo and some hasn't.
19th November 2015	Started re-coding interview 2 – doing line by line coding and then will start to form some loose categories. In interview 2 the participant talks a lot about difference and says that he has an extra female chromosome and that this means he has to go over things a few times before he can answer. It could be that he is getting confused with his learning disability as this would be more likely to lead to him needing to read things more than once and taking time on this.
22nd November 2015	Continuing with interview 2 coding. On page 8 I think I have made a presumption that the participant has changed the way he has communicated with people since doing the group. This may not be the case, and may not be the changes that he thinks he has made. On page 9 I started to think about why the same group of people who knew each other at college ended up in the same hospital as each other. What influenced their behaviour – lack of understanding about relationships? All egged each other on? Hard not to question how this happened or why?
26th November 2015	Continued coding interview 2. On page 14 suddenly dawned on me that this participant's risky situations are all about people being less able than him and also less likely to be able to make an informed decision about whether to have sex. Is this because they are less likely to say anything to anyone? Is it because he feels he cannot have sex or have a relationship with other people who are not vulnerable? Page 15 – the participant mentions coping skills but then proceed to give the same example as before. I wonder whether he knows any other coping skills, or whether this is a term that was used in the group and is talked about and therefore he uses it. Perhaps limited understanding of other coping skills.
29th November 2015	Continued with coding interview 2. Hoping to finish this one by the end of the day. On page 20/21 participant talks about being from a Romany gypsy background and mentions that he would be protected if anyone wound him up outside of hospital – my knowledge and stereotypes infer that this could be physical violence.
3rd December 2015	Started analysing interview 3. Much quicker to do initial coding than previous 2 interviews. I get the sense in this interview that the participant cannot remember much about the group, and from his perspective he does not need to remember as his relapse prevention plan helps him to avoid risky situations when he is out. From this point of view, what is the point in the full SOTP if he cannot remember the content. Participant 3 was contradictory in whether his thoughts about relationships had changed since the group – said both yes and no.

	Completed coding interview 3.
9th December 2015	Started to form categories based on the codes of interview 1 – proving more difficult than I anticipated. Also having to re-code some bits as more descriptive than analytical.
10th December 2015	Submitted Notice of Substantial Amendment – awaiting for authorisation. Also updated documents to reflect methodological changes, including devising a re-visiting consent form. Continued to form loose categories based on codes from interview 1.
11th December 2015	Finished putting codes into categories for interview . For the most part there were clear themes within the data and the categories were quite easy to define. However these will need adjusting and moving of codes to ensure that the category is representing the data accurately. This may be more evident when I eventually come to interview people in the community. There are some parts of categories that seem quite specific to being on an inpatient ward. I hope that when I have a telephone meeting with XXX later that she can tell me about the process of her coding the extract I sent – would really like some security that what I am doing is right before I continue doing any more. Have looked at some past MRP's that have adopted grounded theory, and although all seem to have done the coding slightly differently, I am starting to feel that what I am doing it right. I just need to keep remembering to be analytical. Started categorising the codes from interview 2 based on existing categories from interview 1 and adding new ones. They will have to be re-organised and re-named. Am already starting to see some sub-categories of the bigger categories and how they are linking to one another. On the other hand I have some codes which do not fit into the categories and I don't think are relevant to the research questions. Maybe I need to discard these?? I also think the re-arranging of categories and codes will be easier on paper rather than on the computer (difficult to see all in one go), so will need to print out and cut out. Would be good to take some pictures of the initial categorisation of codes to show the stages of theory development in the write up.
22nd December 2015	Have started transcribing the 5th interview that I did – have been focussing on coding the previous interviews first. However the participant said that they had completed the SOTP individually and only completed the RRP in a group. I have e-mailed my supervisor to confirm whether this is the case – may be difficult to find out as he completed the SOTP in a different place. If he has only done the SOTP on an individual basis I may have to discard his interview and remove him from the dataset, as this was an exclusion criteria.
29th December 2015	Transcribing interview 5.
30th December 2015	Continued transcribing interview 5 – going well! There are some parts of the interview that seemed a bit uncomfortable for the participant, and tended to give one word answers and seemed quite compliant. At times I did check in with him that he wanted to continue or move on, and re-iterated that he did not have to share if did not feel comfortable.
21st January 2016	Have been categorising the codes from interview 4 – some fit into those categories that have already arisen out of interviews 1-3 but some are new. As the categories are now expanding, think I need to print off all the codes so I can lay them out and change them around. This is proving difficult to do

	electronically. Started coding interview 5 using the categories - had to write the categories out separately on a sheet of paper as struggling to use electronic version, as unable to see them all out in front at the same time. Initial ideas of processes of change – being able to have support through talking to staff, being able to trust the group to talk about offence and difficulties with risky thoughts, able to use coping strategies (this changes depending on the individual).
May 2016	Revision of the project is needed based on examiner feedback. Met with my manager and MRP supervisor to discuss feedback and options at this stage. We agreed that I would look at the data that I had already collected and see what this tells me. This will help to know whether the data I have is usable at all, or whether I will need to start a completely new project.
June 2016	Met with my MRP supervisor and another member of course staff. We had a look at the data together and decided that I should be able to use what I have, but may need to collect more and/or go back to interview some participants for further data. I decided that I could use the data but would really need to think about what the data is telling me, to structure my research questions. I am having to do this slightly backwards but it will avoid me having to start a new project completely. This project seems as though it will be quite different to my last project anyway, and so it will seem like a new project within the same area.
19.08.2016	Started re-analysing data using deductive analysis – surprised at how little there is to support existing models of sex offending within my data. I think this is starting to show that there are other factors that need to be considered in treatment approaches for ID sex offenders. Hoping my inductive analysis will show this. Getting the impression that participants have a tendency to blame their offence on external factors such as stressful situations or other people encouraging them to do it or from having bad relationship experiences. Is this how they are making sense of their current situation?
22.08.2016	Beginning to analyse using inductive methods, I have so many codes am sure not all of these will be relevant. Keeping my research questions in mind much more closely than before as don't want to stray off topic. One of my lines of thinking whilst doing the analysis so far is that many of the participants have a diagnosis of autism – unable to read people's emotions so may not be able to judge if the other does not want to have sex if they are not explicit about it. Therefore could this mean that improvements in being able to read others' emotions may deter from sex offending?
23.08.2016	I have developed some loose themes based on my analysis so far. Already been switching these around a lot as not all the codes fit. Themes: developing relationships – subthemes of consent, reading emotions Relationship with staff for support – subthemes of talking to staff/communication, previous loneliness.
26.08.2016	Continuing to analyse data. I have shifted the themes and merged them a lot.

	Is communication and talking to staff linked to loneliness? There is one case where this does link – participant said about not being on how own with his genetic syndrome when met someone else with the same. Theme: Memories – unable to remember treatment or able to remember group with subthemes of sex education and talking about offence. Theme: External locus of control with subthemes of treated badly in relationships, other mental health difficulties, stages of life development. Starting to get a good sense of what is important to ID sex offenders in helping reduce their risk to others. It is interesting that many of them have re-offended but still think they have made progress – need to make sure I acknowledge this in my write up.

Appendix J - Coded transcript

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Appendix K – Deductive codes

Codes were identified based on existing models of sex offending by Finkelhor (1984) and Ward and Hudson (1998). These two models were chosen as they are the most dominant models of sex offending within the literature. These two models also overlap in places, and these overlapping aspects of these models formed the codes used for the deductive analysis of the data.

The code ‘motivation to offend’ was apparent in both of the models identified above, and presumed that offenders had a motivation to commit their sex offence.

The code ‘disorted cognitions’ was used to identify the data which identified the participant as displaying some form of distorted cognition. This may have been in the form of minimisation of the offence, blaming the victim, denying the offence.

The code ‘experience of abusive relationships’ was used throughout the data analysis where a participant made reference to being abused as a child or in other relationships. This is a specific code around being a victim of abuse and does not include more general negative experiences in relationships.

Appendix L: Codes, subthemes and themes

Main theme	Subthemes	Code	Data extracts
Connecting with others	Trust	1-Predictions about partner if have a relationship (Interview 6, line 242-246) 2-Difficult to talk to staff if don't trust them (Interview 6, lines 68-73) 3-Needed trust to be able to talk about offence (Interview 3, 27-33) 4-Difficult to trust others (Interview 13, lines 115-122) 5-Difficult to trust in relationships (Interview 6, lines 249-250) 6-Feels supported if can trust staff (Interview 6, lines 73-81) 7-Harder to have a relationship if don't trust the other person (Interview 13, lines 123-129) 8-Relationships involve trust (Interview 12, lines 209-214) 9-Trust important to sharing in the group (Interview 14, lines 52-55)	*This has been removed from the electronic copy*
	Relationship knowledge	1-Bible has helped him understand behaviour and relationships (Interview 5, lines 592-599) 2-Treats others with respect in	

		relationships (Interview 13, lines 95-97) 3-Important to have commonalities with partner (Interview 5, lines 582-588) 4-Demonstrates learning of consent (Interview 4, lines 389-392) 5-Developed an understanding of consent (Interview 2, lines 74-76) 6-Knows the law around appropriate relationships (Interview 6, lines 201-204) 7-Has learned about respecting others (Interview 11, lines 201-220) 8-Group has helped him to understand how to treat others as he would want to be treated (Interview 5, lines 395-399) 9-Understands how to instigate a relationship (Interview 8, lines 102-115) 10-Understanding of relationships has developed (Interview 2, lines 210-211) 11-Knows how women may be offended by inappropriate behaviour (Interview 5, lines 567-572) 12-Demonstrating knowledge of relationship progression/recognising others feelings (Interview 2, lines 144-	

		161) 13-Demonstrating knowledge of consent (Interview 1, lines 163-164) 14-Demonstrating knowledge of consent (Interview 2, lines 197-200) 15-Knowledge of consent (Interview 7, lines 252-254) 16-Knowledge of the term 'consent' (Interview 2, line 206) 17-Demonstrating knowledge of consent in relationships (Interview 1, lines 108-111) 18-Learned about importance of consent (Interview 3, lines 211-216) 19-Knows how to check age of another person (Interview 13, lines 106-108) 20-Demonstrating understanding of consent (Interview 4, lines 463-464) 21-Knows speaking to young children is inappropriate (Interview 9, lines 152-153) 22-Learned about the law in relation to age (Interview 6, lines 20-27) 23-Learned how to check age of a	

		person before having a relationship (Interview 6, lines 430-434) 24-Learned about understanding relationships or consent in a relationship (Interview 14, lines 423-429) 25- Treatment has helped to develop an understanding of relationships (Interview 14, lines 433-437)	
	Relationship development	1-Developed relationships with other group members (Interview 9, lines 256-263) 2-Getting to know other people in the group (Interview 2, lines 614-616) 3-Gets on with housemates (Interview 12, lines 546-548) 4-Future relationships (Interview 2, lines 514-517) 5-Group has helped him get new friends (Interview 12, lines 501-504) 6-Spends time with friends more now (Interview 12, lines 582-583) 7-Group has helped him get to know more people (Interview 12, lines 640-642) 8-Friendships (Interview 8, lines 192-198)	

		9-Getting to know others in the group made it easier (Interview 5, lines 283-284) 10-Gets on well with other group members (Interview 12, lines 161-167) 11- Helps out other group members (Interview 1, lines 54-56) 12-Mutual understanding between group members helps develop relationships (Interview 9, lines 260-265) 13- Developed relationships with other group members (Interview 9, lines 248-249) 14-Good relationship with staff (Interview 2, lines 135-136) 15-Developed friendship with another group member (Interview 12, 35-38) 16-Got to know others in the group (Interview 10, line 8) 17-Got on with other group members (Interview 12, lines 21-29) 18-Gets on with other patients and staff (Interview 6, lines 100-102) 19-Developed friendships with other	

		group members (Interview 14, lines 67-69)	
	Feeling supported	1-Supported by social worker (Interview 5, lines 239-244) 2-Feels able to talk to staff (Interview 2, lines 228-231) 3-Supported by staff to disclose offence when applying for jobs (Interview 9, lines 137-146) 4-Staff support when in the community (Interview 1, lines 99-102) 5-Supported by staff (Interview 5, lines 844-848) 6-Supported by other group members (Interview 1, line 61) 7-Staff support when in the community (Interview 4, line 186-191) 8-Supported by staff in the community (Interview 2, lines 168-175) 9-Staff provide support when in the community (Interview 6, lines 107-109) 10-Reminded by staff to use coping strategy (Interview 2, line 42-43) 11-Care team always approachable (Interview 2, lines 467-471)	

		12-Supported in the community (Interview 13, lines 195-200) 13-Support from staff in the group (Interview 8, lines 65-72) 14-Supported by staff if need it (Interview 13, lines 238-239) 15-Supported to get to the group (Interview 12, lines 87-89) 16-Aware that staff are available for him to talk to (Interview 4, lines 126-138) 17-Support available if he needs it (Interview 1, lines 17-18) 18-Staff support in using coping strategy (Interview 11, lines 319-321) 19-Supported by staff when he needs it (Interview 1, lines 153-155) 20- Supported by other group members (Interview 1, lines 53-54) 21- Supported by staff when he needs it (Interview 1, lines 35-36) 22-Feels listened to by staff (Interview 7, lines 49-50) 23-Able to speak to staff (Interview 2,	

		lines 137-140) 24-Feels able to talk to keyworker (Interview 12, line 300) 25-Able to speak to staff if needs support (Interview 6, lines 61-65) 26-Support available if he needs it (Interview 5, lines 256-257) 27-Supported by care team (Interview 2, lines 205-207) 28-Supported in RLP group (Interview 6, lines 82-90) 29-Supported by staff to read relapse prevention plan (Interview 5, lines 849-852) 30-Individual and family psychological work (Interview 2, lines 57-62) 31-Individual psychotherapy sessions (Interview 4, lines 581-583) 32-Continued support when he moves (Interview 5, lines 206-208) 33-Feels able to speak to staff about anything (Interview 13, lines 187-194) 34-Supported with difficulties other than sex offending (Interview 9, lines	

		178-183) 35-Supported by other group members (Interview 14, lines 618-619) 36-Supported by other group members (Interview 14, lines 451-457) 37-Talking to staff as a source of support (Interview 14, lines 741-746)	
Factors influencing offending behaviour	Distorted cognitions	1-With other offenders whose crimes were more serious (Interview 5, lines 38-45) 2-Minimising offence (Interview 9, lines 69- 72) 3-Minimising offence (Interview 5, lines 31-32 4-Minimising offence (Interview 1, line 111) 5-Provoked by female (Interview 2, lines 77-83) 6-Blaming drugs for behaviour (Interview 5, line 705) 7-Blaming offending on autism (Interview 1, lines 132-134) 8-Minimisation of sex offence (Interview 9, lines 702-703	

		9-Minimising offence (Interview 9, lines 45-46) 10-Denial of why he is in hospital (Interview 13, lines 213-218)	
	Stressful situations	1-Stressful situation led to offending (Interview 4, lines 165-178) 2-Stess led him to offend (Interview 7, lines 149-156) 3-Hospital limits being able to have a relationship (Interview 3, lines 240-245) 4-Move kept being postponed (Interview 1, lines 132-138) 5-Hospital limits being able to have a relationship (Interview 1, lines 146-149) 6-Not private to be able to speak to staff (Interview 4, lines 113-116) 7- Hospital limits being able to have a relationship (Interview 6, lines 255-258) 8- Hospital limits being able to have a relationship (Interview 7, lines 221-222) 9-Pressure to leave hospital from commissioners (Interview 1, lines 273-279) 10-Stressful living situation led to recall back to hospital (Interview 5, lines 213-	

		223) 11-Move to another hospital was taking a long time (Interview 1, lines 260-271) 12-Pressure to leave hospital (Interview 1, lines 298-302) 13- Had a breakdown at the time of the offence (Interview 5, lines 31-36)	
	Negative relationship experiences	1-Treated badly as a child (Interview 2, lines 207-215) 2-'Used' in previous relationship (Interview 8, lines 79-85) 3-Treated badly in previous relationship (Interview 6, lines 132-142) 4-Treated badly by women in the past (Interview 2, lines 368-369) 5-Girl forced herself on him (Interview 10, line 129-142) 6-Relationship is stressful (Interview 12, lines 222-226) 7-Victim of a sex offence (Interview 10, lines 234-238) 8-Treated badly in a relationship (Interview 2, lines 299-305) 9-Trust has been broken in a previous	

		relationship (Interview 14, lines 527-532)	
	Not feeling supported	1-Not able to ask keyworker for advice (Interview 10, lines 115-118) 2-Does not think keyworker can help (Interview 12, lines 321-325) 3-Difficult to get support as interrupted (Interview 7, lines 53-61) 4-Unsupported (Interview 12, lines 321-327) 5-Does not feel supported by new staff (Interview 6, lines 66-71)	
	Memory difficulties	1-Unable to remember topics covered (Interview 2, lines102-104) 2-Unable to remember group activities (Interview 10, lines 40-43) 3-Unable to remember (Interview 1, lines 4-7) 4-Unable to remember (Interview 1, lines 70-78) 5-Memory difficulties (Interview 13, lines 65-66) 6-Unable to remember as did treatment a long time ago (Interview 9, line 531)	
Perceived successes	Self-management	1-Focussing the mind as a coping strategy (Interview 7, lines 258-276)	

		2- Able to not react to temptations (Interview 1, lines120-126) 3-Keeping busy as a coping strategy (Interview 11, lines 296-323) 4-Keeping busy reduces hurtful thoughts (Interview 1, lines 344-348) 5- Keeping busy stops him offending (Interview 13, lines 144-148) 6-Coping strategy to change focus of thinking (Interview 2, lines 428-437) 7-Coping strategies (Interview 2, lines 455-464) 8- Coping strategies (Interview 9, lines 113-120) 9-Talking to others as a coping strategy (Interview 6, line 159) 10-Keeping busy as a coping strategy (Interview 1, lines 220-226) 11-Coping strategy (Interview 7, lines 86-96) 12-Keeping busy as a coping strategy (Interview 1, lines 247-252) 13-Distraction as a coping strategy (Interview 9, lines 614-619)	

		14-Thinking about the impact on the victim prevents re-offending (Interview 13, lines 247-251) 15-Grounding as a coping strategy (Interview 4, lines 514-517) 16-Coping strategy (Interview 7, lines 248-250) 17-Coping strategy (Interview 7, lines 109-113) 18-Coping strategy (Interview 6, lines 371-372) 19-Keeping busy as a coping strategy (Interview 1, lines 211-217) 20-Distraction as a coping strategy (Interview 9, lines 568-573) 21-Thinking about family is a coping strategy (Interview 4, lines 245-254) 22-Keeping busy as a coping strategy (Interview 11, lines 296-302) 23-Coping strategy (Interview 4, lines 207-227) 24-Coping strategy (Interview 2, lines 195-202) 25-Coping strategy (Interview 12, lines	

		578-582) 26-Coping strategy (Interview 3, lines 314-323) 27-Coping strategy (Interview 7, lines 53-59) 28-Hobbies as a coping strategy (Interview 1, lines 23-26) 29-Walking away as a coping strategy (Interview 1, line 237) 30-Walking away as a coping strategy (Interview 6, line 46) 31-Coping strategy (Interview 8, lines 239-241) 32-Change focus of thinking as a coping strategy (Interview 2, lines 411-412) 33-Back up coping strategies if first doesn't help (Interview 5, lines 343-349) 34-Coping strategy (Interview12, lines 578-580) 35-Religion as a coping strategy (Interview 5, lines 424-433) 36-Keeping mind focussed as a coping	

		strategy (Interview 8, lines 234-238) 37-Coping strategy (Interview 5, lines 329-339) 38- Coping strategy (Interview 2, lines 102-103) 39-Coping strategy (Interview 2, lines 402-404) 40-Focussing on task as a coping strategy (Interview 1, lines 31-34) 41-Focussing on task as a coping strategy (Interview 1, lines 97-98) 42-Coping strategy (Interview 12, lines 565-572) 43-Talking as a coping strategy (Interview 2, lines 469-475) 44- Thinking about the future (Interview 2, lines 508-511) 45-Thinking about the consequences of actions (Interview 13, lines 41-42) 46-Thinking of consequences of actions (Interview 6, lines 373- 379) 47-Thinking of consequences of actions (Interview 9, lines 685-689)	

		48-Impact of offence on others prevents re-offending (Interview 3, lines 266-284) 49-Focussing on task as a coping strategy (Interview 1, lines 388-394) 50-Coping strategy (Interview 2, lines 579-580) 51-Combined coping strategies from different treatments (Interview 2, lines 546-555) 52-Use coping strategies to not re-offend (Interview 12, lines 634-636) 53-Coping strategy (Interview 7, lines 85-90) 54-Keeping busy as a coping strategy (Interview 1, line 344) 55-Coping strategy (Interview 1, lines 375-376) 56-Keeping busy as a coping strategy (Interview 6, lines 371-374) 57-Coping strategy (Interview 4, lines 514-516) 58-Distraction takes mind off risky thoughts (Interview 14, lines 134-135)	

		59-Distraction helps manage risky thoughts (Interview 14, lines 135-147) 60-Distraction when in the community (Interview 14, lines 127-135) 61- Talking to others as a coping strategy (Interview 14, lines 149-151) 62- Distraction helps reduce risky thoughts (Interview 14, lines 287-288) 63- Distraction helps risky thoughts go away (interview 14, lines 404-407) 64- Distraction prevents getting risky thoughts (Interview 14, lines 705-708) 65- When busy he does not get risky thoughts (Interview 14, lines 709-715) 66- Tried to manage thoughts by writing them down (Interview 14, lines 201-215) 67- Has a plan b if distraction ineffective at reducing his risk (Interview 14, lines 303-309) 68-Tries to stay away from situational triggers (Interview 14, lines 332-334) 69-Thinks about impact on relationship with family (interview 14, lines 342-355)	

		70-Refrains from going to places where children will be (Interview 14, lines 672-674) 71-Able to make decisions to reduce his risk to others (Interview 14, lines 756-758) 72-Thinking of the consequences of actions helps him not to re-offend (Interview 6, lines 339-341) 73-Thinking about his daughter reduces his risk (Interview 13, lines 166-169) 74-Thinks about consequences of actions to reduce his risk to others (Interview 2, lines 46-53) 75-Thinking of consequences of actions reduces his risk to others (Interview 6, lines 350-368) 76-Knowing what he will lose if he re-offends motivates him to use coping strategies (Interview 7, lines 288-294) 77-Consequences of going to prison is a deterrent (Interview 9, lines 325-329) 78-Acknowledges consequences of sex offending in going to prison (Interview 9, lines 148-152) 79-Consequences of displaying	

		sexualised behaviour towards women (Interview 14, lines 567-572) 80-Impact of sex offence on getting a job (Interview 9, lines 137-146) 81-Consequences deters him from re-offending (Interview 9, lines 676-680) 82-Consequences deter him from offending (Interview 6, lines 132-133) 83-Consequences of his offence (Interview 2, lines 51-54) 84-Learned about effect of offence on others (Interview 13, lines 35-38) 85-Thinking about consequences of behaviour prevents further offending (Interview 2, lines 103-104)	
	External management of risk	1- Relapse prevention plan helps as a reminder (Interview 3, lines 68-72) 2-Relapse prevention plan (Interview 6, lines 331-334) 3-Relapse prevention plan (Interview 7, lines 285-289) 4- Relapse prevention as a memory aid (Interview 13, lines 55-60) 5-Relapse prevention aids memory (Interview 7, lines 122-127)	

		6-Relapse prevention as a reminder for when in the community (Interview 1, lines 72-79) 7-Relapse prevention plan (Interview 6, lines 29-32) 8-Reads relapse prevention before going in the community (Interview 2, lines 94-102) 9-Relapse prevention will go with him when he moves (Interview 7, lines 130-133) 10-Stay well book prevents him getting into trouble (Interview 5, lines 872-877) 11-Relapse prevention as a memory aid (Interview 5, lines 849-844) 12-Uses keeping safe card when in the community (Interview 8, lines 38-41) 13-Has relapse prevention plan (Interview 6, lines 400-408) 14-Has a relapse prevention plan (Interview 5, lines 849-850) 15-Uses relapse prevention plan when goes into the community (Interview 1, lines 72-74) 16-Can take RLP with him when he	

		moves (Interview 2, lines 127-132) 17-Relapse prevention is continuous (Interview 1, lines 37-42) 18-Uses relapse prevention plan when goes into the community (Interview 3, lines 68-79) 19-Relapse prevention plan contains information about risky situations (Interview 14, lines 662-670) 20- Support from staff in the group (Interview 8, lines 65-72) 21- Supported by staff if need it (Interview 13, lines 238-239) 22- Supported to get to the group (Interview 12, lines 87-89) 23- Staff support in using coping strategy (Interview 11, lines 319-321) 24- Supported by staff when he needs it (Interview 1, lines 153-155) 25- Supported by other group members (Interview 1, lines 53-54) 26- Supported by staff when he needs it (Interview 1, lines 35-36) 27-Support available if he needs it	

		(Interview 5, lines 256-257) 28- Supported by care team (Interview 2, lines 205-207) 29- Supported in RLP group (Interview 6, lines 82-90) 30- Supported by staff to read relapse prevention plan (Interview 5, lines 849-852) 31- Continued support when he moves (Interview 5, lines 206-208) 32- Supported with difficulties other than sex offending (Interview 9, lines 178-183) 33- Supported by other group members (Interview 14, lines 618-619) 34- Supported by other group members (Interview 14, lines 451-457) 35- Talking to staff as a source of support (Interview 14, lines 741-746) 36- Hospital limits being able to have a relationship (Interview 3, lines 240-245) 37- Hospital limits being able to have a relationship (Interview 1, lines 146-149) 38- Hospital limits being able to have a	

		relationship (Interview 6, lines 255-258) 39- Hospital limits being able to have a relationship (Interview 7, lines 221-222) 40- Talking to others as a coping strategy (Interview 6, line 159) 41- Talking as a coping strategy (Interview 2, lines 469-475) 42- Care team provide support (Interview 2, lines 203-205) 43- Talking as a coping strategy (Interview 7, lines 134-139) 44- Coping strategy (Interview 12, lines 460-465) 45- Coping strategy (Interview 4, lines 514-519) 46-Medication management of risky thoughts (Interview 14, lines 157-164) 47-Staff support when in the community (Interview 14, lines 180-184) 48-Believes staff support him in reducing re-offending (Interview 14, lines 221-224) 49-Staff support with relapse prevention	

		(Interview 14, lines 97-103) 50-Reduces his risk by talking to staff when in the community (Interview 14, lines 719-720) 51-Management of risky thoughts by hospital provided activities (Interview 14, lines 135-147) 52-Relapse prevention plan when on community leave (Interview 14, lines 279-285) 53-Back up plan to talk to staff if distraction is ineffective (Interview 14, lines 303-313) 54-Relapse prevention increases awareness of risk triggers (Interview 14, lines 314-316) 55-Risk triggers in relapse prevention plan (Interview 14, lines 323-326) 56-Relapse prevention plan contains information about risky situations (Interview 14, lines 662-670) 57- Supported by staff to take girlfriend out (Interview 12, lines 401-411) 58-Better supported if re-offend in hospital (Interview 12, lines 89-94)	

		59-Sees doctor regularly for support (Interview 5, lines 248-250) 60-Supported by staff when in the community (Interview 7, lines 100-105) 61-Family support (Interview 2, lines 594-604) 62-Support needed in new placement (Interview 1, lines 148-153)	
	Understanding risk	1-Understands that he has to avoid certain places due to sex offending (Interview 12, lines 117-120) 2-Staying indoors prevents him offending (Interview 13, lines 151-153) 3-Knows areas to avoid to reduce his risk to children (Interview 9, lines 591-597) 4-Has understanding of own risky situations (Interview 3, lines 256-262) 5-Knows he is at risk of hurting others (Interview 1, lines 206-207) 6- Has understanding of own risky situations (Interview 2, lines 389-394) 7-Has learned which areas to avoid to reduce his risk (Interview 6, lines 454-456)	

		8-Avoiding situations where there is a temptation (Interview 11, lines 346-354) 9-Has understanding of what leads to his risk increasing (Interview 6, lines 389-393) 10-Avoids situations that may increase his risk to others (Interview 2, lines 108-117) 11-Staying away from situations prevents relapse (Interview 11, lines 339-344) 12-Aware of situation that would increase risk to others (Interview 4, lines 496-507) 13- Has understanding of own risky situations (Interview 6, lines 211-217) 14-Aware of situations that may increase his risk to others (Interview 11, lines 267-282) 15-Places to avoid are important (Interview 3, lines 64-66) 16-Has understanding of own risky situations (Interview 12, lines 456-457) 17-Has knowledge of his risky situations (Interview 8, lines 225-228)	

		18-Keeping away from risky situations would reduce risk to others (Interview 6, lines 48-57) 19-Has understanding of own risky situations (Interview 6, lines 47-48) 20-Relapse prevention plan increases awareness of risk triggers (Interview 14, lines 314-316) 21-Tries to stay away from situational triggers (Interview 14, lines 332-334) 22-Understanding of risky situations (Interview 14, lines 664-670) 23-Refrains from going to places where children will be (Interview 14, lines 672-674) 24-Understands own risky situations that may increase risk to others (Interview 14, lines 108-109)	
	Indicators of remorse	1-Reluctance to talk about how he thought about relationships before treatment (Interview 11, lines 159-161) 2-Did not like talking about his past (Interview 7, lines 38-45) 3- Reluctant to talk about risky situations (Interview 7, lines 244-247) 4-Admitting offence was difficult	

		(Interview 9, lines 285-286) 5-Not like talking about offence (Interview 9, line 252) 6-Did not like to talk about his past (Interview 11, lines 36-41) 7-Ashamed to talk about offence in the group (Interview 13, lines 233-236) 8-Painful to think about offence (Interview 12, lines 181-189) 9-Did not like talking about offences (Interview 3, lines 110-113) 10-Sense of regret about committing offence (Interview 12, lines 553-560)	

Appendix M: Participant study feedback

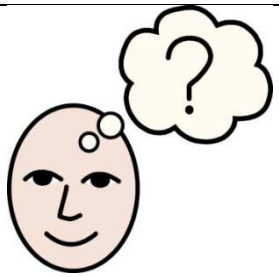
Canterbury Christ Church University

Research study feedback – How do you understand your current situation and efforts to not re-offend?

My name is Nikkita

Thank you for taking part in my student research study.

NHS



This research hoped to understand how you make sense of your current situation and what effort you think you have made in not re-offending.

You took part in an interview with me. I interviewed 13 people in total.

I wanted to tell you about what the research found.

There were 3 main areas that were important in understanding the sex offender treatment:

1. Connecting with other people such as trusting others, developing relationships, understanding relationships and feeling supported.

2. Things that make you more likely to offend such as the way you think about sex offences, stressful situations, having bad experiences in relationships, not feeling supported, and difficulties remembering treatment.

3. Things that you think you have been successful at in relation to sex offending such as managing risky situations, using relapse prevention and understanding your risk to others.

A note has been made in your file that you took part in the study.

If you have any questions about the study you can talk to me (Nikkita) on 0333 011 7070. Please state that you are phoning for Nikkita.

Appendix N: NHS Ethics end of study form

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Appendix O: Study summary for ethics board

Summary of research project for Ethics Committee

Introduction:

There is limited research exploring the effectiveness of sex offender treatment programmes for intellectually disabled (ID) sex offenders. The research that does exist uses case study design and small cohort studies. The research also has many methodological limitations and has variations in outcome in terms of attitudes consistent with sex offending and re-offending behaviour.

The most consistent finding across the literature is that changes in cognitions do not always prevent further sex offending behaviour.

Current models of sex offending have been used to develop sex offender treatment programmes in the general population, and these have been adapted for use with ID sex offenders. There is no specific model of sex offending for the ID population. We need to understand whether the lack of clarity regarding treatment effectiveness is potentially due to the existing models of sex offending, not being applicable to this group.

This research study aimed to explore what is considered to be important by ID sex offenders in their risk being reduced to others. More broadly this study considers the applicability of existing models of sex offending.

Method:

The study adopted a qualitative thematic analysis, which included the use of both deductive and inductive approaches. This approach increased the rigor of the study, and allowed direct comparison between existing models of sex offending and what also requires consideration in understanding sex offending for this group.

Semi-structured interviews with 13 ID sex offenders who had completed a group sex offender treatment programme were completed.

Results:

There were three main themes and 12 that developed from the data:

1. Connecting with others – subthemes of trust, relationship development, relationship knowledge and feeling supported.
2. Possible factors influencing offending behaviour – subthemes of cognitive distortions, not feeling supported, negative experiences in relationships, memory difficulties and stressful situations

3. Perceived success – subthemes of self-management, relapse prevention, understanding risk, indicators of remorse.

Conclusions:

The study gave insight into what was considered important to ID sex offenders in reducing their risk to others. The data supported some aspects of existing sex offender treatment programmes such as distorted cognitions and negative experiences in relationships; however there were other areas that are not considered in existing models that are specifically important for this population, in attempting to prevent re-offending. This centred around understanding relationships and feeling connected to other people. This supports the use of group treatment for this group, but also suggests that treatment may be more effective if support networks are developed as part of treatment. The research also suggests that risk of re-offending may be higher at times of stress, and that extra support may be needed. There is also support for including relapse prevention due to memory difficulties, and needing support to be reminded of useful aspects of treatment.

To summarise, this study is novel and useful in informing of those aspects of existing models of sex offending that may be applicable to this group, but that a specific model of sex offending for the ID population may be more beneficial in preventing re-offending.

Appendix P: Journal submission guidelines

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