

Evaluation of an inpatient sex offender treatment programme for men with intellectual disabilities

Gareth Hickman and Antonia Morris

Abstract

Purpose – *The purpose of this paper is to report on an inpatient cognitive behavioural sex offender treatment group programme developed and provided to people with intellectual disabilities detained in medium and low security hospital settings. The programme was delivered five times between 2012 and 2020. This paper describes the integration of the programme within a wider treatment pathway model and provides analysis of outcome data.*

Design/methodology/approach – *The programme was evaluated over five group programmes using self-report psychometric measures related to treatment targets in the reduction of sexual offending risk, including cognitive distortions, sexual attitudes and knowledge and locus of control; recidivism data spanning up to 7 years post discharge is also provided. The treatment pathway and a description of the programme are provided.*

Findings – *The results of this paper showed improvements in sexual knowledge, cognitive distortions and locus of control, however not to a statistically significant degree. No recidivism was observed in the follow-up period.*

Originality/value – *This paper adds to the evidence base of interventions focused on cognitive behavioural approaches to the treatment and risk reduction of sexual offending in men with intellectual disabilities and adds to the debate regarding the effectiveness of such programmes with offenders with intellectual disabilities.*

Keywords Intellectual disabilities, Sexual offending, Sexually harmful behaviour, CBT, Group programme, SOTP

Paper type Research paper

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Introduction

It is difficult to accurately estimate the frequency of inappropriate or sexually harmful behaviour in individuals with intellectual disabilities (IDs) and definitions of what constitutes this behaviour can vary; however, estimates have been provided ranging from 6% (Swanson and Garrick, 1990) to 33% (Thom *et al.*, 2017). Often sexual offending in this population is underreported or directed away from the criminal justice system, further complicating accurate estimate. The Prison Reform Trust (Talbot, 2008) estimated the prevalence of individuals with IDs in the UK prison system was 7%; Rack (2005) estimated it as high as 20%, further demonstrating the difficulties in quantifying this behaviour. In the period 2019–2020, NHS England commissioned 1,042 secure hospital beds (high, medium and low) for adults with IDs (866, 83% for males); however, accurate data for the number of these beds occupied by those with known sexual offending risk is difficult to quantify. Over the past 15 years, increasing interest has been directed to the treatment and risk reduction of sexually harmful behaviour for individuals with ID, and recent literature reviews and summaries are offered by several authors (Cohen and Harvey, 2016; Marotta, 2017; Jones and Chaplin, 2017; Craig, 2020). The conclusion of these is that, whilst most studies in this area are small scale and lack methodological rigour,

Received 8 April 2022
Revised 24 August 2022
Accepted 27 August 2022

The authors would like to acknowledge the contribution of the Programme Development Unit and Offender Group Treatment Team staff who have been integral to the development and facilitation of the BSOTP.

cognitive-behavioural-based approaches tend to demonstrate some positive effects in reducing recidivism and cognitive distortions and increasing sexual knowledge, self-esteem and a sense of agency. To a lesser degree, other modalities have been documented in the literature including dialectical behaviour therapy, mindfulness, problem-solving therapy and relapse prevention strategies; however, Cognitive Behavioural Therapy (CBT) approaches are most widely reported and focus on four deviancy domains: sexual interests, attitudes supportive of sexual offences, relationships/socio-affective functioning and self-management/problem-solving (Craig and Lindsay, 2010).

There is a growing literature in this area and increases in methodological rigour are being sought. However, most published studies focus on community-based samples or follow-up those who have engaged in prison-based offender programmes and the reader is directed to Rose *et al.* (2002), Rose *et al.* (2012), Craig *et al.* (2006, 2012), Murphy *et al.* (2007, 2010), Heaton and Murphy (2013) and Lindsay *et al.* (2011). The evidence base for inpatient, secure service treatment remains less developed. In such settings, parameters for engagement are often more complex. Participants are likely to have been convicted for sexual offences rather than exhibiting sexually inappropriate or risky behaviour that has not come to the attention of the criminal justice system. As such, participants are generally subject to court-enforced treatment orders or detained under the Mental Health Act (1983/2007) in England and Wales, meaning that engagement and compliance are often compelled to reduce risk and be discharged. Within the recent literature, there is a limited number of studies that focus on interventions for this group of offenders.

Keeling *et al.* (2006) evaluated the effectiveness of a 12-month, cognitive-behavioural sexual offender treatment programme for 18 incarcerated participants with “special needs” in an Australian setting. Findings demonstrated significant change after treatment on measures of attitudes associated with sexual offending, victim empathy and self-control. No significant change was observed on measures of social intimacy, emotional loneliness and criminal attitudes. It is noted that seven of the participants were discharged before completing treatment. The treatment approach is outlined within the report.

For the most part, published studies have focused on community samples; however, some of these studies have included those in secure setting. Samples are typically small. Murphy *et al.* (2010) have been, and continue to be, involved in a series of studies validating manualised CBT treatment for people with ID who engage in sexually harmful behaviour through the Sex Offender Treatment Services Collaborative-Intellectual Disabilities or SOTSEC-ID. SOTSEC-ID sought to evaluate the effectiveness of a group CBT approach adapted from the treatment of mainstream sexual offenders regarding distorted attitudes and beliefs, sexual knowledge and recidivism. This UK multi-site study included a total of 46 men; 67.4% community-based participants, 4.3% low secure and 28.3% from medium secure settings. Intervention included one treatment session of 2 h, once a week for 12 months, with a 6-month follow-up period. It is reported that 6.52% engaged in further Sexually Assaultive Behaviour (SAB) during the treatment and 8.69% engaged in further SAB during follow-up. In all, 8% did not complete the treatment. Significant improvements were recorded in distorted attitudes, sexual knowledge and victim empathy. Linked to this original study, Heaton and Murphy (2013) examined the re-occurrence of SAB throughout a longer follow-up period (mean 44 months, range 15–106 months). Findings indicated that 24% engaged in further SAB since the end of the treatment group. At follow-up, significantly fewer men lived in secure services (15%) compared to before treatment (24%) and more lived in the community at follow-up (85%) compared to before treatment. Significantly fewer men required an escort when in the community, compared with at the start of the treatment and improvements in distorted attitudes and sexual knowledge were maintained.

Langdon and Talbot (2006) offer an exploration of the role of locus of control in sexual offending in this population. In all, 41 participants with ID were recruited into three groups, 1) 12 sex offenders who had undergone CBT-based psychological treatment, 2) sex

offenders who had no history of treatment and 3) non-offenders. Participants completed a measure of *locus* of control and a measure of distorted cognitions. There was a significant difference between those who had and had not completed treatment in terms of cognitive distortions relating to sexual offending but not on the LOC measure. Whilst the offender participants were recruited from secure services, no detail is provided on the intervention, as the current study was not an evaluation of the intervention *per se*.

A further study from the literature focusing on intervention completed within an inpatient facility in the USA is provided by [Singh *et al.* \(2011\)](#), who moved away from CBT principles and examined the effectiveness of mindfulness-based procedures for sexual offenders with ID to control their sexual arousal. Mindfulness therapy was administered four times weekly lasting 30 to 60 min for 35 to 40 weeks. Results indicate that improvements in reported self-control and sexual arousal were identified, however not at a clinically significant level. This study involved three participants and no further follow-up was conducted.

These studies often had small-scale sample sizes, lack of control groups or adequate comparison groups, a lack of randomisation and limited explanation or clarity of the specific intervention delivered. The current study reports specifically on the treatment of sexual offenders with ID detained under the Mental Health Act in a UK medium- and low-secure service, with a requirement to attend intervention to reduce the risk of sexual recidivism.

The current study seeks to evaluate the Brooklands Sex Offender Treatment Programme (BSOTP). This programme has been developed to address the factors important for individuals who have convictions for sexual offending. The BSOTP is based on CBT, the Self-Regulation model and Good Lives Model of Offender rehabilitation ([Ward and Stewart, 2003](#)).

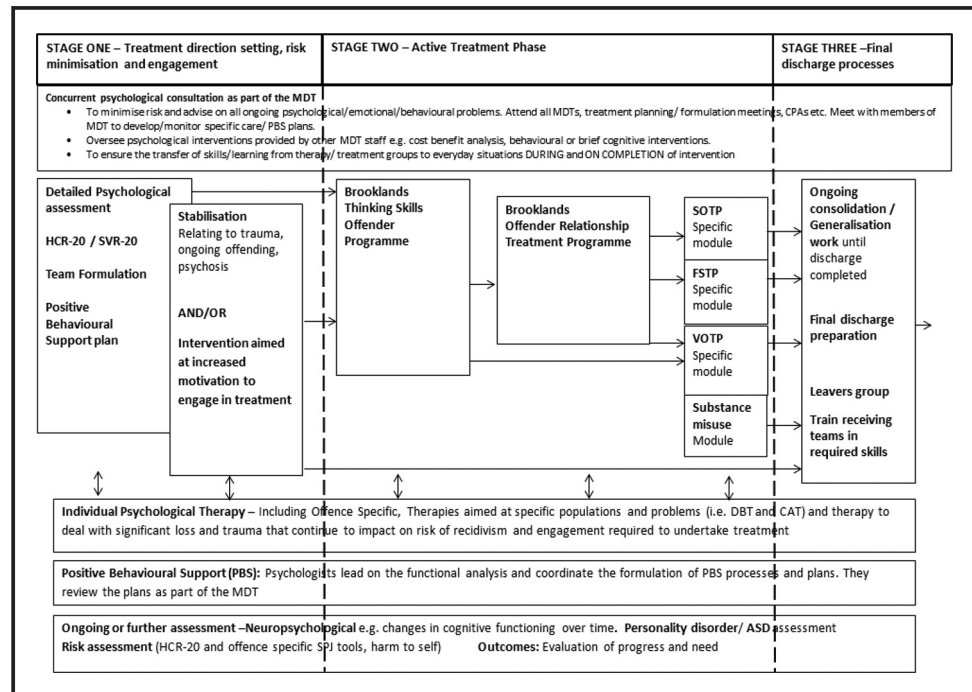
The BSOTP has been developed for male inpatients who have been formally assessed as having ID and who have convictions for offending behaviours. It forms part of the Psychological Treatment Pathway for many of the service users at Brooklands, alongside other offender groups such as the Brooklands Thinking Skills Programme (referred to as BTSP here for clarity) ([Hickman *et al.*, 2017](#)), the Brooklands Offender Relationships Treatment Programme (BORTP, [Murphy, 2014](#)), Fire-Setter Programme and individual psychological therapy. Of significance, the BSOTP is usually attended upon the completion of the BTSP and BORTP which seek to improve social problem-solving and interpersonal relationship skills. The present psychological treatment pathway at Brooklands can be seen in [Figure 1](#).

The current paper seeks to contribute to the evidence base, in particular in the context of inpatient secure services, by outlining some current practices at Brooklands Secure Services and offering evaluation of the effectiveness of the BSOTP. The Secure Service at Brooklands consists of medium- and low-secure facilities over four wards (41 beds; 29 male and 12 female) for adults with ID and autism spectrum disorder. This paper provides an overview of the development and key aspects of this programme, including an adapted “diary tool” used to communicate CBT principles and monitor sexual risk. The paper seeks to establish the effectiveness of this programme and provides outcome evaluation.

Method

Between the period January 2012 and January 2020, BSOTP group sessions were delivered weekly. Sessions lasted 4 h with 15-min breaks hourly and a 1-h mid-point interval; the duration of the programme was 12 months. The structure of sessions took a predominantly CBT format, involving the following elements: ice-breaker, update from the week, review of external practice/monitoring, main content and setting further practice/monitoring. The first two hours of the session also include reflection on active sexual risk management using completed diaries discussed between the group members. The key methods of the programme are outlined below.

Figure 1 Treatment pathway



Participants

Since the introduction of the updated treatment pathway at Brooklands, the BSOTP has been delivered five times between 2012 and 2020. The 16 service users who have attended the group were all male inpatients in medium- and low-secure services, detained under the Section of the Mental Health Act (1983/2007), other than one outpatient not subject to Mental Health Act restrictions. Participants were all adult service users assessed as meeting service criteria for ID. All participants had convictions for sexual offending and were assessed as presenting with a current risk of sexually harmful and offending behaviour (Table 1).

The Brooklands Sex Offender Treatment Programme. Main aims: The BSOTP has the primary aim of reducing risk of sexual offending by developing insight into offending and developing more appropriate risk and non-offending ways to meet goals.

The BSOTP builds on the treatment that group members have previously undertaken during their thinking skills and/or relationship groups with specific focus on sexual offending. Group members learn to recognise their offending and risks and to gain insight into the specific factors relevant to their sexual offending. Focus then moves to identifying and developing more appropriate and non-offending ways to meet appropriate relational goals.

Programme structure

The programme is based on CBT, the Self-Regulation and Good Lives Model of Offender rehabilitation (Ward and Stewart, 2003) and involves some mindfulness components. The programme also builds on the BTSP, which follows D’Zurilla *et al.*’s (1999) model of social problem-solving.

A number of methods outlined below have been developed to enable the men to comprehend and retain these complex and often novel concepts and how they link together.

Table 1 Demographic information

<i>Dates groups delivered between</i>	<i>2012 and 2020</i>
Total number of groups	5
Total N	16
Mean group N	3.2
Mean age	33 (range 21–60)
Mean FSIQ	62 (range 50–72)
MHA Section	
37	9
37/41	5
45a	1
Outpatient (non-MHA)	1
Index Offence Type	
Rape over 16 years	3
Rape under 16 years	2
Contact sexual assault over 16 years	3
Contact sexual assault under 16 years	5
Inciting a minor into sexual activity	1
Indecent exposure	1
Possession of indecent images	1
Comorbid presentation	
Autism spectrum disorder	2
Anti-social personality disorder	2
Previous treatment pathway	
BTSOP	14
BORTP	9

Block approach

All offender group treatment programmes at Brooklands use a block approach. Each block contains related concepts and the material is adapted to the needs of the men in that specific group. This format allows for flexibility in the process of delivery, allowing the group to progress at a pace that permits greater emphasis on different parts of the programme in different groups, dependent on need. It also ensures that the group members can be clear where they are in the group process without having to be prescriptive about how long each block or group will last. The BSOTP consists of 12 modular sections ("blocks") which link together and build upon the preceding concept (Table 2).

Individual sessions

The BSOTP also has in-built individual sessions at the end of each block to supplement the weekly group sessions. The aims of these sessions are to support patients' understanding of the personal relevance of the material in terms of their current sexual risks and critically the link to their sexual offending and sexually harmful behaviour, including past, present and potential future risk. Additional sexual education is provided to address knowledge deficits.

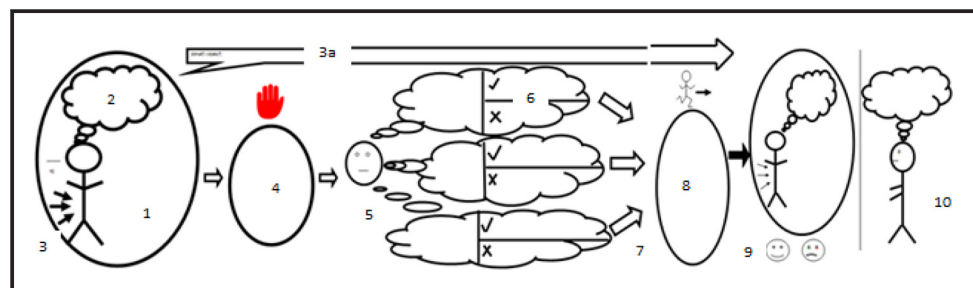
Diary tool

The self-monitoring diary tool is central to the programme. Group members are introduced to the diary tool during the BTSP and have developed competence and skill in the use of this tool at the point of commencing the BSOTP. Where individuals may have not previously completed BTSP, individual preparation sessions are provided before the commencement of BSOTP to teach the tool (Figure 2).

The primary differences between the application of the tool during the BSOTP compared to BTSP is the specific focus on sexual risk and the rating of sexual arousal on a four-point scale: 0 no sexual arousal, no sexual thoughts; 1 slightly aroused (no physical arousal, but

Table 2 Block outlines

Block	Example conceptual ideas
1 Introduction	General introduction to the programme, group formation, motivation and support networks
2 What is SOTP?	How BSOTP will help group members and why they are in the group Introduction to sexual risks, arousal and urges, tools for self-monitoring
3 Arousal	Develop concept of sexual arousal and urges Begin self-monitoring diary Introduce mindfulness for managing arousal and urges
4 Relationships and the law	Legalities surrounding sexual activity and issues of consent
5 Sex and the media	Identifying positive and negative aspects of the media, sexual portrayal in media and online, pornography and associated beliefs. Staying safe online
6 Costs and gains of offending	Enables group members to identify the immediate and long-term consequences of their offending, including developing victim empathy Introduces Good Lives Model enabling participants to identify which life "goods" they sought to achieve through offending Identify prosocial means of achieving these goods
7 Cognitive distortions	Recognise the concept and role of seemingly irrelevant decisions and cognitive distortions (including blame, denial, minimisation and externalisation) Understand role of personal distortions in offending and how to challenge these
8 Creating opportunities to offend	Recognise what participants have done in preparation for their offending Recognise offence pattern Understand what to do when risk is increasing This block draws together all elements of the individuals' offending and applies it to a theoretical model of offending (Finklehor model)
9 Life mapping	To map life history to understand important contributory factors in offending and trauma links
10 Goals	Developing understanding of future life goals and compatibility with offending behaviour
11 Managing risky situations	Relapse prevention module focusing on high risk factors (situations, thoughts and feelings) and managing these using an ACE model (avoid, control and escape)
12 Endings	Reflect on ongoing risk and strategies created to manage risk Identify ongoing support networks Endings and ongoing needs

Figure 2 Diary tool

some sexual thoughts); 2 aroused (some physical arousal); and 3 very aroused (clear physical arousal) (Table 3).

Link to wider treatment pathway

As highlighted previously, the BSOTP builds upon the foundations and concepts of the BTSP and the BORTP. This means that the BSOTP is not an isolated intervention and can be better understood in the context of a wider integrated treatment pathway. A number of core components are carried through from these treatment programmes, such as emotional literacy, impulse management, problem-solving, understanding issues of capacity, consent, power, balance and equality in relationships, boundaries and roles in relationships including the concept of reciprocity and the significant impact of early trauma on the development of modes of thinking and patterns of behaviour.

Procedure

The programme: The BSOTP was implemented according to the structure and content as described above following a comprehensive treatment manual.

Facilitators: All Brooklands offender groups are co-delivered by the Offender Group Treatment Team. Facilitator teams, therefore, included Clinical Psychologists, Nurses and Health-Care Assistants; supervision was provided by a Consultant or Principal Clinical Psychologist throughout.

Data analysis: Data were collected using a series of assessment measures at pre- and post-BSOTP group intervention. Long-term follow-up/recidivism data was collected by establishing consent to follow-up on a yearly basis after discharge. Follow-up interviews were conducted in person or via telephone with service users and their support providers.

Measures

Questionnaire on Attitudes Consistent with Sexual Offenders (QACSO) (Lindsay et al., 2007; Broxholme and Lindsay, 2003): The QACSO was developed for use with individuals with

Table 3 Constituent elements of the diary tool		
Block		Example conceptual ideas
1	What is going on?	Identify sexual risk situation
2	Thoughts	Identify thoughts regarding the sexual risk situation specifically targeting cognitive distortions
3	Feelings	Identify emotional experience related to problem situation and thoughts
3a	Goal setting	Identify and rate state of sexual arousal using 0–3 scale States “What do I want” and permits consideration of desired outcome, that is, goal of managing sexual risk (focus on ACE strategies)
4	Stop	Identify cognitive and/or behavioural stops used to prevent problem situation escalating, reduce impulsivity and provide time to engage in active problem-solving
5	Options	Identify potential options and methods to manage sexual risk (use ACE strategies, behavioural and cognitive)
6	Evaluate	Evaluate the identified options by stating the pros and cons of each option
7	Choice	Circle the chosen option
8	Go	Implement the most appropriate option to manage sexual risk
9	Did it work	Identify and evaluate the effectiveness of the selected option, identifying the new situation, thoughts and feelings Circle face to identify if desired outcome was achieved
10	Reflection	Looking back on the process what has been learned? Identify thoughts regarding the efficacy of the process

learning disabilities who are sexual offenders to assess attitudes that are consistent with or permissive of sexual offending. It assesses cognitive distortions across seven offence-related areas: rape and sexual assault; voyeurism; exhibitionism; dating abuse; stalking and sexual harassment; homosexual assault; and offences against children. A dichotomous scoring system is used: "1" for an attitude consistent with sexual offending and "0" for a socialized response. Internal consistency coefficient of each domain is around $\alpha = 0.8$ with adequate test-retest reliability.

Assessment of Sexual Knowledge (ASK) (Butler and Tonge, 2004): The ASK is an assessment tool used to assess the sexual knowledge and attitudes of people with an intellectual disability. Within the Knowledge Section, there are 15 subscales comprising of: Parts of the Body, Public and Private, Puberty, Menstruation, Menopause, Masturbation, Relationships, Protective Behaviours, Sexuality, Safer Sex Practices, Contraception, Pregnancy and Birth, Sexual Health Screening Tests, Sexually Transmitted Infections and Legal Issues Regarding Sexuality. Items in this Knowledge Section are scored as 0 for incorrect, 1 for partially correct and 2 for correct. The maximum possible score for the Knowledge Section is 248.

Locus of Control Modified Adapted Locus of Control-Internal External (MANSIE) (Nowicki, 1976; Goodman et al., 2007): The MANSIE assesses the extent to which respondents believe events to be internally or externally controlled. Goodman et al. (2007) adapted the original Nowicki (1976) ANSIE for an ID population and reported an internal consistency coefficient of $\alpha = 0.53$ and test-retest reliability $r = 0.66$. An increase in internal locus of control score would indicate an increase in a participants self-efficacy beliefs and feelings of agency and control in their life. This would indicate a response to treatment and is linked to better treatment outcomes (Langdon and Talbot, 2006).

Results

Brooklands Sex Offender Treatment Programme outcome evaluation

Data are offered from groups delivered between 2012 and 2020. The data presented in Table 5 highlight 100% completion rate. Of group completers, 62.5% were successfully discharged from hospital directly to community settings on the completion of the group. Four individuals (25%) were transferred to other services of equal or lower security, with no one being escalated upwards in the system. Of the total participants, one individual remains in active treatment at Brooklands at the time of writing. There are no recorded reconvictions for either sexual offences or non-sexual offences (Table 4).

Psychometric evaluation

Specific data are offered here from the validated psychometric self-report measures.

Table 5 shows that there was improvement in scores following treatment. A Wilcoxon signed-ranks test was performed, as the data were not normally distributed. Bonferroni corrections were conducted because of the number of comparisons. For the total QACSO scores, participants scores were higher before ($M = 23.63$) than after intervention ($M = 19.69$). A Wilcoxon signed-rank test indicated that this difference was not statistically significant ($z = -1,509$ and $p = 3.28$). For the total ASK scores, participants scores were lower before ($M = 200.81$) than after intervention ($M = 208.50$). This difference was not statistically significant ($z = 2,276$ and $p = 0.58$) but indicates an improvement in scores. For the Internalised Locus of Control scores, participants scored lower before ($M = 22.69$) than after intervention ($M = 23.25$). This difference was not statistically significant ($z = 0.598$ and $p = 137.5$). For the Externalised Locus of Control scores, participants scored higher before ($M = 17.25$) than after intervention ($M = 16.13$). This difference was not statistically significant ($z = -1,226$ and $p = 5.5$).

Table 4 Outcome analysis

<i>Dates groups delivered between</i>	<i>2012 and 2020</i>
Total N	16
Completers	16
Attrition rates (non-completers)	0
Discharged from section on the completion of group	10 (62.5%)
Transferred under section on the completion of group	4 (25%)
<i>Lower security</i>	3
<i>Equal security</i>	1
<i>Higher security (including HMP return)</i>	0
Remain in active inpatient treatment	1
Outpatient remains living in community	1
Years since discharge from Brooklands Hospital (as of January 2022)	
<1	1
1	0
2	0
3	2
4	6
5	2
6	2
7	1
Reconvictions	0

Table 5 Profile of pre- and post-group measures

<i>Measure</i>	<i>Pre</i>		<i>Post</i>	
	M	SD	M	SD
<i>QACSO</i>				
Total	23.63	11.03	19.69	13.54
Rape	5.19	3.15	4.50	3.56
Voyeurism	3.38	1.75	3.25	2.44
Exhibitionism	2.56	1.46	2.88	2.33
Dating	2.56	2.39	1.75	1.61
Homosexuality	2.88	2.19	1.88	1.59
Children	3.13	2.39	1.75	2.05
Stalking	3.94	2.05	3.69	2.82
<i>ASK</i>				
Total	200.81	20.91	208.50	18.10
Body parts	38.06	1.95	39.06	1.39
Public	11.25	1.39	11.81	0.40
Puberty	9.56	2.00	9.56	1.82
Menstruation	6.50	3.18	7.75	2.27
Relationships	19.88	4.11	21.13	1.41
Protective	13.38	1.20	13.69	1.01
Sexuality	21.44	3.48	21.63	3.90
Safe Sex	2.81	1.56	3.31	1.40
Contraception	19.50	4.27	19.94	4.85
Pregnancy	6.75	1.24	6.56	1.26
Sexual health	7.50	3.52	7.44	2.31
STIs	8.06	3.51	9.50	2.53
Rights	10.75	1.88	11.56	0.96
Illegal behaviours	15	1.63	15.06	1.44
<i>MANSIE</i>				
LOC internal	22.69	4.91	23.25	5.22
LOC external	17.25	4.93	16.13	4.88

Discussion

Summary of findings

The current paper has sought to contribute to the evidence base of psychotherapeutic practice in the field of forensic ID, specifically by illustrating current practice within the Brooklands Secure Service in relation to sexual offence risk reduction intervention. In addition, this paper provides further information and transparency on the intervention approach taken to SOTP in inpatient services and positions this in a wider treatment pathway context. The results of the current evaluation provide mixed reading: Improvements in sexual knowledge, cognitive distortions and *locus* of control were observed; however, these were not statistically significant. Promisingly, there were no instances of recidivism up to 7 years after discharge.

The current evaluation raises some interesting considerations in regard to the existing literature. To an extent, the findings may lend support to the Counterfeit Deviance Hypothesis ([Hingsburger et al., 1991](#); [Griffiths et al., 2013](#)), which suggests that inappropriate sexual behaviour in some men with ID is precipitated by factors such as a lack of sexual knowledge, poor social and interpersonal skills, limited opportunities to form appropriate sexual relationships and sexual naivety, rather than sexual deviancy alone. The improvement in sexual knowledge and subsequent low recidivism rates after participation in the intervention may be understood in this context.

Of importance, 87.5% of the participants in the current BSOTP evaluation had previously completed the BTSP (which has been previously demonstrated to significantly increase social and interpersonal problem-solving and *locus* of control, [Hickman et al., 2017](#)), and a further 56.3% had completed the relationships intervention, which taken together may indicate the mechanisms through which these interventions have contributed to risk reduction.

Of note, there were no observed significant improvements in distorted sexual attitudes, which is inconsistent with previously reported studies. Reviews of the literature by [Marotta \(2017\)](#), [Cohen and Harvey \(2016\)](#) and [Jones and Chaplin \(2017\)](#) have demonstrated that changes in attitudes consistent with sexual offending is a key treatment target and empirically supported factor associated with sexual offending. Whilst these have not been significantly ameliorated through the current BSOTP, there has been no further offending at follow-up.

Further questions arise with regard to the active mechanism of recidivism prevention observed. It is noted that those leaving secure services are likely to be subject to on-going supervision orders, license or discharge conditions and high levels of supervision, support and monitoring. Similarly, this level of enforced compliance (via MHA Treatment Orders) may account for the low attrition rate in the current evaluation, which is reported higher in other programmes ([Murphy, 2010](#)) and other community-based interventions.

Limitations

There are a number of limitations to this study. Similar to many other published studies in this area, this evaluation reflects clinical practice in the context of the NHS, and a systematic research approach was not taken from the outset. A small sample size was available, which may impact the sensitivity of statistical analysis and generalisability; there is no control group, which is practically and ethically challenging in applied settings; offence types (such as contact, non-contact and offences against children/adults) have been treated together in the BSOTP, which may have confounding effects on data and treatment outcome; and one group participant, whilst required to attend treatment, was not an inpatient. Additionally, other specific variables linked to sexual offending were not historically measured, such as victim empathy or self-esteem.

A critical factor in understanding the impact of the BSOTP is that the treatment outcomes of this specific intervention are contaminated by service users' engagement in a wider treatment pathway. As stated, significant numbers of group members had completed prior social problem-solving and relationship intervention. These interventions will potentially have reduced and ameliorated risk, shifted distorted thinking styles and enhanced skills. This is by intention and, thus, by design reduces treatment pathway duration and provides a more holistic treatment approach. As an illustrative example, it may be hypothesised that QACSO results at pre-group assessment have already been ameliorated to a degree following up to two years of prior intervention targeting related factors. Similarly, LOC scores will have been improved during BTSP and, therefore, unlikely to significantly improve further during BSOTP. It is of note that QACSO pre-intervention and post-intervention mean total scores in the current evaluation, which focuses on convicted sexual offenders, are low relative to existing published reports ([Craig et al., 2012](#); [Murphy et al., 2010](#); [Heaton and Murphy, 2013](#); [Langdon and Talbot, 2006](#); [Murphy et al., 2007](#); [Rose et al., 2002](#); and [Rose et al., 2012](#)). Of course, there are multiple potential explanations for this including socially desirable responses, deceit, insight and sensitivity of the measure.

Finally, it is important to reflect on outcome assessment with individuals with ID, which can be confounded by multiple factors, for example, level of intellectual impairment, level of understanding, retention, acquiescence, suggestibility, response biases, the level of adaptation provided by different assessors, impression management, effort and motivation to list a few, all of which can impact the reliability and validity of the obtained scores and should be born in mind when considering the findings. Indeed, [Keeling et al. \(2007\)](#) have suggested that lower scores in post-treatment on the QACSO could reflect a suppression of cognitive distortions, an improved understanding of social desirability or deceit. It is important to use the measure alongside other variables associated with risk, as it may not reflect a true change in attitudes ([Lindsay et al., 2007](#)).

Clinical implications

How then can these findings be understood? Positively, there is no reported recidivism at follow-up, which indicates the treatment pathway, and/or BSOTP in combination with dedicated care packages after discharge can be an effective risk management approach. The next stage of development is to establish if it is possible to gain equivalent or improved outcomes with a reduced length of treatment programme. This is particularly relevant in the transforming care era of reducing duration of inpatient hospitalisation. Certainly, such approaches, with the use of active risk monitoring tools as described here, provide in-depth risk assessment and access to the internal world of participants, and this can contribute significantly to the risk management of these individuals when discharged to community settings. Supervision alone would not give this level of understanding to those responsible for monitoring and supervision and may outweigh argument for enhanced supervision rather than treatment. Clinically, the findings reported here provide further reflective focus on any required programme adaptations and a review of measurement and treatment targets.

Future steps

At present, the BSOTP remains an active intervention under continual review at Brooklands. Further evaluation will focus on the relationships programme, specifically seeking to identify the extent that this (and other programmes) may ameliorate cognitive distortions and reduce sexual offending risk. Additional current research is ongoing in regard to exploring qualitative understandings of the transition of offenders with ID back into the community.

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