Piloting an Evidence-Based Group Treatment Programme for High Risk Sex Offenders with Intellectual Disability in the New Zealand Setting

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Background

There is a paucity of research on the effectiveness of sex offender treatment programmes particularly with sex offenders with intellectual disability (ID). There is a lack of concerted effort to develop evidenced-based sex offender treatment programmes for individuals with ID in New Zealand (NZ). This study aimed to run a pilot study on the use of an adapted sex offender treatment programme for individuals with ID in NZ who have been found to be at high risk of sexual recidivism and are placed in secure settings.

Method

A multiple case study design was used to assess the viability of an adapted sex offender treatment programme which was developed for forensic clients with intellectual disability who were placed in a secure facility and were assessed to be at high risk of sexual recidivism. This adapted programme was based on a community-based ID sex offender treatment programme developed in the UK. The three participants considered in this study were assessed for risk of sexual recidivism, sexual knowledge, victim empathy and cognitive distortions and attitudes to condone and/or support sex offences prior to attending the programme, upon completion and at one-year follow up. The SAFE-ID was a seven-month pilot programme which was largely guided by the SOTSEC-ID treatment manual. In addition, it incorporated an adapted dialectic behaviour therapy (DBT) coping skills training developed by the authors to teach the participants behavioural coping skills to deal with emotional dysregulation, poor frustration tolerance and poor social skills.

Results

The study result showed that the three participants demonstrated a marked improvement in sexual knowledge and victim empathy as well as a marked reduction in cognitive distortions and attitudes that condone and/or support sex offences after completing the programme. Furthermore, there was a noted decrease in the dynamic risk factors after completion of the programme and at one-year follow up. Two of the participants who were residing in a secure facility were reported by staff to show a marked reduction in inappropriate and/or sexually abusive behaviours and other problematic behaviours. The participant, who was under a community secure order, came off his order a year after completing the programme.

Conclusions

This pilot study indicated that the SAFE-ID programme showed promise as a potentially viable treatment programme for ID sex offenders who carry a high risk of sexual offending within a secure setting. However, caution should be taken as only three case studies were involved. There is a need to validate the effectiveness of this programme with larger sample size, longer follow-up period and a randomised controlled trial. Further research on the use of DBT in the treatment of sex offenders with ID is recommended.

A plethora of methodological difficulties has made it problematic to determine the true prevalence of sex offenders with an intellectual disability (ID) in most developed countries (Lindsay, 2002). A wide range of methodological problems have been identified including inappropriate samples, variable inclusion criteria and determination of ID, and diversions provided by the court to this group for their "challenging behaviours" (e.g., Lindsay, 2002; New South Wales Law Reform Commission, 1996, etc.). Several researchers have argued that there is a high prevalence with estimates of up to 21% to 50% of offenders with ID who have committed sexual offences (Gross, 1985; Walker & McCabe, 1973). On the other hand, more conservative studies have estimated that around 3% to

4% (Hayes, 1991; Swanson & Garwick, 1990). Notwithstanding, it is difficult to rely on these estimates because of the severe limitations of current research. In New Zealand (NZ), research on the incidence and prevalence of sex offenders with ID in NZ is virtually non-existent.

There is paucity of research on evidenced-based sex offender treatment programmes for individuals with ID. Most of the existing programmes in developed countries (e.g. US, UK, Australia and NZ) are largely adapted versions of mainstream sex offender treatment programmes (SOTP) (Marshall et al., 1991). These programmes are mostly cognitive-behaviourally based which generally involves addressing issues around cognitive distortions that support or condone sex offences. These ID-specific sex offender treatment programmes involved the use of simplified concepts, visual imagery, frequent repetition and rehearsal, and assistance with generalisation of skills across different settings (Lambrick & Glaser, 2004). Research literature on the effectiveness of these programmes have been intermittent and majority of them had small sample designs (e.g., Garrett, 2006; Craig et al., 2006, Lindsay & Smith, 1998, etc.). Lindsay and his colleagues (2006) employed a community cognitive behaviour therapy (CBT)-based sex offender treatment programme which recruited 29 sex offenders with ID with a history of sexual recidivism. The study showed a significant harm reduction of 70% after these participants completed the group. Murphy and colleagues (SOTSEC-ID, 2010) carried out a study on the effectiveness of the Sex Offender Treatment Services Collaborative – Intellectual Disabilities (SOTSEC-ID) programme in the UK which recruited 46 men with ID who had sexually abusive behaviours. The programme consisted of different modules that include (1) human relations and sexual education; (2) cognitive model; (3) sex offending model; (4) victim empathy; and (5) relapse prevention. The study findings showed a significant increase in sexual knowledge and victim empathy as well as reduction in cognitive distortions and attitudes that condone or support sex offences. Treatment gains were maintained on six-month follow up and only four men (9%) engaged in further sexually abusive behaviours.

In NZ, there has not been any concerted effort to evaluate the effectiveness of evidence-based sex offender treatment programmes for individuals with ID. Existing programmes include the Adapted Te Piriti Sex Offender Treatment Programme, which is a CBT-based programme developed by the Department of Corrections specifically for child sex offenders who are currently service their prison sentence and were diagnosed with ID. On the other hand, WellStop Inc., which is a non-governmental organisation (NGO) which provides community-based sex offender treatment programmes, offers a specialist programme for youth and adults with intellectual disabilities. WellStop Inc. employs the Good Way model which is a strength-based programme that makes use of a more narrative approach and which also incorporates relapse prevention (Ayland & West, 2007). Ayland and West (2006) reported that their programme has been relatively successful; however, recidivism rates have not been formally evaluated.

The authors have not encountered any systematic published studies on the effectiveness of these adapted programmes targeting ID sex offenders to date. Furthermore, the authors recognise the difficulties of carrying out studies with sample sizes sufficient for the application of inferential statistics, due to limited numbers of potential participants in clinical and custodial settings in NZ.

The enactment of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act 2003) in NZ in October 2004 highlighted the need to provide rehabilitation to individuals with ID who come into contact with the criminal justice system (Ministry of Health, 2004). Therefore, there is a pressing need to develop an evidence-based sex offender treatment programme for individuals with ID who have been charged with a sexual offence and are under a legal order.

The aim of this pilot study is to assess the viability of an adapted SOTSEC-ID programme with sex offenders with ID who pose high risk of sexual recidivism and are placed in a secure setting in Auckland, NZ. The authors consider this study as an initial attempt to modify the SOTSEC-ID programme for its use in a forensic ID inpatient setting.

Method

Design

The authors employed a multiple case study design to assess the effectiveness of the adapted SOTSEC-ID programme with a group of high-risk sex offenders with ID admitted in secure settings. A multiple case study design was deemed appropriate in this case given that there are very few numbers of high-risk offenders with intellectual disability placed at secure ID facilities across NZ particularly in the Auckland and Northland regions. A case study design can be considered one of the most flexible research designs because it allows the researcher to retain the holistic characteristics of real-life events while investigating empirical events (Yin, 1984). In this study, a multiple case study design provided the researchers with the opportunity to examine individual cases and discuss in the detail the participant's journey and experience going through the programme and their individual progress and learnings.

The participants in this study were recruited from the group of participants who attended a pilot programme. Of the five participants who attended the group, two participants were recruited from a hospital secure ID facility and one participant was recruited from a community secure residential ID facility. The participants were recruited for this study as they were assessed to be at high risk of sexual recidivism.

Description of the Programme

The SAFE-ID programme was largely based on the SOTSEC-ID (2010), which is a community based ID sex offender treatment programme developed in the UK. The SAFE-ID programme was developed by the ID Offender Liaison Service (IDOLS) team, which is a specialist team within the Regional Forensic Psychiatry Service, Auckland, New Zealand, that attends to forensic clients with intellectual disability within the Auckland and Northland Regions. The programme

was developed in collaboration with SAFE, which is an NGO that provides community-based sex offender treatment programmes in the Auckland region. This programme maintained some fidelity to the SOTSEC-ID by running the same set of modules and using their core assessment measures. The modules included: (1) Human Relations and Sex Education; (2) the Cognitive Model; (3) Sexual offending model based on the Finkelhor model (Finkelhor, 1984); (4) General Empathy and Victim Empathy; and (5) Relapse Prevention. In addition, it incorporated an adapted Dialectical Behavior Therapy (DBT) groups coping skills programme developed by the authors (Sakdalan et al., 2010). The adapted DBT group coping skills training programme was incorporated to provide the participants with behavioural coping skills to effectively manage emotional dysregulation, poor frustration tolerance and poor interpersonal effectiveness skills. These coping skills are particularly useful in helping these participants deal with negative emotion that may arise when they discuss their sex offending and their personal histories. In addition, the therapists used the concept of 'Wise Mind-Risky Mind'. The Wise Mind-Risky Mind dialectical construct was used to assist the participants and the therapists use a common language, which could capture and validate their experiential difficulties of having risky thoughts, feelings and behaviours as well as their abilities to effectively manage their risk of sexual re-offending (Sakdalan & Gupta, 2012).

The SAFE-ID was a seven-month programme that consisted of two-hour weekly sessions. In addition, each participant received one-hour weekly individual psychotherapy that was mainly geared to reinforce learning from the group and process issues that were inappropriate to address in the group. Arrangement was made such that there was at least one male and one female therapist in the session as per SOTSEC-ID protocol. There were five therapists involved in the programme. The therapists were registered clinical psychologists, two nurses and an occupational therapist. The clinical psychologists in the team have extensive clinical experience in the assessment and treatment of sex offenders while the other therapists have experience running skills-based group programmes. Some caregivers were required to be present in all the sessions due to the participants' need for high levels of supervision. Two of the participants required 1:1 close supervision due to their levels of risk.

Participants

Three participants considered in this study were under a secure order (two under hospital secure and one under community secure) under the IDCCR Act 2003. The authors consulted the Knowledge Centre, Waitemata District Health Board Research Committee, Auckland, New Zealand, and were informed it was sufficient for the researchers to obtain consent from the participants and that approval from an ethics committee was not required. Notwithstanding, consent was obtained from the participants and/or their welfare guardians to participate in the study. The participants and welfare guardians (where applicable) were provided with information about the study which included measures to protect confidentiality, duty of care, and an agreement that the participants would not be identified in any published research. The researchers explained these issues to the participants and/or welfare guardian. The participants and/or welfare guardian were encouraged to ask any questions or clarify any issues before they signed the consent form.

Measures

The participants were assessed using a standard set of outcome measures at the start of the group to provide baseline then were re-assessed after they had completed the programme. In addition, they were re-assessed on one-year follow up. The outcome measures used in this study were based on the measures recommended by the SOTSEC-ID group except for the Assessment of Sexual Knowledge (ASK) and the Sexual Violence Risk – 20 (SVR-20). The outcome measures were used to assess participant's progress within each module (e.g. Assessment of Sexual Knowledge used to assess learning in the Sex Education Module). These included:

1. Sexual Violence Risk – 20 (SVR-20) - The SVR-20 is a 20-item checklist that was developed to improve the accuracy of assessments for the risk of future sexual violence. The authors used the adapted SVR-20 version developed by Boer (2010) and his colleagues specifically for assessing risk of sexual recidivism with sex offenders with ID. The Psychopathy item was not scored. Higher scores indicate higher level of risk; however, clinical judgement is required to arrive at a final decision.

2. Assessment of Sexual Knowledge (ASK) (Butler, Leighton, & Galea, 2003). - The Assessment of Sexual Knowledge (ASK) is a new test that aims to provide workers within disability services and other health professionals with a tool to assess the sexual knowledge and attitudes of people with an ID. Scores range from 0 to 248. High scores indicate higher levels of sexual knowledge.

3. Adapted Sex Offender Self-Appraisal Scale (SOTSEC-ID, 2010) - The SOSAS was adapted from the Sex Offence Attitude Scale and has been used in the SOTSEC-ID group to assess cognitive distortions related to sex offending. Scores range from 19 to 95. High scores indicate higher levels of cognitive distortions that condone sex offending.

4. Questionnaire attitudes Consistent with Sex Offending (QACSO) (Lindsay et al., 2000) - The QACSO has been used to assess the participants' attitudes that condone sex offences. Scores range from 0 to 174. A high QACSO score suggests greater cognitive distortions/attitudes towards sex offending.

5. Victim Empathy Scale (VES) (Beckett et al., 1994) - The VES consists of 30 questions and statements rated on a four-point Likert Scale. The modified version used for people with ID was used. Scores range from 0 to 84. High scores reflect low victim empathy.

Results

The unit psychologist who was not a therapist in the group was in charge of assessing the participants' level of risk. The SVR-20 was administered pre, post and at one-year follow-up to assess risk of sexual recidivism (see Table 1). These participants carried dynamic risk factors

Table 1. SVR-20 Scores pre-, during and one- year follow up

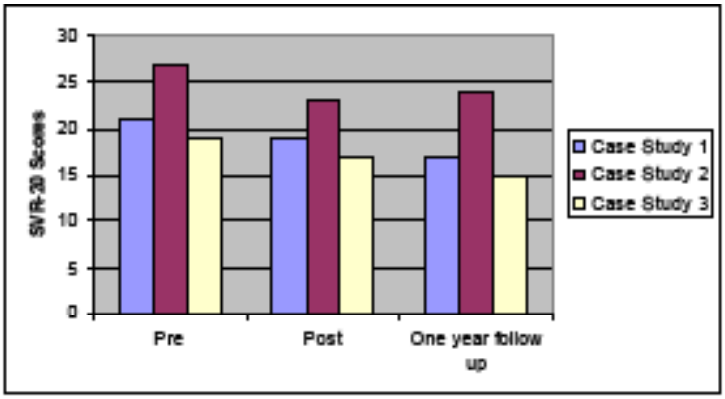


Table 2. Assessment of Sexual Knowledge Scores

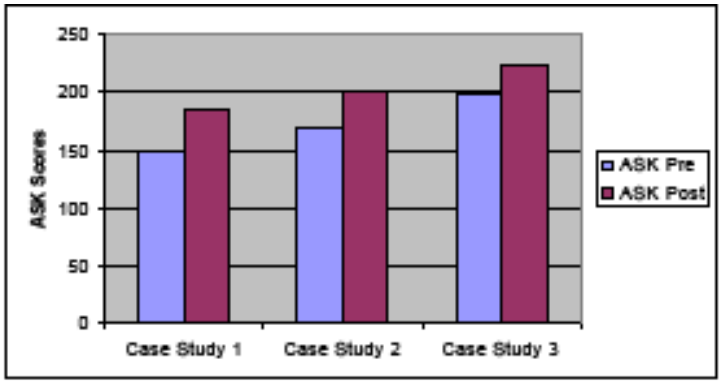


Table 3. Result of QACSO, VES, and SOSAS

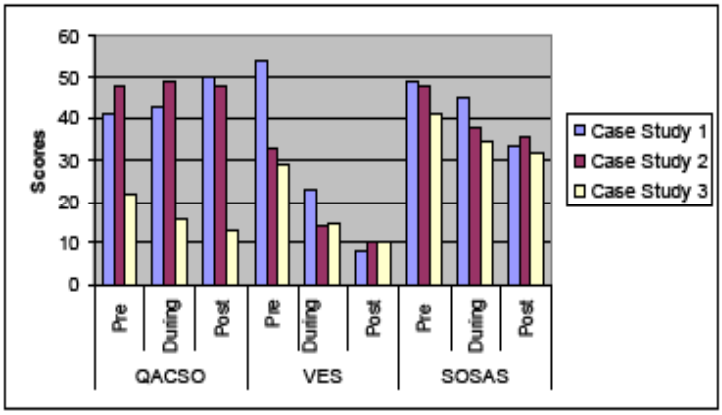
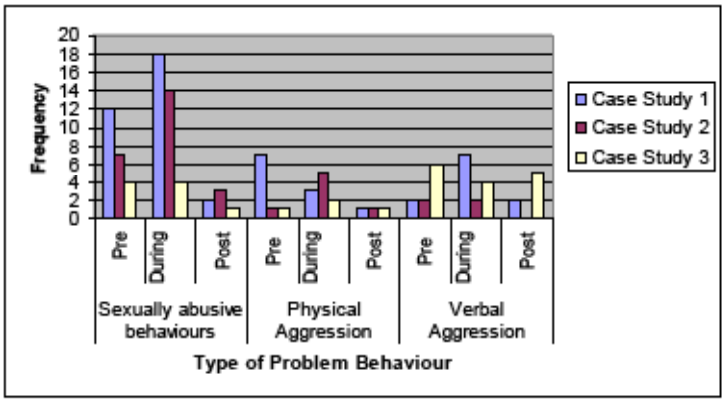


Table 4. Reported Incidents



(i.e. attitude that condone sex offences, realistic plans, negative attitude toward intervention, extreme minimisation of offences, etc.) that contributed to their high levels of risk. Overall, it can be noted that there was a decrease in SVR-20 scores upon completion of the group and at one-year follow up.

The authors tabulated the SAFE-ID pre- and post-assessment results on the three participants (see Tables 2 and 3). These results will be discussed in conjunction with the different case studies. Overall, there was a marked improvement across all measures (i.e. sexual knowledge, victim empathy and a reduction in cognitive distortions and attitudes that support or condone sex offences). Treatment gains were maintained after one-year follow-up. The ASK instrument was not re-administered as the authors post-assessment result on all participants showed high levels of sexual knowledge and clinical assessment from the inpatient psychologist showed that this issue did not relate to their risks of re-offending.

In addition, the authors collected information regarding incidents through the staff clinical notes and incident reporting for the three participants, six months prior, during the group, and six month after completing the group (see Table 3). The incidents collected did not only include sexually abusive behaviours but also other problematic behaviours (i.e. physical and verbal assault, absconding, etc.). There is a marked increase in sexually abusive behaviours when the participants were attending the group which may be attributed to their need to address their sex offending issues in the group. Reported incidents of physical and verbal aggression at six-month follow up decreased to pre-group levels. On the other hand, reported incidents of sexually abusive behaviours markedly decreased after completion of the group. Feedback from participants indicated that they have used the coping skills that they have learned to effectively manage their general and sex offending behaviours as mentioned above.

Case Study 1

Case study 1 is a mid-30's male of European and Maori descent. He has been diagnosed mild to moderate ID.

He had a lengthy history of paraphilic and antisocial behaviours resulting in numerous prior sexual offences, general and violent offences. His index offence was indecent assault of an adult female. He was found unfit to stand trial and was placed under a secure care order and was admitted to a forensic ID secure facility. He was assessed to be at high risk of sexual recidivism. In addition, he scored high on the Psychopathy Checklist – Screening Version (PCL-SV).

Prior to attending the group, pre-assessment findings (see Table 2) showed that he had limited sexual knowledge, high levels of cognitive distortions (i.e. blaming, minimisation) and attitudes that condone sex offences (i.e. rape attitudes towards women, stalking and sexual harassment). Furthermore, he had low victim empathy and he scored high on risk of sexual recidivism.

He was initially hesitant to join the group; however, he decided to attend the sessions with on-going support and encouragement from the staff. As the sessions progressed, he became more open to participating in the group; however, his level of engagement remained variable. He gradually stepped up and became more forthcoming with sharing his experiences (including disclosure of his own abuse) and even spoke about his index offence voluntarily and was appropriate with the information that he shared with the group. He also learned appropriate social skills and started to self-initiate and volunteer to help with the group activities. He completed the programme without missing any sessions.

After completing the group, staff reported that he appeared to have improved insight into sexually abusive behaviours particularly stalking and sexual abusive behaviours towards female staff. There was reported increased engagement with staff and actively disclosing concerns around risky thoughts and behaviours as they occur were reported. Overall improved pro-social behaviours and general emotional regulation were observed.

The post-assessment findings showed marked improvement in sexual knowledge and victim empathy (see Table 2). There was also a marked reduction in cognitive distortion and attitudes towards sex offences. He managed to maintain his gains across all measures on one-year follow-up. Furthermore, there was a marked reduction in inappropriate and/or sexually abusive behaviours, and physical and verbally abusive behaviours (see Table 3).

Case Study 2

Case study 2 was a mid-20's male participant of European descent. He has been diagnosed with mild ID and had a historical diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). This participant had an extensive history of involvement with special education and mainstream ID services and history of challenging and antisocial behaviours. His index offences were indecent assault of two pre-pubescent girls. He was found unfit to stand trial and was placed in an ID forensic secure facility following an assessment which found him to be at high risk of sexual recidivism.

Prior to attending the group, he exhibited severe sexual dysregulation and often resorted to verbal and physical aggression when he became frustrated. The staff reported that there was a strong association between negative emotions (i.e. anger, anxiety, etc.) and sexually aroused states. Pre-assessment findings showed that he had limited sexual knowledge, low victim empathy and high levels of cognitive distortions (i.e. blaming, minimisation) and attitudes that condone sex offences (i.e. rape attitudes towards women, stalking and sexual harassment).

During the group sessions, he was able to engage in discussions about sex education when previously he could not even cope with talking about sex. As the weeks progressed, he managed to learn how to accept challenge by the therapists and other group participants. He also started to appropriately challenge other participants on their behaviours in the group in a mature respectful manner. He later disclosed his 'life story' including his index offence.

The staff reported that he exhibited a marked decrease in frequency of masturbation and decreased sexual excitability. Furthermore, it was reported that he became more mature in his interaction with staff and more open and honest in talking about his difficulties. Improved emotional regulation and frustration tolerance was also reported and no incidents were reported leading to progression to supervised leaves from secure unit. He reportedly continued to attend individual therapy and has seemed to be insightful of his need to continue addressing his sex offending issues in treatment.

The post-assessment findings showed marked improvement in sexual knowledge and victim empathy. There was also a marked reduction in cognitive distortion and attitudes towards sex offences. He managed to maintain his gains across all measures on one-year follow-up (see Table 2). There was also a marked reduction in inappropriate and/or sexually abusive behaviours. Furthermore, there was also a reduction in physical and verbally aggressive behaviours (see Table 3).

Case Study 3

Case study 3 is a mid-30's male of European descent. He has an extensive history of antisocial behaviours and drug problems. He was charged with sex offences against two prepubescent girls. He was found fit to stand trial and was placed under a community secure order. He was placed in an ID community secure facility due to his level of risk.

Pre-assessment findings (see Table 2) showed that he held some attitudes that condone or support dating abuse. Interestingly, he did not endorse items that support sex offences against children. The SOSAS scores showed that he exhibited cognitive distortions specifically that of minimisation and denial. His VES score indicated that he had moderate to high victim empathy. The ASK result showed that he had good knowledge of body parts, relationships and legal issue, men's sexual health, however, he demonstrated limited knowledge in the area of women's sexual health.

At the start of the group, he was somewhat reluctant to engage in a sex offending specific treatment group. He expressed his sense that he did not see the need to revisit these issues as he felt that he had already addressed them in individual therapy which he did for a year. During the first part of the group, he seemed to be 'talking the talk' and that

he was relative supportive of the other group members. He seemed fairly aware of the fundamental treatment goals of taking responsibility for one's offending and had good knowledge of coping skills which he appears to have learnt from his individual sessions. As the group progressed, some of his difficulties became more apparent, as he struggled with his circumstances of being under a care order and the limitations that it imposes on him. During treatment, his staff reported an incident where he was caught taking pictures of female teenagers in public. This was addressed with him in treatment and his service provider. In time, he seemed to move to a fuller acceptance that this relapse is his responsibility and to move away from blaming the system for his actions.

The post-assessment results showed improvement across most measures (see Table 3). It showed marked improvement in sexual knowledge and victim empathy. He continued to exhibit cognitive distortions particularly that of denial and minimisation. He maintained his gains across all measures on one-year follow-up. Furthermore, his risk of sexual recidivism further decreased after one-year follow-up. Overall, he appeared to have benefited from the programme. He attended another SAFE-ID programme after a year. He recently came off his care order and that preparation was being made for his transition back in to the community.

Conclusions

The case studies showed that all three participants markedly improved across all outcome measures after completion of the group. Furthermore, it can be noted that they generally maintained their gains after one-year follow-up. There was also marked reduction in incidents with all participants not only for sexually abusive and/or inappropriate sexual behaviours but for other problematic behaviours such as physical and verbal aggression. This finding may indicate that the incorporation of the adapted DBT coping skills training might have helped address issues around other challenging and/or offending behaviours.

The issues and challenges for the therapists include: (1) not having much opportunity to do staff training and supervision; (2) limited time to do an in-depth analysis of safety and risk issues due to the compressed nature of the pilot programme; (3) some sessions are more didactic in nature; (4) too many facilitators running different parts of the programme; and (5) inclusion of key caregivers due to legal restrictions.

Overall, the pilot study showed that the SAFE-ID programme showed promise as a potentially viable treatment programme for high-risk sex offenders with ID who are placed in a secure facility within the NZ setting. Furthermore, this study also showed that a short, intensive sex offender treatment programme with specific treatment targets can be effective in decreasing the risk of sexual recidivism. The study findings appear to be comparable with the UK SOTSEC-ID programme however, caution should be taken as only three case studies were involved.

Limitations and clinical implications of the study

This study is a preliminary attempt to assess the viability of an adapted ID sex offender treatment programme with high-risk ID offenders placed in secure settings. Given that the study made use of a multiple case study design, the study findings are largely tentative and the results are not generalisable. The researchers are committed to carrying out further research on the effectiveness of this programme. There is a need to validate the effectiveness of this programme with larger sample size, longer follow up period and a randomised controlled trial. Furthermore, there is a need to lengthen the programme to at least one year so that it would be more in line with standard SOTP programmes which usually run for a minimum of a year and the provision for clients to repeat the programme as necessary. The authors recommend the need for these participants to also receive individual therapy in conjunction with attending the programme given the level of identified risk with these individuals. Further research on the use of DBT in the treatment of sex offenders with ID is recommended. It is also important to take into consideration that the SAFE-ID programme is an adapted SOTSEC-ID programme. The main difference was the incorporation of DBT concepts and skills given that the SAFE-ID programme catered to high risk sex offenders with intellectual disability who had serious problems with emotional dysregulation and poor frustration tolerance. Given this consideration it would be difficult to make direct comparisons between the two programmes. Notwithstanding, both programmes that employed a more cognitive-behavioural approach making use of more simplified concepts and visual materials seemed to work well with this client group. Further, research is needed to explore the different components of the programme which might be associated with the observed change.

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