



Journal of Intellectual Disabilities and Offending Behaviour

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Article information:

To cite this document:

Gareth Hickman, Su Thrift, Rani Dhaliwal, Chénelle Taylor, (2017) "Sixteen years of the Brooklands Thinking Skills Offender Programme", Journal of Intellectual Disabilities and Offending Behaviour, Vol. 8 Issue: 3, pp.132-143, <https://doi.org/10.1108/JIDOB-03-2017-0002>

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Sixteen years of the Brooklands Thinking Skills Offender Programme

Gareth Hickman, Su Thrift, Rani Dhaliwal and Chénelle Taylor

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Abstract

Purpose – The purpose of this paper is to report on the Brooklands Thinking Skills Offender Programme (BTSOP), a social problem-solving skills group programme developed and provided to people with intellectual disabilities (IDs) detained in conditions of medium and low security. The programme has been running and evolving since 2001 and has undergone consistent development over this time. Within the past five years, there have been significant developments of the Secure Service Treatment Pathway and the current paper describes the integration of the BTSOP within this new pathway model.

Design/methodology/approach – The programme was evaluated over five years using self-report psychometric measures related to treatment targets. Evaluation data in relation to attrition rates, discharges, transfers, treatment engagement and recidivism are also provided from a 16-year period. The updated treatment pathway and a description of the programme are provided.

Findings – Results showed statistically significant improvements in Rational Problem Solving, increased internal locus of control and decreased external locus of control. Reflection on the limitations and challenges to outcome assessment in this area is offered.

Originality/value – This paper builds on the existing evidence base of interventions focused on developing social problem-solving skills in offenders and presents evidence of the effectiveness of such programmes with offenders with IDs.

Keywords CBT, Intervention, Offenders, Intellectual disabilities, Group programme, Social and interpersonal problem solving

Paper type Research paper

Introduction

Maladaptive or faulty thinking patterns and cognitive deficits have been demonstrably linked to recidivism in offenders (Dodge and Frame, 1982; Zamble and Porporino, 1988; Porporino and Fabiano, 2000; Friendship *et al.*, 2003). In mainstream adult offenders, a number of programmes have been developed to help improve cognitive skills and decrease re-offending rates. The two accredited cognitive skills programmes most widely delivered in prisons are Reasoning and Rehabilitation (R&R; Ross *et al.*, 1988) and Enhanced Thinking Skills (ETS; Clark, 2000). Both programmes use cognitive-behavioural modification techniques to replace well-established, maladaptive patterns of thinking with cognitive skills that promote appropriate reactions and pro-social behaviour by teaching offenders to “stop and think” before acting.

Goodman *et al.* (2011) suggest that mainstream offending behaviour programmes, such as the ETS programme, could be a useful treatment for offenders with intellectual disabilities (IDs). However, such programmes are often inaccessible to offenders with an ID due to programme complexity, with high literacy and comprehension demands being made of participants (Davies *et al.*, 2004; Loucks, 2007). As such, a review of the literature reveals only a small number of cognitive skills programmes being delivered for patients detained under the Mental Health Act (1983, 2007) in medium- or high-security conditions. These include delivery of R&R, R&R2MHP and ETS in secure inpatient settings with mentally disordered

Received 14 March 2017
Revised 3 August 2017
Accepted 4 August 2017

The authors would like to acknowledge the contribution of the Programme Development Unit and Offender Group Treatment Team staff, in particular the contributions of Andrew Hordell and Claire Carberry, who have been integral to the development and facilitation of the BTSOP.

offenders (MDOs), which have been found to be effective in improving thinking styles and social problem-solving skills (see Donnelly and Scott, 1999; Tapp *et al.*, 2009; Cullen *et al.*, 2012; Yip *et al.*, 2013; Ashford *et al.*, 2008).

The efficacy of cognitive skills programmes for offenders with ID is less well established, however. Within the literature, there are few published studies that have evaluated the effectiveness of cognitive skills programmes with ID offenders. Waugh *et al.* (2014) conducted a pilot study of R&R2MHP to ascertain whether it is feasible to deliver the programme to inpatient MDOs with ID through assessing programme completion. A total of 25 male inpatients from two medium secure hospitals received the group intervention and 23 (92 per cent) of the patients completed the programme, suggesting that the programme is potentially feasible for use with ID offenders. The research offers preliminary findings of the appropriateness of this intervention for offenders with ID. However, a limitation of this study is that it focussed primarily on assessing programme completion, and no outcomes were reported on the effectiveness of the programme and how patients benefited from it.

A further study was conducted by Kelly (2014), who evaluated the development of a thinking skills programme for adults with ID at risk of offending. The programme is based on the Good Thinking! course (Goodman *et al.*, 2011), which targets socio-cognitive deficits. The study was conducted over a three-year period with 20 service users from inpatient and community settings. Self-report measures and feedback from participants were used to evaluate the programme. The results of the study demonstrate significant improvement in general empathy and perspective taking. However, no improvement was found in relation to impulsivity and locus of control.

Lindsay *et al.* (2011) conducted a pilot evaluation of the Social Problem-Solving and Offence-Related Thinking Programme, which is based on established theoretical principles for use with offenders with ID. Ten male participants attended the programme and one self-report measure was used to evaluate their progress. The study's findings showed that participants became less both impulsive and more positive in their style and orientation towards social problem solving.

As mentioned, Goodman *et al.* (2011) developed the Good Thinking! course for people with ID in a community setting. Insufficient data were produced to enable a formal evaluation of the programme. Therefore, the course was subjected to local evaluations (see Nathwani, 2003; Benians, 2006 and cited in Goodman *et al.*, 2011). These consisted of small participant samples ($n=4$ and 6, respectively) who provided semi-structured feedback documenting perceived treatment gains.

Taylor *et al.* (2008) assert that while the evidence base is small, it does suggest that the majority of people with mild ID have the ability to engage in and benefit from cognitive-behavioural interventions. None of the above-mentioned studies utilised a qualitative approach to explore participants' lived experience of the cognitive skills programmes; however, related research has been published from Brooklands Secure Services, such as Rose *et al.* (2016) which focuses on ID offender' experiences of participating in Fire-Setting treatment programmes, and more recently Dhaliwal (2017) which focuses specifically on ID offenders' lived experience of a cognitive skills programme.

Given the limited literature in this area, the current paper seeks to contribute to the evidence base and increase the transparency of offender interventions in this field by outlining some current practices at Brooklands Secure Services and offering evaluation of the effectiveness of the Brooklands Thinking Skills Offender Programme (BTSOP). The Secure Service at Brooklands consists of Medium and Low Secure facilities over four wards (57 beds; 42 male and 15 female) for adults with ID.

The BTSOP is a cognitive-behavioural group programme that has been developed for male patients 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 relationships group (see Murphy, 2014), Sex Offender and Fire-Setter Programmes and individual psychological therapy.

The present psychological treatment pathway, which was redesigned in 2011, at Brooklands can be seen in Figure 1. The BTSOP is therefore frequently the first episode of therapeutic intervention that the men detained at Brooklands engage in.

This paper provides an overview of the development and key aspects of this programme, including an adapted “diary tool” used to communicate CBT principles. The paper seeks to establish the effectiveness of this programme and provides outcome evaluation.

Method

Between January 2012 and January 2017, the BTSOP sessions were delivered weekly. Sessions lasted four hours with 15-minute breaks hourly and a one-hour mid-point interval, the duration of the programme was 10-12 months. The structure of sessions took a predominantly CBT format, involving the following elements: ice-breaker, update from the week, review of external practice, main content and setting further practice. The first two hours of the session also include active problem solving and reflecting on completed diaries discussed between the group members. The key methods of the programme are outlined below.

Participants

Since the introduction of the updated treatment pathway at Brooklands, the BTSOP has been delivered five times between 2012 and 2017. The 28 service users who have attended the group were all male inpatients in Medium and Low Secure Services, detained under Section of the Mental Health Act (1983, 2007). Participants were all adult service users assessed as meeting service criteria for ID. All were assessed as having social and interpersonal problem-solving deficits considered to have been contributory factors to their offending (Table I).

The BTSOP

Main aims. The BTSOP has one primary aim and multiple subsidiary aims, which relate to the specific needs of each individual group member and the composition of each group.

The primary aim is for group members to internalise effective, non-offending means to resolve interpersonal problems and to be able to implement these independently. The additional aims both enhance the social problem-solving skills of group members and are expected to reduce

Figure 1 Treatment pathway

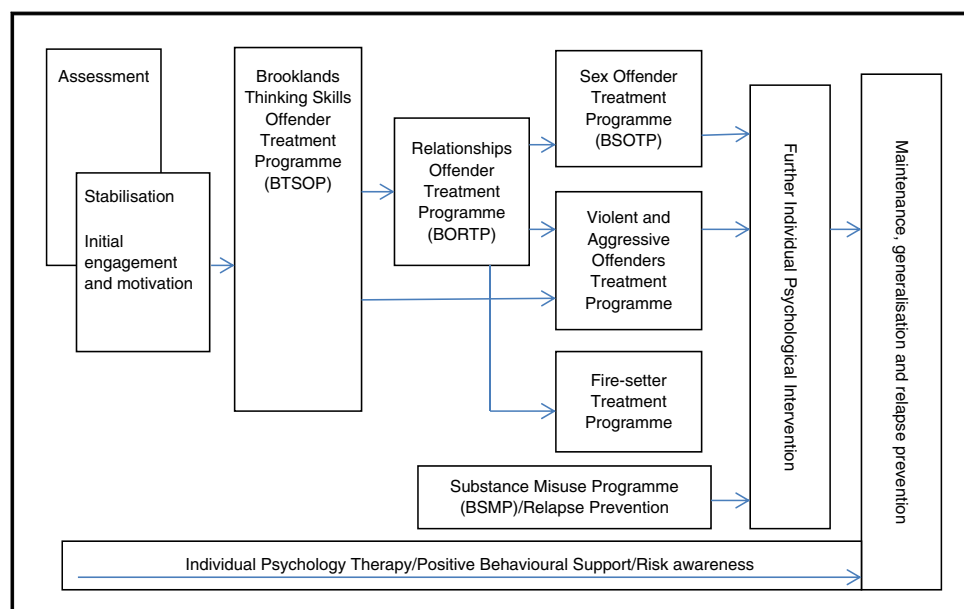


Table I Demographic information

	2001-2017	2012-2017
Total number of groups	10	5
Total <i>n</i>	50	28
Mean group <i>n</i>	5	5.6
Mean age	–	31.7 (range 19-57)
Mean IQ	–	61 (range 53-69)
<i>MHA Section</i>	–	
47/49		4
37		11
37/41		9
Notional 37		1
3		3
<i>Index offence type</i>	–	
Fire setting		1
Sexual offence		16
Violence and aggression		11
Mean number of prior offences	–	6.7 (range 0-39)
<i>Comorbid presentation</i>	–	
Autism spectrum disorder		4
Personality disorder		1
Psychotic illness (inc. Schizoaffective disorder)		2
Cannabis dependency syndrome		1
Conduct disorder		1
ADHD		1
XXX syndrome		1
Bipolar disorder		1
Note: –, Indicates full data unavailable		

their risk of re-offending. These include emotional recognition and management components, understanding and developing relationship skills, addressing attitudes and general cognitive styles linked to offending, lifestyle components (such as associations, peer pressure and substance misuse), increasing cognitive flexibility and motivation enhancement.

Programme structure. The programme follows D'Zurilla *et al.*'s (1999) seven-stage model of Social Problem Solving. However, existing literature (Goodman *et al.*, 2011; Davies *et al.*, 2004; McMurren and McGuire, 2005) and clinical experience indicated that a five-stage model is more appropriate for offenders with ID and the BTSOP was developed to reflect this in the manner as shown in Table II.

Table II Comparison of seven- and five-stage models

<i>D'Zurilla et al.'s (1999) seven-stage model</i>	<i>Adapted five-stage model</i>
1. Problem orientation: "I've got a problem"	1. What's going on? This includes problem orientation, definition and goal setting
2. Problem definition: "What's my problem?"	
3. Goal setting: "What do I want?"	2. STOP: impulse control. This element is not included in D'Zurilla's model but is considered necessary for this population in order for the rest of the sequence to proceed successfully. Goal setting is emphasised throughout the process
4. Generation of alternatives: "What are my options?"	3. THINK: generation of alternatives, consideration of the benefits and costs, decision making
5. Decision making: "What's the plan?"	
6. Action: trying it out	4. GO: action
7. Evaluation: "Did it work?"	5. Did it work? Evaluation and reflection

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.

Block approach. All offender group treatment programmes at Brooklands utilise 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. This maintains motivation and ensures shared expectations. The BTSOP consists of ten modular sections (“blocks”) which link together and build upon the preceding concept (Table III).

Individual sessions. The BTSOP 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 problems and critically the link to their offending behaviour, including past, present and potential future risk.

Diary tool. The diary tool is central to the programme and is introduced in stages as each new concept is presented in the group. In its entirety, it has the primary five components outlined in Table II. In keeping with most cognitive-behavioural diaries, it is a tool that enables practice in the group and for homework. It also allows the group facilitators to work with the men to identify their specific areas of need and ongoing difficulties. This diary has been developed for use with an intellectually disabled population, many of whom have significant literary deficits. Therefore, it contains symbolised components and allows for it to be completed in pictures rather than words if preferred.

This novel tool presents some concepts differently to the traditional cognitive-behavioural diary to enhance understanding and improve implementation of what has been learnt. For example, instead of there being individual boxes in which the situation, thoughts, feelings and actions are described, these are combined together in the first section of the diary “What’s going on?” This section captures all four components in one diagram. Contrary to some traditional CBT approaches which suggest that aspects of a person’s experience occur or be perceived in a linear order, clinical experience suggests that group participants often cue into different aspects of salience at different times. Table IV identifies the constituent elements of the diary (refer to Figure 2).

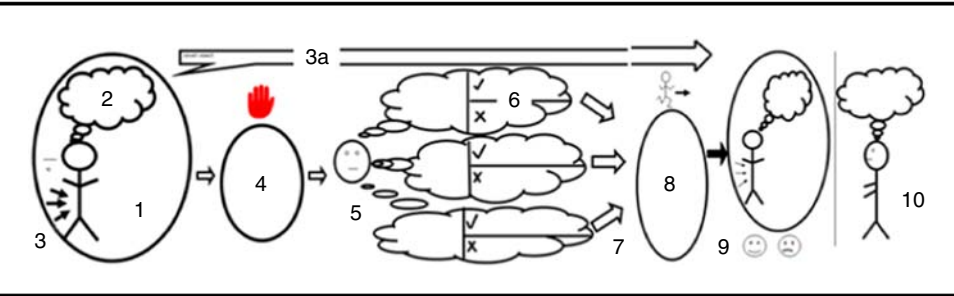
Table III Block outlines

<i>Block</i>	<i>Example conceptual ideas</i>
1 Introduction	General introduction to the programme, risk and group formation
2 What are problems?	Introduce the concept of problems and problem solving, introduce CBT concepts
3 Learning about your feelings and thoughts	Understanding emotional experiences and the link between thoughts and feelings
4 Dealing with your feelings and thoughts	Understanding of emotional arousal and regulation
5 Stop	Recognising why, when and how to stop and reducing impulsivity. Includes goal setting
6 Think	Understanding that there is a range of options for how to respond to problems; learning to evaluate options and to seek to select appropriate pro-social options
7 Go	Understanding the link between “stop-think-go”; maximising the success of the chosen problem solution
8 Did it work	Evaluation and reflection
9 Practicing	Independent problem solving; internalising the model; obstacles; and lapses
10 End of group, what next?	Understanding that this is a lifelong process; group dissolution; ongoing support

Table IV Constituent elements of the diary tool

Block	Example conceptual ideas
1 What's going on?	Identify problem situation
2 Thoughts	Identify thoughts regarding the ongoing situation or problem
3 Feelings	Identify emotional experience related to problem situation and thoughts
3a Goal setting	States "What do I want" and permits consideration of desired outcome i.e. goal
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 a number of potential options and problem-solving strategies
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
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

Figure 2 Diary tool



Link to wider treatment pathway. As highlighted above, the BTSOP frequently represents the first episode of therapeutic intervention experienced by service users with the psychological treatment pathway at Brooklands. The subsequent intervention programmes that follow seek to build upon the foundations and concepts of the BTSOP in order to reduce offending risk and minimise duration of hospitalisation. To this end, a number of core components are carried through into further group treatments, such as the emotional literacy (particularly the thought-feeling-action sequences and the emotional awareness, recognition and regulation components), managing impulsivity, evaluating decisions, implementing actions and evaluation and reflection. To this end, the BTSOP diary outlined above is a central intervention strategy that is retained and utilised in subsequent group programmes. By preventing repetition and implementing incremental learning the ultimate length of subsequent groups, particularly the BSOTP, BFSTP and BVOTP, interventions can be reduced as new diary tools do not need to be introduced.

Procedure

The programme. The BTSOP 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-BTSOP group intervention.

Measures

Locus of control Modified Adapted Locus of Control-Internal External (M-ANSIE) Nowicki (1976), Goodman et al. (2007). The M-ANSIE 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 $r = 0.66$.

Social Problem-Solving Inventory-Revised (SPSI-R) D’Zurilla et al. (1999). The SPSI-R consists of 52 items linked to the five-dimensional model of social problem solving (Maydeu-Olivares and D’Zurilla, 1996). It is constructed of five subscales: Positive Problem Orientation; Negative Problem Orientation; Rational Problem Solving (RPS), including Problem Definition and Formulation, Generation of Alternative Solutions, Decision Making, and Solution Implementation and Verification; Impulsivity/Carelessness Style; and Avoidance Style. Whilst this has not been normed on an ID population, it has been found to have the following internal consistency coefficients: PPO = 0.80, NPO = 0.92, RPS = 0.95, ICS = 0.89, AS = 0.89. The following test-retest reliability coefficients are reported: PPO = 0.68, NPO = 0.91, RPS = 0.85, ICS = 0.79, AS = 0.85.

Novaco Anger Scale (NAS) (Novaco, 2003)

In seeking to enhance social problem solving, the BTSOP also aims to develop emotional recognition and management skills, including the management of anger. The NAS was therefore used to assess a number of facets of anger: anger engendering cognitions, anger arousal and behavioural anger. In addition, it provides a measure of the individual’s ability to regulate their anger. Whilst this has not been normed on an ID population, it has been found to have the following internal consistency coefficients: cognitive anger = 0.82; anger arousal = 0.84; behavioural anger = 0.89; anger regulation = 0.76, NAS total = 0.94. The following test-retest reliability coefficients are reported: COG = 0.47, ARO = 0.78, BEH = 0.81, REG = 0.72, NAS total = 0.76.

Results

BTSOP outcome evaluation

Data are offered from 2001 to 2017 inclusive and from 2012 to 2017 following the introduction of the new treatment pathway. The data presented in Table V highlight low attrition rates with a high level of group completion. Since the introduction of the new pathway model, 93 per cent of service users who access BTSOP go on to participate in further intervention on the pathway. A total of 46 per cent of service users who have completed BTSOP have gone on to be discharged from section with a sizeable number anticipated to be discharged imminently.

Table V	Outcome analysis	
	2001-2017	2012-2017
Total <i>n</i>	50	28
Completers	43 (86%)	23 (82%)
Attrition rates (non-completers)	7 (14%)	5 (18%)
No. successfully continued on (OGTT) treatment pathway	–	26 (93%)
Discharged from Section	23 (46%)	7 (25%)
<i>Transferred under Section</i>		
External lower security	2 (4%)	1 (4%)
External equal security	8 (16%)	3 (11%)
Higher security (inc. HMP return)	0	0
Remain in active treatment	11 (22%)	11 (39%)
Completed treatment awaiting discharge	6 (12%)	6 (21%)
Reconvictions	In collation	0

Of note, no service users who have accessed the BTSOP have been escalated to higher levels of security, with a number of service users stepping down to lower levels of security. A small number of service users have moved to equal levels of security when risk has remained static. A proportion currently remains in active treatment. Limited data are available for reconviction rates overall; however, for the 2012-2017 group, there are no recorded reconvictions. Available clinical information indicates that non-completion in the 2012-2017 groups can be attributed to four participants' mental health deteriorating and one participant withdrawing through lack of motivation.

Given the nature and requirements of detention under Section of the Mental Health Act and the requirements to provide treatment, adequate control data and randomisation are evidently difficult to provide. Table VI however displays data from all service users who were admitted to Brooklands Secure Service since 2012 and declined or were unable to access the BTSOP. Of those who did not engage, 40 per cent have returned to prison. Two service users were unsuitable for the BTSOP due to mental ill health; however, following receipt of treatment addressing this, both were successfully discharged. A small number remain at Brooklands and are currently in a stabilisation/engagement phase and one individual was transferred to conditions of equal security. There are no recorded reconvictions for those discharged.

Psychometric evaluation

Whilst a range of outcome measures is administered to evaluate treatment progress in the BTSOP, specific data are offered here from the validated psychometric self-report measures.

Table VII shows that there was improvement in both locus of control and some elements of Social Problem Skills. There were no specific effects in regard to anger. A statistically significant increase in internalised locus of control was observed ($t = -0.217$, $df = 21$, $p < 0.05$). Effect sizes were calculated using the formula recommended by Cohen (1992) and were found to be $r = 0.21$.

Table VI Control data from 2012 to 2016

No. admitted not attended BTSOP (2012-2017)	10
No. successfully continued on treatment pathway	2 (20%) received individual work
Discharged from Section	2 (20%)
<i>Transferred under Section</i>	5 (50%)
Lower security	0 (0%)
Equal security	1 (10%)
Higher security (inc. HMP return)	4 (40%)
Remain on Section at Brooklands	3 (30%)
Completed treatment awaiting discharge	0 (0%)

Table VII Profile of pre- and post-group measures

Scale	Pre mean	Post mean	n	t	df	Sig (two-tailed)
<i>Locus of control</i>						
Internal	10.59 (SD 2.677)	12.09 (SD 2.827)	22	-0.217	21	0.038*
External	9.36 (SD 2.888)	7.91 (SD 2.827)	22	2.192	21	0.040*
<i>SPSI</i>						
PPO	15.53 (SD 3.642)	17.18 (SD 3.746)	17	-1.807	16	0.090
RPS	46.13 (SD 17.305)	62.19 (SD 18.476)	16	-3.154	15	0.007*
NPO	21.53 (SD 9.913)	20.82 (SD 10.026)	17	0.376	16	0.712
ICS	21.65 (SD 6.451)	23.18 (SD 7.716)	17	-0.889	16	0.387
AS	12.71 (SD 7.481)	11.59 (SD 8.360)	17	0.508	16	0.618

Notes: PPO, Positive Problem Orientation; RPS, Rational Problem Solving; Implementation and Verification; NPO, Negative Problem Orientation; ICS, Impulsivity/Carelessness Style; AS, Avoidance Style; *Indicates statistically significant values

A statistically significant decrease in externalised locus of control ($t = 2.192$, $df = 21$, $p < 0.05$), effect size $r = 0.20$.

t-Tests using Bonferroni corrections were conducted. In regard to Social Problem Solving, the RPS Skills domain – which is comprised of Problem Definition and Formulation, Generation of Alternative Solutions, Decision Making and Solution Implementation and Verification domains – saw a statistically significant improvement, effect size $r = 0.41$. The remaining assessed domains (PPO, NPO, ICS, AS) were not statistically significant. No significant changes were observed in relation to assessed anger domains on the NAS.

Discussion

The current paper has sought to contribute to the evidence base of psychotherapeutic practice in the field of forensic IDs; however, it has also purposefully sought to increase the transparency of offender interventions in this field by outlining current practices. From the evaluation data of this programme, it is concluded that the BTSOP appears effective at improving RPS and also increasing internal locus of control and reducing external locus of control. Given the evidence indicating that these constructs are considered important in offending risk, it appears that this programme may therefore be effective at contributing to reducing risk of recidivism in ID offender populations. Whilst no significant changes were observed in relation to anger, it is noted that the BTSOP is not specifically an anger management intervention; therefore, a number of participants are referred into the programme who do not have assessed anger problems. Preliminary analyses of data from only participants with assessed above average anger have demonstrated improvements in all anger domains; however, this requires further exploration with more participants.

The current evaluation supports evidence provided by Waugh *et al.* (2014) that these programmes are accessible for offenders with ID and extends this somewhat with the inclusion of a small number of participants completing the BTSOP with diagnosed ASD and personality disorder. These findings are also consistent with Lindsay *et al.* (2011) in regard to treatment gains in relation to social and interpersonal problem-solving skills and locus of control (Kelly, 2014). All of which would lend further support to the increasingly comprehensive evidence base that the majority of people with mild ID have the ability to engage in and benefit from cognitive-behavioural interventions (see Taylor *et al.*, 2008).

Certainly, the evidence presented here indicates that the BTSOP is effective at engaging people as a first step in their treatment pathway and that this supports later engagement in subsequent intervention. There appears to be a better opportunity for discharge or transfer to Lower Security if service users engage in the BTSOP and the wider treatment pathway than if they do not; indeed the evidence indicates those who do not engage are highly likely to escalate in regard to level of security. Additionally, a noteworthy evaluative outcome is that there are no known reconvictions for those who have completed the BTSOP in the previous five years.

Clinical application

Clinically, the BTSOP appears to be an effective intervention at contributing to reducing risk of recidivism in ID offender populations. Whilst this programme is designed for use with inpatient populations it could feasibly be adapted to community samples and even specifically targeted for individuals deemed “at risk” of offending. Indeed, work is currently in progress exploring this at Brooklands Secure Service. It is noted that the programme may be considered resource intensive, although within inpatient services, this resource can be accommodated. Community adaptations would seek to review this. The current paper also presents novel concepts such as the diary which can be used in multiple interventions and has been deemed effective in communicating cognitive-behavioural concepts to individuals with IDs.

Limitations

There are a number of limitations that require addressing. First, outcome assessment with individuals with IDs 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. In regard to reliably establishing the effectiveness of interventions in this area, these factors have historically proved challenging and the existing literature reflects this (see Kells, 2011; Dagnan *et al.*, 2007; Stenfort Kroese *et al.*, 1997).

The current findings report high completion rates indicating accessibility of programmes; however, attention should be paid to the nature of detention under Criminal Sections of the Mental Health Act and the implicit and explicit level of coercion this applies to service users. Indeed, treatment completion is a virtual prerequisite in order to attain discharge. It is also important to highlight that outcome evaluation in Secure Inpatient Services contains the inherent difficulties of separating the effects of subsequent treatments and the wider therapeutic effects of a multi-disciplinary approach involving medical, nursing and health care, speech and language, and occupational therapy, which is offered as part of an inpatient treatment approach, as well as resettlement under supported, often supervised conditions. However, the current data demonstrate clearly that the BTSOP contributes to successful risk reduction.

Additionally, it is noteworthy that missing and incomplete data sets reduced the N size in the analysis. This can be attributed partly to the historical use of adapted, non-standardised formats of assessments, unavailable archived data and participant refusal to complete measures, which is likely to reflect the nature of repetitive outcome measure completion requests with forensic patients. The power of the analyses is likely to have been impacted by the small sample size; however, the current results are encouraging and further analyses with additional data sets may be worthwhile in future.

Finally, as highlighted, there are obvious challenges to providing control data, which the current paper has sought to address. There are also limited data available on those who did drop out and what the critical factors were in this, which would warrant further exploration.

Future steps

At present, the BTSOP remains an active intervention at Brooklands, with ongoing research exploring qualitative understandings of the programme to add to its evaluation. In addition, it is anticipated that further outcome data from the past 16 years will be generated. Further analysis, currently in preparation, is focusing on producing outcome data for the related Brooklands Offender Programmes and analysis of the full treatment pathway.

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