Development and Evaluation of a Treatment Package for Men with an Intellectual Disability who Sexually Offend

Appendices

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2011

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Appendices

Appendix 1: Part 1 Sexual Offences from Sexual Offences Act 2003

Part 1 Sexual Offences from Sexual Offences Act 2003 (downloaded from http://www.legislation.gov.uk/ukpga/2003/42/contents on 21.12.2010)

1. *Rape*
    1. 1.Rape
2. *Assault*
    1. 2.Assault by penetration
    2. 3.Sexual assault
3. *Causing sexual activity without consent*
    1. 4.Causing a person to engage in sexual activity without consent
4. *Rape and other offences against children under 13*
    1. 5.Rape of a child under 13
    2. 6.Assault of a child under 13 by penetration
    3. 7.Sexual assault of a child under 13
    4. 8.Causing or inciting a child under 13 to engage in sexual activity
5. *Child sex offences*
    1. 9.Sexual activity with a child
    2. 10.Causing or inciting a child to engage in sexual activity
    3. 11.Engaging in sexual activity in the presence of a child
    4. 12.Causing a child to watch a sexual act
    5. 13.Child sex offences committed by children or young persons
    6. 14.Arranging or facilitating commission of a child sex offence
    7. 15.Meeting a child following sexual grooming etc.
6. *Abuse of position of trust*
    1. 16.Abuse of position of trust: sexual activity with a child
    2. 17.Abuse of position of trust: causing or inciting a child to engage in sexual activity
    3. 18.Abuse of position of trust: sexual activity in the presence of a child
    4. 19.Abuse of position of trust: causing a child to watch a sexual act
    5. 20.Abuse of position of trust: acts done in Scotland
    6. 21.Positions of trust
    7. 22.Positions of trust: interpretation
    8. 23.Sections 16 to 19: exception for spouses and civil partners
    9. 24.Sections 16 to 19: sexual relationships which pre-date position of trust
7. *Familial child sex offences*
    1. 25.Sexual activity with a child family member
    2. 26.Inciting a child family member to engage in sexual activity
    3. 27.Family relationships
    4. 28.Sections 25 and 26: exception for spouses and civil partners
    5. 29.Sections 25 and 26: sexual relationships which pre-date family relationships
8. *Offences against persons with a mental disorder impeding choice*
    1. 30.Sexual activity with a person with a mental disorder impeding choice

16. *Preparatory offences*
    1. 61.Administering a substance with intent
    2. 62.Committing an offence with intent to commit a sexual offence
    3. 63.Trespass with intent to commit a sexual offence
17. *Sex with an adult relative*
    1. 64.Sex with an adult relative: penetration
    2. 65.Sex with an adult relative: consenting to penetration
18. *Other offences*
    1. 66.Exposure
    2. 67.Voyeurism
    3. 68.Voyeurism: interpretation
    4. 69.Intercourse with an animal
    5. 70.Sexual penetration of a corpse
    6. 71.Sexual activity in a public lavatory
19. *Offences outside the United Kingdom*
    1. 72.Offences outside the United Kingdom
20. *Supplementary and general*
    1. 73.Exceptions to aiding, abetting and counselling
    2. 74."Consent"
    3. 75.Evidential presumptions about consent
    4. 76.Conclusive presumptions about consent
    5. 77.Sections 75 and 76: relevant acts
    6. 78."Sexual"
    7. 79.

Appendix 2: Treatment Components Summary

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The overall orientation and model of the treatment programme described here is a group cognitive behavioural approach, consistent with previous published programmes for both intellectually disabled and non-disabled offenders. The content is based on an adaptation of mainstream sex offender programmes such as that described by Marshall, Anderson & Fernandez (1999), and took account of treatment programmes published or extant prior to the commencement of this project in 1999, including the Adapted Sex Offender Treatment Programme developed by the Janet Shaw Clinic and HM Prison Service. These developments were reviewed previously in Chapter three.

Table 1: Summary of major components in the group treatment programme

Treatment Component	Content
Group rules, purpose, initial social skills and establishment of a common language	The purpose of the group, that is, a group to assist and treat people who have committed sexual offences not to offend again. Group rules to facilitate confidentiality and mutual respect. Skills of talking about oneself, sustaining attention and engagement, and basic social interaction. Agreeing terms to use in speaking about sexual matters, which leads into the second section.
Human relations and sex education	Education about body parts, social rules of undressing and touching, legal, illegal and risky behaviour, age of consent and consequences of illegal behaviour.
The cognitive model	Introduction of the cognitive model of thoughts, feelings, actions and their interrelationship, and the cognitive model, that feelings are largely determined by cognitions with examples of general behaviours, e.g. breaking possessions. The aim is to introduce the men to the concepts of thinking and feeling in relation to their own behaviour. Identification and change of cognitive distortions in general and in relation to sexual offending.
Sexual offending model	Introduction of the adapted four stage model described by Finkelhor (1984), namely 1. Thinking not Ok sexy thoughts; 2. Making it OK; 3. Planning; 4. Offending. Initial non-sexual examples of general offending. Specific sex offending, that is, understanding of the four stage model in relation to specific sex offending for a specific individual. This includes perpetrator accounts, both active and passive.
The development of general empathy and victim empathy	Introduction of emotional recognition in others. Victim empathy to an unknown victim of sexual assault, for example, a newspaper report. Empathy as related to self as a victim of sexual or other assault. Specific victim empathy, for example, victim empathy related to specific victims of men in the group including each man's specific victim.
Relapse prevention	Application of the four-stage model in relation to specific sex offending for specific individuals, with particular emphasis on coping skills and alternative behaviours to offending. Development of risk management plan from the relapse prevention plan. Application of cognitive model to prevent further sex offending.

Group rules, purpose, initial social skills and establishment of a common language

Appendix 2: Treatment Components Summary

The first treatment component seeks to establish the social and therapeutic framework within which the group treatment will proceed. Although cognitive behavioural interventions are more known for their focus on tasks and techniques than their focus on process (Marshall et al. 1999), groups by their very nature demand that careful attention is paid to this social and therapeutic framework. Groups can create a climate in which the focus of treatment is clear, responsibility for treatment progress is shared across the group to some extent, and a safe environment is created which reduces defensiveness while at the same time permitting appropriate confrontation (Beech & Fordham, 1997). Indeed these features, and the avoidance of destructive therapist-client power struggles, are what Scott (1994) argues from a psychodynamic perspective are the advantages of group over individual treatment in this area.The development of such a climate within an actual group is a gradual and developmental process (Houston, Wrench, & Hosking, 1995) in which the first few sessions are clearly crucial.

The first formal element of this climate, the establishment of group rules, was introduced in the first 1-2 sessions. Establishment or imposition of group rules (e.g., in probation groups) is common in mainstream group sex offending work (Newbauer & Blanks, 2001; O'Reilly, Morrison, Sheerin & Carr, 2001), and Swanson & Garwick (1990) asked their clients to sign an explicit treatment philosophy contract. However, Lindsay, et al. (1999) argue against elaborate rules for offenders with an intellectual disability in order to keep the process simple for clients. Lindsay, et al. impose only two rules, one about attending every session and attending on time, and one about confidentiality.

The rules should address most of the following issues: attending and being on time; confidentiality; no violence or abusive behavior; treating all participants

respectfully; speaking truthfully; listening to others; time-out arrangements if people feel overwhelmed or angry, or persistently violate group rules. The rules were used flexibly and sensibly to enhance group functioning and establish a therapeutic climate, not in an authoritarian manner. Indeed, members were often tougher on each other than facilitators, and sometimes their interjections about rule violations had to be 'toned down'. When the facilitators identified rule violations, any discussions about these violations should be conducted in a non-directive and educative manner by using Socratic questioning. An example of a set of rules developed with an actual group is included in Appendix X.

The group purpose element serves to ensure there is no doubt that the men are attending a group for men who are at risk of committing sexual offences, and that all men in the group have engaged in sexually abusive behaviour in the past. While perhaps an obvious point to others, the effect of continued denial and distortion over time may be that the perpetrator himself may not fully accept that he is attending a group for men who have engaged in sexually abusive behaviour, and that he has also engaged in such behaviour. Lindsay et al. (1997) have argued that "...it may take up to 6 months for the offender with a learning disability to accept that he is attending treatment because he has committed a sex offence." (pp. 9 - 10). There are a number of social skills that are important to both the purpose and smooth functioning of the group. Participants may not have fully developed these skills at the commencement of the group and may need to learn to take turns in a conversation, listen to each other, sit in a group format for an hour at a stretch and challenge each other respectfully.

The final element of this component is the establishment of a common language for describing parts of the body. This vocabulary of appropriate terms and labels is

generated by the group for each relevant anatomical feature by generating all possible terms, including all colloquialisms, and writing them on flip charts, and then selecting an agreed and appropriate term for each feature. It is recommended that the words selected be the commonly used dictionary terms for each anatomical area (e.g. penis, vagina).

This exercise serves to eliminate the titillation value of many of these words by dealing with them at one time, and by explicitly allowing slang and colloquial descriptions to be aired. It also removes some awkwardness around describing anatomical features, and leads naturally into the next component on human relations and sex education.

Human Relations and Sex Education

As discussed earlier, this area has already been well covered in the literature, and is also covered in the treatment manual by Sinclair et al. (2002).

The Cognitive Model

In undertaking cognitive restructuring with sexual offenders, Murphy (1990) argues that clinicians will need to know about the particular victim(s) for each client and the impact of the offence on the victims, and understand in general the links between cognitive distortions supportive of particular types of sexual offending and the actual offending, as well as being aware of the broad range of cognitive distortions that offenders are likely to utilize. Murphy also warns that a defensive and even angry reaction should be expected when cognitive distortions are challenged.

The cognitive model is used in the early stages of this component of treatment to evaluate every day situations that the men bring to the group using the thoughts → feelings → actions table illustrated below. The notion of correcting or reconstructing cognitive distortions is initially broached by talking with the participants about the

internal voice or automatic thoughts that make up our thinking (emphasising that this voice is not the same as hearing voices).

Figure 1: Thoughts, feelings and actions model

Situation:

Thoughts	**Feelings**	**Actions**
		

Once the participants are comfortable with the notion of an 'internal voice ' or 'monitor', the thoughts → feelings → actions table was used for difficult experiences the men have had in the previous week. The procedure adopted was to:

- Begin by naming the emotions which were experienced in the difficult situation in some detail, avoiding non-specific descriptors such as "fine", "good", "bad" "not so good" etc in favour of specific descriptors such as "angry", "hurt"," frustrated", etc.
- Once there is a clear understanding of the emotions experienced at the time of the difficult situation, the thoughts or ruminations which were occurring at the time are then identified, without at this stage identifying whether there are any distorted thoughts (although there almost invariably are).
- The behaviour (action) displayed by the person in response to the difficult situation is described and evaluated for appropriateness or otherwise (the men usually agree with the facilitator's evaluations of appropriateness

without any prompting).

- If the evaluation is that the behaviour is appropriate, no review of thoughts occurs, but if the evaluation is that the behaviour was not appropriate, then the thoughts are reviewed and reconstructed to eliminate most cognitive distortions.
- This revision of thoughts usually leads to a change in the emotions the person reports they would experience and also to the behaviours they are likely to display.

The whole process makes extensive use of "Socratic Questioning" referred to above where the facilitator leads the process by asking questions in such a manner that the person who is the focus "discovers" the adaptive cognitions or beliefs rather than being told or advised. A more detailed exposition of the Socratic method in this context can be found in Overholser (1993), and a brief account in Thornton & Mann (1997).

An example of the use of this table is shown below. The situation referred to one of the men expecting to go home to visit his mother, but at the last minute his mother advised that he could not go home. He reported feeling a mixture of sadness, anger and disappointment. The underlying thoughts leading to these emotions he then identified as:

- I don't see my mother very often and I will miss her.
- She shouldn't say I could go home then let me down.
- She doesn't love me
- She always lets me down;
- and the resulting behaviour (action) was to cry and slam doors and be abusive to staff at his residential home.

Sarah: Could we include this as a figure, please: Figure X: Example of thoughts, feelings and actions model)

Situation: I was going to go and visit my mother for the weekend and she phoned the staff at the last minute to say I couldn't go.

	Thoughts	**Feelings**	**Actions**
			
What Happened	• I don't see my mother very often and I will miss her. • She shouldn't say I could go home then let me down. • She doesn't love me • She always lets me down	Sad Angry Disappointed	Cry Slam doors and shout and swear
What I will do next time	• May be something urgent came up which she couldn't do anything about • It's not like I won't see her again. • Just because she let me down doesn't mean she does not love me.	Sad but more understanding Disappointed (less) Not so angry	Phone mother to see what happened. Plan something else for the weekend.

Figure 2: Thoughts feelings actions Table

Cognitive reconstruction was undertaken in the following manner:

- There was a discussion about the way in which the thoughts and feelings created a self-fulfilling cycle, for example thinking "she always lets me down" will lead to increased feelings of disappointment, which will strengthen the thought "she always lets me down" which in turn will lead to strengthening of the feelings of disappointment and so on;

- The action of slamming doors, shouting and swearing at residential service staff was agreed as an undesirable and, importantly, ineffective behaviour (action) in terms of the desired outcome, seeing his mother;
- The best way to change a sequence of thoughts, feelings and actions was agreed as changing the underlying thoughts;
- A more objective, fairer, and constructive set of thoughts relevant to the situation was elicited with Socratic questions (e.g., "Does your mum cancelling this trip mean that she doesn't love you?");
- The resulting emotions and likely course of action were then identified.
- This process was written down on flip sheets in the same form as the above diagram.

The above process needs to be applied numerous times with each of the participants on a range of relatively neutral or at least low-valence issues and situations until the participants are very familiar with the model. By this stage they can remember the components and can routinely apply the model with minimal prompting. The model is then applied to:

- General non-sexual offending examples, some of which may come from the men's history and some of which may be fictitious,
- Followed by application to general sex offending examples, which are nominally fictitious, but deliberately selected to approximate some of the sexual offences the participants have committed,
- Followed by actual examples of the men's previous offences, which the men need to supply.

Examples of non-sexual offending and sexual offending applications are shown in Appendix 12 in the Treatment Manual.

The model is also a useful heuristic device in addressing cognitive distortions related to lack of victim empathy. The model can be used to show a victim's thoughts, feelings and actions at the time of a sexual offence, and then again at each life stage after the offence for the next twenty to thirty years. This can be a powerful way to show the extensive and long-term impact of sexually abusive behaviour using a model with which the men are now familiar, and which has also been applied to their own situation, thoughts, feelings and behaviours.

A four-stage model for explaining sexual offending adapted from Finkelhor (1984)

The Finkelhor (1984) model as adopted in this programme follows very closely the adapted sex offender treatment programme and consists of the following stages: Thinking not OK sexy thoughts; Making it OK; Planning to offend; and Offending. Each of these is discussed in turn below.

Thinking Not OK Sexy Thoughts

This stage refers to the use of visual imagery to replay previous offences or situations, and the fantasy of future possible offences and risky situations. The point is made when explaining this stage that sexual fantasies are common and acceptable, provided they refer to legal sexual activity. Although it is important to be clear that having these fantasies is not illegal, it is also important to be very clear that having fantasies about previous or future possible offences is the "first step" towards sexual offending or sexually abusive behaviour, and makes future offending or sexually abusive behaviour more likely rather than less likely. The link between masturbation, sexual arousal and the presence of illegal imagery should also be pointed out, along with the

conditioning effect of orgasm and illegal sexual images. We argue that future accidental encounters with potential victims will be more likely to lead to offending or sexually abusive behaviour if there is a continued association between such images and sexual pleasure, especially orgasm.

Although being clear that legal fantasy is OK, facilitators should initially argue for the development of alternative not-sexual images that are less likely to lead to sexual arousal and thence to illegal images. Facilitators should try to gain an acknowledgement that the men have sexual fantasies and the content of some of these fantasies, although this usually takes quite a number of sessions. This process may proceed along the following lines:

- Clarify the legality and prevalence of sexual thoughts, that is, most adults have sexual fantasies;
- Clarify that it is only sexual fantasies which involve illegal activities (children, force, lack of consent) which we are asking the men to desist from;
- Establish that sexual fantasies are common, and then gradually draw out the acknowledgement that the men each have sexual fantasies;
- Draw out the acknowledgement that these fantasies often contain illegal elements, and build, over successive disclosures (within a session and between sessions) to acknowledge masturbating to illegal sexual fantasies on a regular basis.
- The broad details of such fantasies are filled in for each man so that the acknowledgement is sufficiently detailed to prevent later denials, but without allowing the account to become sexualised.
- Alternative non-sexual visualisations are developed for each man which are multi-sensorial (sight, sound, touch, smell), vivid and personally meaningful.

Making it OK

This stage refers to the extensive web of cognitive distortions which each of the men has usually developed to rationalise or justify their sexually abusive behaviour to themselves. These distortions are very similar to those displayed by mainstream offenders and include such distortions as: 'No-one will ever know', 'It won't hurt them', 'It's how I look after them', 'It never hurt me', 'They don't seem to mind'.

These distortions are also quite difficult for the men to acknowledge, and it is only when there is a well-established therapeutic climate within the group that the men start offering their particular distortions. We raise these distortions within the four stage model and teach how the presence of such distortions represent a second step towards future offending or sexually abusive behaviour as it allows the men to convince themselves that they can do an activity which they know is both illegal and wrong. We characterise the distortions as 'excuses', and develop a specific "truth" to counter each of the distortions, and then encourage the men to tell themselves the "truth" about a particular situation rather than the distortion. Examples are listed below:

Table 2: Examples of cognitive distortions and "truths"

Distortion ("excuse")	"Truth"
'No-one will ever know'	*'People usually find out sooner or later'*
'It won't hurt them'	*'Sexual offending hurts people a lot, it hurts their heart and messes up their future'*
'Never hurt me'	*'It actually hurt me a lot both at the time and for my whole life'*
'They don't seem to mind'	*'They are probably terrified and worried'*

Some cognitive distortions do not appear to be distorted initially, however further examination of the underlying thoughts and assumptions may reveal that they are in fact distorted. This allows for a 'truth' or at least a more positive assumption to be

developed. An example ...of such a distortion might be "I felt so excited" which seems truthful and undistorted, but the full self-talk is probably more like: *"I feel so excited that I don't care (it's OK) if I hurt them."* This can then be reconstructed to: "*I can feel excited but this doesn't mean its OK to hurt someone else.*"

Other distortions may be partially true, or use a socially appropriately term or description to hide something else. For example the self-talk: *"I really love kids"* is probably a socially acceptable form of saying *"I lust after kids"*, and the "truth" to counter this could be something like: "*Loving kids means protecting them, being kind to them, not violating them or having sex with them.*" or "touching kids sexually is hateful and hurtful rather than loving." Facilitators therefore anticipate these types of distortions and draw out their underlying content so that appropriate cognitive restructuring can occur which counters the distortion and contribute to the development of a non-offending set of cognitions.

Planning to offend

Most sex offenders, whether mainstream or intellectually disabled, usually deny any explicit or implicit planning of their previous offences. As for both of the above stages it is often difficult to coax the acknowledgement and details of this step from the men. After detailed discussion of some of their actual offences and challenging of some of their alleged reasons (e.g., for being in the particular locale, or for being alone with the victim, etc.), it is usually clear that a considerable degree of planning did occur. (This planning may be unsophisticated in comparison to mainstream sex offenders). This questioning allows a detailed picture to develop of the individual features of the pre-offence planning for each member. This can then be used to

construct with the individual and the group a plan about how not to offend. Some planning examples include:

- Taking sweets, extra money, or cigarettes to the local shop when young girls may be there;
- Following (described as targeting) young girls when out in the community;
- Watching for young boys to go into the toilet whilst in shopping centres;
- Waiting until there are no staff around before approaching a potential victim;
- Brushing up against children when out shopping;
- Going to the local shop through the park in summertime (where children are liable to gather);
- Going to un-staffed areas in day centres (to see who is there).

Offending or sexually abusive behaviour

The final stage in committing a sexual offence is obviously the offence itself. During this stage the offender must ignore any concerns for the well-being of the victim (victim empathy), and focus on short-term sexual and other gains (such as power assertion) to the exclusion of long-term consequences to themselves (such as involvement with the police, court and legal consequences), to say nothing of the long-term consequences for the victim. The strategy adopted to overcome their desire to offend, even in situations where there is an opportunity, is to focus on the devastating consequences for the victim, as well as focusing on the long-term consequences for themselves. As some of the men will have experience of the criminal justice system and the restriction of some of their freedom of movement, even if informally, this latter strategy seems to have a more immediate effect within the group. By focusing on the strategies necessary to obtain compliance from the victim at this stage of offending, the violation involved can be made more explicit and clearer to the men.

At the initial stage, the model is presented in general terms. Once the men understand the model in broad terms and can reconstruct the model without any prompting, facilitators use a non-offending example, and show how it can be used to explain

other behaviour, such as taking someone else's chocolate or stealing. The model may be applied to specific but anonymous sexual offending examples that are chosen to be close to actual examples of offending by group participants. The model is illustrated below with both a non-offending example and a sexual offending example.

Table 3: Four-Stage Model: Non-sexual and sexual offending example

Non sex offending example	**Sex offending example**
Thinking/having not OK sexy thoughts (Film):	
Thinking about eating the chocolate bar, imagining unwrapping it, the taste, the smell...	Me touching their genitals. Them touching mine.
Making it OK to offend (Excuses):	
Telling yourself he/she won't miss it, I'm really hungry, I'll only have one bite, he/she should share it anyway...	Making it OK to offend (Excuses): It won't hurt anyone. They won't tell. I'll be OK.
Planning to Offend:	
Going into the kitchen when no-one else is around, opening the fridge to see if it is still there, pretending to look for something else in the fridge...	Get close to victim. Ignore long-term consequences. Focus on short-term thrill of being with girl and touching her
Offending:	
Taking the bar when you are on your own and eating it.	Go to shops, schools, parks, amusement arcades, bus shelters etc. where young girls are Talk to girls. Ask up to bedroom show how to operate computer Offend

The Development of General Empathy and Victim Empathy

This section is covered in some details in the treatment manual (Sinclair, Booth & Murphy, 2002).

Relapse Prevention

The model used here combines the adapted Finkelhor (1984) model of sexual offending (a simple offence-chain) with the decision matrix originally developed by Marlatt (1985, p. 58) and described for sexual offender treatment by Jenkins-Hall

(1989). This results in a relatively simple model that shows the four-stage offence chain in contrast to a four-stage non-offence chain. This model builds on the understanding of the offending model already developed, and includes within each cell specific tactics and strategies to assist in preventing relapse at that stage. These include the positive and negative, and short and long term consequences identified in the decision matrix described above, and are specific to each individual. The model allows inclusion of relevant victim empathy information, restructuring of cognitive distortions, and strategies to avoid risky situations. These plans are very detailed and take several hours of group time to develop for each individual client. They do provide, however, a convenient way to capture the particularities of each client's previous fantasies, distortions, planning and offending in such a way that they can be specifically counteracted in the non-offending column. The relapse prevention plan thus developed for each individual serves as a summary of the relevant points of the group treatment programme, as well as a portable relapse prevention plan that can be distributed to relevant parties such as the residential service and Care Manager, as well as the client. Marshall et al. (1999) similarly distribute their offence chain described above to the Parole Board and an external supervisor as well as the client (P144). The model is described in figure twelve below.

Table 4: Example relapse prevention plan

Adapted Four-Stage Model of Offending (after Finkelhor, 1984)	GOOD: NOT OFFENDING	BAD: OFFENDING
1. Thinking not OK sexy thoughts: Fantasy stage	Pink Elephant: Alternative non-sexual visualisation	Film: Illegal sexual fantasy
2. Making it OK: Cognitive distortions	Truth: Truthful cognitions about sexual offending	Excuses: Justifications for sexual offending
3. Planning	Planning not to Offend:	Planning to Offend:
4. Offending	Not Offend:	Offend:

The above table shows in the first column the four-stage model used, and in the second and third columns the two components of the relapse prevention plan developed with each client. The concept of film or pictures in the first stage was used to convey the notion of visual or other fantasy, and pink elephant refers to an alternative non-sexual visualisation that was well developed and very familiar to the client. The second stage of cognitive distortions was called excuses for the offending chain and truth for the non-offending chain. Specific 'truths' were developed to counteract each of the distortions that were identified for the particular client. For the third stage, planning, the subtle and other forms of planning that preceded the offence in the past (what were called apparently irrelevant decisions or "AIDs" in the original Marlatt model Marlatt, 1985) were identified and then counteracted in the planning not to offend stage. For example, planning to avoid shops during school holidays when these were previously frequented. In the final stage, offending, the short and long term consequences for the victim are emphasised, and the medium and long-term consequences for the offender if an offence was committed. An example of a finished relapse prevention plan is shown in the table below. This plan is presented to the group by the person whose plan it is, and distributed to relevant people in the person's network. The relapse prevention plan can also serve as the basis for follow-up and maintenance sessions after main treatment has concluded.

Treatment manual and training

In order to provide a common framework a 244 page treatment manual was developed to guide therapists and provide some assurance of standardisation and model fidelity so that the treatment could be said to be equivalent at different locations. Treatment manuals were made available to those running groups at a low cost and therapists

were asked to adhere to the manual. A two-day training programme, based on the manual, was provided for all clinicians running the treatment programme. This included a detailed exposition of the treatment components as well as some practical exercises in utilising the cognitive and sex offending models. These annual training sessions have been provided every year since 2002.

Operational details of the treatment programme

Treatment groups were normally for 4-6 men. New group members were not introduced to the group once it has started as the treatment model is that of a closed group. Given some of the difficulties in establishing regular attendance, the group need not be closed until after the first few weeks. The main reason for having a closed group is to build trust and rapport.

Research has shown that CBT for men who commit sex offences needs to be lengthy (Lindsay & Smith, 1998), so all treatment groups ran for a full year, with sessions once per week. Some men may need further treatment and were offered a second treatment group. Sessions were two hours long and adequate breaks were important, as well as coffee and tea making facilities and biscuits.

Venues were in the community if possible, with due consideration given to safety of other users of the centre, especially children. waiting areas for the men and ensure that the men are supervised there if necessary.

It is extremely important to ensure that there are **good records** of each session, including those present, the topics covered and each man's behaviour in the group. These are important in order to provide good reports for individual men at the end of treatment and an account (e.g. for the probation service) of attendance. *Post*

Session Checklist/Documentation forms were filled out for most sessions, providing a record of the amount of time on each content area and attendance as a record of anything untoward. Structure of the sessions each week was as follows: Weekly roundup – how has each man's week been?; Revision of last week's work (and hand-out summaries); Discussion of homework from last week; Coffee / tea break (about 15 minutes); New work and any Homework setting. Facilitators deviated from the plan for the session if it seemed appropriate. The purpose of the session plan was to guide engagement and teaching of the key issues. At the start of the year of the treatment sessions, facilitators will need to spend quite some time each week planning the session for the next week. This is often best done immediately after the previous week's session, to take account of where the men have got to so far. Responsibilities for producing resource materials and collecting tea/coffee/biscuits for the following week's session needs to be clear. Initially, facilitators may need prompt sheets during the sessions (usually just a brief list of topics and how to approach them) but as the facilitators become more practised, these can often be omitted. Suggested planning times for organizing the groups were as follows:

- 30 minutes before group begins: meeting of the 2 facilitators, for final planning and amassing of resources, preparation of room, etc
- 2 hours for the group (with 15 minute break in the middle)
- 30 minutes after the group: ensuring all men have left safely; clearing up in the room; debriefing; completion of *Post Session Checklist/Documentation*; planning of next week's group.

Facilitators were encouraged to meet for substantial planning of content and allocation of facilitators along with a rota and arrangements for room booking, tea and coffee etc, as well as contingency plans for illness.

Appendix 2: Treatment Components Summary

This treatment manual is deliberately not too rigid. Nevertheless, facilitators may find it helpful to get an overall view of the sort of session framework to be expected. Most groups covered the content areas in the following order: Sex education (including consent and legal issues); Cognitive behavioural model; Four stage model; Victim empathy; and Relapse prevention.

A difficult issue is when to tackle the problem of getting each man to describe his index (and other) 'offences.' In mainstream sex offender work, this is usually done in the first session (i.e. men will admit of what they were convicted). However, for men with intellectual disabilities, many of whom have not been convicted and are therefore attending voluntarily, this can be very threatening. Tackling the issue too early may frighten some men away permanently. Nevertheless, much of the cognitive work requires that men do feel able to discuss their 'offences' so it should be tackled as early on as possible. Probably such issues are best brought up after initial rule setting and sex education. We have found it is useful to run a carer's meeting every so often (at the start of the group and then every four months or so). The purpose of this meeting is to discuss the above issues and to ensure that carers know what the group's aims and methods are, and so carers can ask questions about topics that worry them.

It is anticipated that treatment groups will be run by a number of facilitators. It is essential to ensure that:

- Each session is facilitated by at least two therapists (so that, for example, any difficulties in the group can be safely dealt with and/or if a service user needs to leave the group someone can go with him)
- If possible, one male and one female therapist should facilitate each session
- Each session should have at least one facilitator who was present in the previous session, to ensure continuity

- Facilitators should be as consistent and predictable as possible (for example, three or four therapists can rotate so that two run the session each week; alternatively one main therapist can be present most weeks, with different co-facilitators).

The lead facilitator should be a clinical psychologist or behaviour therapist, specialising in intellectual disabilities. Co-facilitators are likely to be clinical psychologists, forensic psychologists, behaviour therapists, behaviourally trained nurses, social workers or probation officers. It is often helpful to combine therapists who have forensic experience or experience of mainstream sex offender programmes, with therapists who have expertise in intellectual disabilities (but may have less expertise in sex offender treatment).

The lead facilitator needs to ensure that:

- All referrals to the group are properly processed and referring agencies are responded to in writing
- All those men accepted for the group are sent appropriate treatment consent letters and have sufficient information and support to make informed consent decisions
- All men are sent (MREC-approved) research consent letters and research information sheets (can be done after the group has started), and have sufficient support to make decisions
- Men's carers and GPs/consultants/RMOs/probation officers, as appropriate, are sent information on the treatment and research (using MREC-approved information sheets)

- All men have a risk assessment and risk management strategy and these are accessible to all facilitators.
- All agreed pre- and post-treatment assessments are completed
- Facilitators are clear when they are needed for sessions
- There is good pre-session planning and post-session debriefing
- Responsibilities for producing any resource material for sessions are clear
- A file is available at all sessions giving service users names, addresses, carer contact details and level of supervision required, in case of emergencies. (See model form detailing such information in Appendix 14).
- All sessions are properly recorded (with service users presence/absence; tasks for the group; behaviour of each group member), using the *Post-Session Checklist* (see Appendix 10).
- Any issues of concern arising from sessions are passed on to the lead facilitator and to the relevant carers / care managers / RMOs / probation officers, if necessary
- There are occasional planning meetings for all facilitators (about every three months) to discuss and plan broader issues associated with the group.
- All facilitators have access to clinical supervision. This may include:
    - frequent 'peer supervision' for day-to-day events that come up in the treatment group
    - less frequent external supervision or debriefing for dealing with difficult feelings raised by issues that come up in the group ('feelings supervision')
    - 'technical supervision' for resolving tricky issues, by bringing them to the SOTSEC-ID group for discussion

It is also the responsibility of the facilitators to ensure that consent and confidentiality rules are obeyed by group members and facilitators and that risk management guidelines are complied with for all men when they attend the groups. In general, it is inappropriate for facilitators to engage in self-disclosure about personal circumstances. For example, it is not appropriate for facilitators to discuss their own relationships or sexual interests. They should also not disclose their own home addresses or phone numbers. Disclosing censored information (e.g. an appropriate 'good' and 'bad' event from the previous week, or occasionally expressing emotions and thoughts), can help serve as a good model and may aid in the establishment of rapport (see the end of section 7.2.3 of the Treatment Manual for a further discussion of this issue).It is, however, helpful for facilitators to make general comments which may reflect their values and other peoples', such as: *Women don't wear short skirts because they want sex; Men should not expect sex on a first date.*

There were clear recommendations for dealing with persistent absenteeism from the participants and any challenging behavior in the groups which is detailed in the treatment manual. Men were removed from the group if they missed 40% or more of the group content, if they had a significant decline in mental illness, or if their behaviour is serious enough to affect the physical and/or psychological integrity of group members/facilitators, though facilitators used a range of strategies and tactics to retain truculent members such as quiet one to one talks during coffee, warnings, temporary exclusions and the like. Confidentiality breaches were dealt with similarly. The expectations and sanctions were applied regardless of the legal basis on which men were attending.

Appendix 3: Mens Group Data Base I, II & III

MEN'S GROUP BACKGROUND INFORMATION AND DATA BASE SCHEDULEPHASE ONE

Purpose

The purpose of the schedule is to provide a systematic way of gathering background information on each of the men who have agreed to participate in the SOTSEC-ID research. A further purpose of the schedule is to provide codes for entering data onto the database.

Introduction

The Men's Group Background Information and Data Base Schedule was designed to provide a way of coding information following a clinical interview or whilst reviewing a participant's medical or other health records. The Men's Group Background Information and Data Base Schedule is split into three phases:

- Phase One collects demographic and background information for participants prior to the beginning of the Men's Group.
- Phase Two collects information at the completion of the Men's Group
- Phase Three collects information at 6 months follow-up.

Phase One contains 8 sections each designed to obtain background and current information about the individual.

Section 1: Demographic Data and Current Situation: Gathers demographic information for the participant prior to the start of the group.

Section 2: Background Information - Family: Gathers information about who the participant lived with during childhood.

Section 3: Background Information - Educational: Gathers information about the amount of formal education received by the participant.

Section 4: Background Information - Medical/Psychiatric/Psychological Problems: Gathers information about the actiology of the participant's learning disability along with psychiatric diagnoses and psychological problems suffered during childhood and adulthood.

Section 5: Background Information - Sexual: This section gathers information regarding consenting sexual experiences as an adult.

Appendix 3: Mens Group Data Base I, II & III

Section 6: Background Information – History of Sexual Assault (as Victim): Describes non-consenting sexual experiences of participant as both a child and an adult.

Section 7: Index Sexually Abusive Incident (as Perpetrator): Gathers information about the sexually abusive incident perpetrated by the participant that resulted in the referral to the Men's Group.

Section 8: Background Information – History of Sexually Abusive Incidents (as Perpetrator): gathers information on the number and type of sexually abusive incidents perpetrator by the man.

Categories for some of the questions are based on findings in previous studies/publications including:

A. Kalinsky (personal communication July 24, 2003). The Offenders Index Codebook. November 2002.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders.* Forth Edition, American Psychiatric Association, Washington D.C.

Research Development and Statistics Directorate (1998). *The Offenders Index: Codebook.* Home Office.

Research Development and Statistics Directorate (2003). Home Office Counting Rules for Recorded Crime. Home Office. Retrieved 24 July 2003, from http://www.homeoffice.gov.uk/rds/countrules.html

McCarthy, M. & Thompson, D. (1997). A prevalence study of sexual abuse of adults with intellectual disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities*, 10(2), 105 - 124.

Thompson, D. (1997). Profiling the sexually abusive behaviour of men with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 10(2), 125 - 139.

Appendix 3: Mens Group Data Base I, II & III

Definitions

Boyfriend is used in the schedule to refer to any man defined by the participant as their 'boyfriend.' The nature of this relationship would usually be more intimate than a plutonic friendship with the same sex, and may refer to a (presumed) consensual sexual relationship.

Child is someone who is 18 years or younger.

Close Relatives: refers to any relative or step relative. For example, auntie/uncle, grandparents/stepgrandparents, brother/sister, step brother/sister.

Course of Therapy refers to a block of therapy designed to help the individual with a specific problem.

Dissociative Disorders. In DSM-IV the 'essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment' (p. 477). Please refer to DSM-IV for further information on Dissociative Disorders.

Factitious Disorders in DSM-IV are 'characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role... [and] are distinguished from acts of Malingering. In Malingering, the individual also produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known. For example, the intentional production of symptoms to avoid jury duty, standing trial or conscription into the military would be classified as Malingering' (p. 471). Please refer to DSM-IV for further information on Factitious Disorders.

Formal Education includes attendance at primary school, secondary school/college and any further approved education course.

Girlfriend is used in the schedule to refer to any woman defined by the participant as their 'girlfriend.' Usually the nature of this relationship would be more intimate than a plutonic friendship with the opposite sex, and may refer to a (presumed) consensual sexual relationship.

Index Sexually Abusive Incident (Section 7) is defined as a sexually abusive behaviour that was the most recent in terms of the start of the Men's Group. *Sexually Abusive Behaviour* has been used in *Section 7* to refer to all sexually abusive behaviour that occurs on a specific day. Please see below for a definition of *Sexually Abusive Behaviour.*

Offence has been defined in this schedule as a behaviour that has resulted in a conviction through the courts.

Parent refers to primary adult responsible for caring for the individual. For example biological parents, adopted parents, same sex parents or anyone defined by the participant as their 'parent' as long as this does not include persons paid to look after the participant.

Public Place: Please note the following:

- If the participant engages in self only masturbation, whilst alone in a public place, but in private area (where others cannot gain access or accidentally come across him/discover him) – this is NOT coded as a sexual assault (For example if participant goes to public place, e.g. sports centre, and masturbates in a locked private toilet cubicle).
- If the participant engages in self only masturbation whilst either alone or in presence of others, in a public place but not in a private area (where others may discover him, even if he thinks he is hiding) – this is CODED as a sexual assault regardless of whether there is/are identifiable victim(s). (For example the following would be coded as a sexually abusive incident: 1) if participant goes to public place, e.g. sports centre, and masturbates in general toilet area, where there is the potential for him to be discovered by public. 2) if participant goes to public place, e.g. railway bridge/park, and masturbates by bridge/in park behind a tree where he thinks he is hiding but where could be discovered by public).

These definitions exclude behaviours such as voyeurism, where the participant may be masturbating in a locked private area following viewing nudity or sexual activity of another person without their knowledge and consent. This definition also excludes a perpetrator (participant) masturbating a victim, or masturbation in front of a victim in a private and locked area (e.g. bedroom). In addition, this definition excludes other illegal sexual behaviours that may occur in private areas.

Set of Sexual Assaults (Section 6) is defined as the participant being the victim of any number of assaults with a specific perpetrator. Please note that sexual assaults may continue over a period of time (e.g. months/years), yet are still considered to be one 'set' of sexual assaults if the same perpetrator is implicated.

Set of Sexual Assaults (Section 8) is/are defined as the participant being the perpetrator of any number of sexual assaults with a specific victim. Assaults on different victims, even if they occur on the same day, are coded as different 'sets' of assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time (e.g. months/years). If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults. If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexually Abusive Behaviour is defined as occurring when the other person is non consenting and/or the behaviour(s) would be regarded as illegal if it came to the attention of the police. This term refers to behaviours that have resulted in a conviction as well as those behaviours that have not come to the attention of the police, the court, or resulted in a conviction through the courts but which meet the above criteria. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexual Relationship(s) refers to (presumed consensual) sexual experiences with a specific partner (of legal age). For example, where the individual has had a number of different sexual experiences

with the same partner, the experiences are coded as one sexual relationship. Sexual contact could include such behaviours

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as genital touching, kissing, mutual masturbation, intercourse, oral sex etc.

Support Person refers to an individual who is paid to look after a person with intellectual disabilities in the support person's own home. This includes adult placements and adult foster arrangements.

Staff refers to employees of institution (e.g. residential facility, hospital) who are paid to care for the individual.

Type of Concurrent Therapy. Please indicate only one type of therapy under this section. Where the therapist is adopting an eclectic approach for working with the participant, please determine the predominant type of therapy that is being given.

Instructions for use

Please cross categories that apply, by clicking in the relevant box(es). Please only cross one box on questions requiring a Yes/No response. You may cross as many categories as are relevant for open-ended questions. Some questions require you to calculate the number of times a particular behaviour has occurred. Please put the number in the relevant box.

Please fill in as much information as possible for each of the questions. If there is no documentary information for a particular question then please state underneath the question that there is no information documented.

If the question does not have the response that is needed please use space underneath the question to document what is written in the file.

Questions/phrases with further explanations in the 'definitions' section are indicated by a *. **Please complete**

Name of person filling out form:

Please indicate where information for filling out the schedule was obtained (more than one may apply):

- ☐ Clinical interview with individual
- ☐ Clinical interview with family/carer/key worker/doctor/probation officer Learning
- ☐ Disability Service clinical records
- ☐ Psychiatry clinical records
- ☐ Social services clinical records
- ☐ Other. Define:

Appendix 3: Mens Group Data Base I, II & III

Section 1: Demographic Data and Current Situation

1. **Participant's first name:**

2. **Initial of participant's last name:**

3. **Participant's date of birth:** **(dd/mm/yyyy)**

4. **Ethnicity (taken from last census): (Ask the Man)**

White

White British = 1 ☐
White Irish = 2 ☐
Other White backgrounds = 3 ☐

Mixed

White and Black Caribbean = 4 White and Black African = 5 ☐
White and Asian = 6 ☐
Any other Mixed backgrounds = 7 ☐

Asian or Asian British

Indian = 8 ☐
Pakistani = 9 ☐
Bangladeshi = 10 ☐
Other Asian background = 11 ☐

Black or Black British

Caribbean = 12 ☐
African = 13 ☐
Other Black background = 14 ☐

Chinese or other ethic group

Chinese = 15 ☐
Any other ethic group = 16 ☐

Not known = 99 ☐

☐ 5. **Participant's research status: (Please cross only one of the options below).**

Participating in research as <u>treatment</u> participant = 1 ☐
Participating in research as <u>control</u> participant (i.e. is not receiving group CBT treatment according to SOTSEC-ID model) = 2 ☐

6. Location of Men's Group:

7. Level of security of venue for Men's Group:

- ☐ community venue = 1
- ☐ secure environment - low secure = 2 secure
- ☐ environment - medium secure = 3 secure
- ☐ environment - high secure = 4

8. Name of lead facilitator:

9. Group start date: (dd/mm/yyyy)

10. Date(s) that filling out this form:

11. Participant's residential status at start of group:

- ☐ own home (supported) = 1
- ☐ own home (unsupported) = 2
- ☐ family (or close relative) = 3
- ☐ group/residential home = 4
- ☐ secure environment - low secure = 5
- ☐ secure environment - medium secure = 6
- ☐ secure environment - high secure = 7
- ☐ with support person* in support person's home = 8

12. Legal status at start of group:

- ☐ Informal = 1
- ☐ Under Mental Health Act = 2. Define Section:
- ☐ Community Rehabilitation Order (used to be Probation Order) = 3. Define length and conditions:
- ☐ Guardianship Order = 4. Define conditions:

13. Level of security/escort required by participant when in community?

- ☐ no escort required = 1 1:1 escort required = 2 2:1 escort required = 3 3:1 escort required = 4 no community outings regardless of number of escorts = 5

14. Is the participant receiving concurrent therapy at start of Men's Group? (Please note that previous therapy will be coded under Section 4)

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

15. Reason for participant receiving concurrent therapy. (N.B indicate all that apply) *(Code Yes = 1, No = 2, Not Known = 99, Not Applicable = 999)*

- ☐ Perpetrating sexually abusive behaviour Other.
- ☐ Define:
- ☐ Not known
- ☐ Not applicable

16. Type of concurrent therapy. Please only complete if answer to question 14 is 'perpetrating sexually abusive behaviour' or indicate 'question not applicable':

- ☐ individual cognitive behaviour therapy = 1
- ☐ group cognitive behaviour therapy (excluding the Men's Group) = 2 'other' type
- ☐ concurrent therapy = 3. Define:
- ☐ not known = 99
- ☐ Question not applicable = 999

17. Professional conducting therapy (N.B. therapy is for perpetrating sexually abusive behaviour)

- ☐ Clinical psychologist = 1
- ☐ Social worker = 2
- ☐ Psychiatrist = 3
- ☐ Behaviourally trained nurse = 4 Learning
- ☐ disability trained nurse = 5 Counsellor = 6
- ☐ Probation officer = 7
- ☐ No formal qualification = 8
- ☐ Other. = 9. Define:
- ☐ Not known = 99
- ☐ Question not applicable = 999
- ☐ Name of therapist:

18. Frequency of concurrent therapy (on average) (N.B. therapy is for perpetrating sexually abusive behaviour)

- ☐ ≥ 3 times per week = 1
- ☐ ≥ times per week = 2
- ☐ Once per week = 3
- ☐ once per fortnight = 4
- ☐ < once per fortnight = 5
- ☐ not known = 99
- ☐ question not applicable = 999

19. Duration of this current treatment to date (calculated backwards from the start of Men's Group)

☐ < 6 weeks = 1
☐ 7 - 12 weeks = 2
☐ 13 - 24 weeks = 3
☐ 25 - 52 weeks = 4
☐ > 52 weeks = 5
☐ not known = 99
☐ question not applicable = 999

20. Current Psychotropic Medications (please cross all categories that apply). *(Code Yes = 1, No = 2, Not known = 99)*

☐ Stimulants e.g. amphetamine, methylphenidate
☐ Antidepressants: tricyclic antidepressants, serotonergic antidepressants SSRIs (e.g.fluoxetine), Monoamine oxidase inhibitors
☐ Lithium
☐ Neuroleptics: phenothiazines (e.g. chlorpromazine), butyrophenones (e.g.haloperidol), thioxanthenes (e.g. flupenthixol)
☐ Minor tranquillizers: anxiolytic and hypnotic drugs e.g. benzodiazepines and antihistimines
☐ Anticonvulsants e.g. carbomazepine
☐ Antilibidinal e.g. androcur
☐
☐
☐ On no medications
☐ None of the medication types is known

Please list **ALL** medications that the participant is taking and dose:

Section 2: Background Information - Family

1. How many siblings or step siblings does the participant have?

- ☐ none = 1
- ☐ 1 sibling = 2
- ☐ 2 – 3 siblings = 3
- ☐ 4 – 5 siblings
- ☐ > 5 siblings
- ☐ not known = 99

2. Participant's primary residence as a child* (until age 18)

With at least one biological parent = 1

- ☐ with close relatives*= 2
- ☐ adopted/fostered = 3
- ☐ residential facility = 4
- ☐ hospital facility = 5
- ☐ multiple = 6
- ☐ not known = 99

3. If participant lived with *biological parents/step -parents, close relatives* or was *adopted/fostered*, please give parent's* main occupation during participant's childhood:

Parent One's Occupation: Parent

Two's Occupation:

4. During the participant's childhood, were there changes in main parents* (e.g. due to divorce, separation or new partners)?

Rarely/never (once or twice over duration of participant's childhood) = 1 Occasionally (every 2 – 5 years) = 2

- ☐ Frequently (>_ every 1 – 2 years) = 3
- ☐ Not known = 99

5. Death of participant's parent*? (only count if parent living with participant):

Yes = 1
No = 2

- ☐ Not known = 99

6. Age of participant when parent* died:

- ☐ <5 years of age = 1
- ☐ >6 - <12 years of age = 2 >12 - <18 years of age = 3 >_ 18 years of age=4
- ☐ not known = 99
- ☐ not applicable = 999

7. If participant lived in *residential facility* or *hospital facility*, please detail the number of years in care as a child:

- ☐ < 1 year = 1
- ☐ >_ 1 year - <5 years = 2
- ☐ >_ 5 years - <10 years = 3
- ☐ >_ 10 years = 4
- ☐ not known = 99
- ☐ question not applicable = 999

8. How many children does the participant have?

#

☐☐ number of biological children number of step children

9. How many of these children live with the participant?

#

☐☐ number of biological children living with participant number of step children living with participant

Section 3: Background Information - Education

1. **Age at which left school:**

2. **Attended Special Primary School?**
   - Yes = 1
   - No = 2
   - Not known = 99

3. **Attended Special Secondary School?**

Yes = 1
- No = 2
- Not known = 99

Section 4: Background Information - Medical/Psychiatric/Psychological Problems

1. **Please document any known cause of intellectual disability and any chronic medical conditions diagnosed in *childhood:***

Cause of Intellectual Disability: Other Medical Conditions:

2. **Did participant have contact with psychiatric/psychology/learning disability services as a *child*?***

Yes = 1
No = 2
Not known = 99

3. **Number of years in contact with psychiatric/psychology/learning disability services as a *child*:***

< 1 year = 1
1 - 2 years = 2
2 - 3 years = 3
3 - 4 years = 4 >4
years = 5 Not known
= 99
Not applicable = 999

4. Define participant's psychological/psychiatric problems in *childhood* (Please cross all categories that apply).
(Code: Yes = 1, No = 2, Not Known = 99).

The following categories relate to DSM-IV diagnoses. Please note that DSM-IV does not make a distinction between disorders diagnosed in childhood and adulthood, i.e. adults may be diagnosed with disorders in the section 'Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence.' Likewise children can be diagnosed with disorders in other parts of the manual e.g. mood disorders, anxiety disorders.

Intellectual Disability (i.e. DSM-IV diagnosis 'Mental Retardation') Learning Disorders (e.g. Reading Disorder, Mathematics Disorder) Motor Skills Disorder (e.g. Developmental Coordination Disorder)

☐ Communication Disorders (e.g. Expressive Language Disorder, Stuttering) Pervasive Developmental Disorders (e.g. Autistic Disorder, Asperger's Disorder)

☐ Attention-Deficit and Disruptive Behaviour Disorders (e.g. ADHD, Conduct Disorder) Feeding And Eating Disorders of Infancy or Early Childhood (e.g. Pica)

☐ Tic Disorders (e.g. Tourette's Disorder).

☐ Elimination Disorders (e.g. Encopresis, Enuresis).

☐ Other Disorders of Infancy, Childhood or Adolescence (e.g. Separation Anxiety Disorder).

☐ Please give details:

☐ Delirium, Dementia, and Amnestic and Other Cognitive Disorders

☐ Mental Disorders Due to a General Medical Condition Not Elsewhere Classified Substance Related Disorders

☐ Schizophrenia and Other Psychotic Disorders

☐ Mood Disorders

☐ Anxiety Disorders

☐ Somatoform Disorders

☐ Factitious Disorders*

☐ Dissociative Disorders* (e.g. Dissociative Identity Disorder)

☐ Sexual and Gender Identity Disorders

☐ Eating Disorders

☐ Sleep Disorders

☐ Impulse-Control Disorders Not Otherwise Classified

☐ Adjustment Disorders

☐ Personality Disorders. Define:

☐ Other Conditions that May Be a Focus of Clinical Attention. Give Details:

☐ It is not known whether the participant had any formal diagnoses of psychiatric/psychological problems in childhood.

☐

5. Has participant received therapy in *childhood* for any of the problems listed above? (Do not include therapy for perpetrating/suspected of perpetrating sexually abusive behaviour - refer to question 7)

Yes = 1

☐ No = 2
☐ Not known = 99
☐ Not applicable = 999
☐

6. If answer to question 5 is 'yes', please document the number of courses* of therapy in *childhood*: (Do not include therapy for perpetrating/suspected of perpetrating sexually abusive behaviour)

#

number of courses individual cognitive behaviour therapy (CBT) = 1 number of courses of group CBT = 2

number of courses of 'other' treatment = 3. Define:

☐ number of courses where therapy type is not known = 99

☐ Question not applicable = 999

☐ **7. Has the participant been convicted of any offences (i.e. including sexual offences) in *childhood*?**

yes = 1

no = 2

not known = 99

☐ **8. If answer to question 7 is 'yes', how many offences in *childhood* has the participant been convicted?**

☐

#

total number of convictions for other offences

total number ofconvictions for sexually abusive behaviour (details of these behaviours are coded in Section 8)

☐ Question not applicable = 999

☐

9. Please document the number of 'other' convictions for offences (i.e. excluding sexual offences) in *childhood*:

#	
☐	violence against the person e.g. murder, grievous bodily harm (gbh), actual bodily harm (abh)
☐	burglary/robbery/theft and handling stolen goods
☐	fraud and forgery
☐	criminal damage e.g. arson
☐	drug offences
☐	motoring offences
☐	other. Define:
☐	type of offence that participant convicted of in childhood is/are not known
☐	

☐ question not applicable = 999

10. Please document any known chronic medical conditions (including mental disorders) diagnosed in *adulthood:*

11. Does/has the participant have/had contact with psychiatric/psychology/learning disability services as an *adult*?

Yes = 1

No = 2

☐ Not known = 99

☐

☐

12. Number of years in contact with psychiatric/psychology/learning disability services as an *adult*?

< 1 year = 1

≥1 - <2 years = 2 >2 - <3 years =

3 ≥3 - <4 years = 4 >4 years = 5

☐ Not known = 99

☐ Not applicable = 999

☐

☐

☐

☐

13. Define psychological/psychiatric problems in *adulthood* (Please indicate all categories that apply) *(Code Yes = 1, No = 2, Not known = 99)*

The following categories relate to DSM-IV diagnoses. Please note that DSM-IV does not make a distinction between disorders diagnosed in childhood and adulthood, i.e. adults may be diagnosed with disorders in the section 'Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence.' Likewise children can be diagnosed with disorders in other parts of the manual e.g. mood disorders, anxiety disorders.

- ☐ Intellectual Disability (i.e. DSM-IV diagnosis 'Mental Retardation')
- ☐ Learning Disorders (e.g. Reading Disorder, Mathematics Disorder)
- ☐ Motor Skills Disorder (e.g. Developmental Coordination Disorder)
- ☐ Communication Disorders (e.g. Expressive Language Disorder, Stuttering)
- ☐ Pervasive Developmental Disorders (e.g. Autistic Disorder, Asperger's Disorder)
- ☐ Attention-Deficit and Disruptive Behaviour Disorders (e.g. ADHD, Conduct Disorder)
- ☐ Feeding And Eating Disorders of Infancy or Early Childhood (e.g. Pica)
- ☐ Tic Disorders (e.g. Tourette's Disorder).
- ☐ Elimination Disorders (e.g. Encopresis, Enuresis).
- ☐ Other Disorders of Infancy, Childhood or Adolescence (e.g. Separation Anxiety Disorder).
- ☐ Please give details:
- ☐ Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- ☐ Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
- ☐ Substance Related Disorders
- ☐ Schizophrenia and Other Psychotic Disorders
- ☐ Mood Disorders
- ☐ Anxiety Disorders
- ☐ Somatoform Disorders
- ☐ Factitious Disorders*
- ☐ Dissociative Disorders* (e.g. Dissociative Identity Disorder)
- ☐ Sexual and Gender Identity Disorders
- ☐ Eating Disorders
- ☐ Sleep Disorders
- ☐ Impulse-Control Disorders Not Otherwise Classified
- ☐ Adjustment Disorders
- ☐ Personality Disorders. Define:
- ☐ Other Conditions that May Be a Focus of Clinical Attention. Give Details:

☐ It is not known whether the participant had any formal diagnoses of psychiatric/psychological problems in childhood.

Has the participant received psychological treatment in *adulthood* for any of the problems listed above? (Do not include therapy for perpetrating/suspected of perpetrating sexually abusive behaviour - refer to Sections 7 & 8)

Yes = 1

No = 2
Not known = 99
Not applicable = 999

14. If answer to question 14 is 'yes,' please document the number of courses* of psychological treatment in *adulthood*:
(Do not include therapy for perpetrating/suspected of perpetrating sexually abusive behaviour)

	number of courses individual cognitive behaviour treatment (CBT) = 1 number of courses of group CBT = 2
	number of courses of 'other' treatment = 3. Define:
	number of courses where the type of therapy not known = 99

☐ Question not applicable = 999

#

16. Has the participant been convicted of any offences (i.e. excluding sexual offences) in *adulthood*?

yes = 1
no = 2
Not known = 99

17. If answer to question 16 is yes, how many 'other' offences (i.e. excluding sexual offences) in *adulthood* has the participant been convicted?

#
total number of convictions for 'other' offences Question not

☐
☐
☐

☐

Applicable =

Appendix 3: Mens Group Data Base I, II & III

999

Phase One
Version 4
25.7.03
19

18. Please indicate the number of convictions for each 'other' offences (i.e. excluding sexual offences) in *adulthood*:
(N.B. convictions for 'other' offences that occur during or following the group will be coded in phase two and three).

#	
☐	violence against the person e.g. murder grievous bodily harm (gbh), actual bodily harm (abh)
☐	burglary/robbery/theft and handling stolen goods
☐	fraud and forgery
☐	criminal damage e.g. arson
☐	drug offences
☐	motoring offences
☐	other. Define:
☐	type of offence that participant convicted of in adulthood not known
☐	

☐ question not applicable = 999

Section 5: Background Information - Sexual

1. Has the participant had any girlfriends/boyfriends*?

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

2. If answer to question 1 is 'yes', please indicate the number of girlfriends/boyfriends* the participant has had:

1 girlfriend/boyfriend = 1

2 - 3 girlfriends/boyfriends = 2 4 - 5

- ☐ girlfriends/boyfriends = 3 >5
- ☐ girlfriends/boyfriends = 4
- ☐ number of girlfriend(s)/boyfriend(s) not known = 99
- ☐
- ☐ Question not applicable = 999

☐

3. Has he (participant) had any sexual relationships* (presumed consensual) over the age of 16?

Yes = 1

No = 2

Not known = 99

☐

☐

☐ **4. If answer to question 3 is 'yes', please indicate the number of sexual relationships* (presumed consensual) the participant has had:**

1 sexual relationship = 1

2 - 3 sexual relationships = 2 4 - 5 sexual relationships = 3 >5 sexual relationships = 4

number of sexual relationships not known = 99

- ☐
- ☐ Question not applicable = 999
- ☐
- ☐
- ☐

☐

5. What is/are the perpetrator's sexual interest(s)? (Indicate all that apply) *(Code: Yes = 1, No = 2, Not Known = 99)*

- ☐ Adult men
- ☐ Adult women
- ☐ Male children
- ☐ Female children
- ☐ Animals
- ☐ None of perpetrator's (participant's) sexual interest(s) are known

Appendix 3: Mens Group Data Base I, II & III

Section 6: Background Information: History of Sexual Assaults (as Victim)

1. Has the participant been the victim of sexual assault in childhood and/or adulthood? (If 'no' or 'not known', then do not fill out the rest of the section.) (*In this situation, code questions 2 – 9 as: question not applicable = 999)*

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

A *set of sexual assaults* is defined as: the participant being the victim of any number of assaults with a specific perpetrator. Please note that sexual assaults may continue over a period of time (e.g. months/years), yet are still considered to be one 'set' of sexual assaults if the same perpetrator is implicated.

2. How many different sets of sexual assaults* has the participant suffered? (Do not count assaults by the same perpetrator as different assaults)

#

Total number of sets of sexual assaults

☐

3. **Please indicate the number of sexually abusive behaviours that occurred for the set(s) of sexual assaults:** (N.B. where man/research participant was victim. Each set of sexual assaults may have more than one type of sexually abusive behaviour).

#	
	Perpetrator masturbates victim
	Perpetrator masturbates in public place* Perpetrator performs oral sex on victim Victim made to masturbate perpetrator
	Victim made to perform oral sex on perpetrator
	Perpetrator: attempted/actual anal penetration of victim. Define type (if known):
	Victim made to penetrate other. Define type (if known):
	Perpetrator touch of victim's genitals and/or bottom and/or chest (unclothed)
	Perpetrator touch of victim's genitals and/or bottom and/or chest (through clothing)
	Victim made to touch perpetrator's genitals and/or bottom and/or breasts/chest (unclothed) Victim made to touch perpetrator's genitals and/or bottom and or breasts/chest (through clothing) Perpetrator performs indecent exposure
	Victim shown pornography
	Victim photographed pornographically Verbal sexual harassment by perpetrator Sadomasochistic sex
	Stalking behaviour
	Other. Define type

4. **Please indicate the number of sets of sexual assault(s)* where the perpetrator's gender is:** (N.B. the total number should add to equal the total for question 2).

	Male
	Female
#	Gender of perpetrator not known

5. Please indicate the number of sets of sexual assault(s)* where the perpetrator's relationship to victim (participant) was: (N.B. the total number should add to equal the total for question 2).

#	
	Female sibling/step sibling
	Male sibling/step sibling
	Female parent; adopted/foster/step parent
	Male parent; adopted/foster/step parent
	Other relative (e.g. uncle/auntie, grandparents, including step relatives) Close friend of participant
	Close friend of participant's parents
	Other service user
	Staff member
	Support person
	Acquaintance/Stranger
	Other. Define:
	Number of sets of sexual assaults where perpetrator's relationship to victim is not known

6. Number of sets of sexual assault(s)* where the victim (participant) was aged: (N.B. the total number should add to equal the total for question 2).

#	
	< 5 years old
	>5 – <12 years old
	>12 years of age, < 18 years of age adult
	>60 years old
	age of victim (participant) not known

Exact age of victim (participant) for each of the sets of sexual assaults (please list):

7. How many convictions have there been for sexual assaults against the victim (participant)?

#	
	Total number of convictions for sexual assaults on victim (participant)

8. How many convictions were there for: (N.B. the total number should add to equal the total for question 7).

#	
Buggery	
	Indecent assault on male/female
	Gross indecency between males
	Rape of a male/female
	Unlawful sexual intercourse with girl under 13 Unlawful sexual intercourse with girl under 16 Incest
	Abuse of position of trust
	Gross indecency with a child
	Stalking
	Indecent exposure
	Sexual harassment
	Other (e.g. procuration, abduction, bigamy, soliciting or importuning by a man. Define:
	Type of conviction not known
☐	question not applicable

9. Please take the one set of sexual assaults, where the sexual assaults continued over the longest period of time, and state how frequently this same one perpetrator sexually assaulted the victim (participant):

Once (includes numerous incidents with same perpetrator if occur only on one day)= 1 several times (total of 2 – 4 times over different days) = 2

	continuously over months = 3
☐	continuously over years = 4
☐	not known = 99
☐	
☐	
☐	

Section 7: Index Sexually Abusive Incident (as Perpetrator)

Index Sexually Abusive Incident (As Perpetrator) is defined as a sexually abusive behaviour that was the most recent in terms of the start of the Men's Group. *Sexually Abusive Behaviour* has been used in *Section 7* to refer to all sexual behaviour on a specific day where the other person/people is/are non consenting and/or would be regarded as illegal if it came to the attention of the police. This term refers to behaviours that have resulted in a conviction as well as those behaviours that have not come to the attention of the police, the court, or resulted in a conviction through the courts but which meet the above criteria.

1. **Brief description of what is documented/alleged to have happened:** (please include date of incident if possible).
2. **Please indicate the number of sexually abusive behaviours that occurred during index incident:** (N.B. where

man/research participant is perpetrator).

#

Perpetrator masturbates victim

Perpetrator masturbates in public place* Perpetrator performs oral sex on victim Victim made to masturbate perpetrator

Victim made to perform oral sex on perpetrator

Perpetrator: attempted/actual anal/vaginal penetration of victim. Define type (if known):

Victim made to penetrate other. Define type (if known):

Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (unclothed) Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (through clothing) Victim made to touch perpetrator's genitals and/or bottom and/or chest (unclothed) Victim made to touch perpetrator's genitals and/or bottom and/or chest (through clothing) Perpetrator performs indecent exposure

Victim shown pornography

Victim photographed pornographically Verbal sexual harassment by perpetrator Sadomasochistic sex

Stalking behaviour

Other. Define type

None of the sexually abusive behaviour(s) is/are known = 99

Appendix 3: Mens Group Data Base I, II & III

3. Number of victim(s) of index sexually abusive behaviour(s)?

- ☐ One = 1
- ☐ Two = 2
- ☐ Three = 3
- ☐ Four = 4
- ☐ Five = 5
- ☐ >_ six = 6
- ☐ not known = 99

4. Victim group that sexually abusive behaviour directed at:

- ☐ Individual only = 1
- ☐ Small group of people (2 - 5 people) = 2 General
- ☐ public = 3
- ☐ Combination of above types = 4
- ☐ Not known = 99
- ☐

5. Victim Gender:

- ☐ Male = 1
- ☐ Female = 2
- ☐ Both = 3
- ☐ Not known = 99
- ☐

6. Victim age range:

- ☐ <5 years old = 1
- ☐ >5 – <12 years old = 2
- ☐ >12 – <18 years old = 3
- ☐ Adult = 4
- ☐ >60 years old = 5
- ☐ Range of ages (general public) = 6
- ☐ Not known = 99

Exact age of victim(s) for each of the sets of sexual assaults (please list):

7. Victim's relationship to perpetrator:

- ☐ Own son/step son = 1
- ☐ Own daughter/step daughter = 2
- ☐ Female sibling/step sibling = 3
- ☐ Male sibling/step sibling = 4
- ☐ Female parent; adopted/foster/step parent = 5
- ☐ Male parent; adopted/foster/step parent = 6
- ☐ Other relative (e.g. uncle/auntie, grandparents, including step relatives) = 7
- ☐ Close friend of participant = 8
- ☐ Close friend of participant's parents = 9
- ☐ Other service user = 10 Staff member* = 11 Support person* = 15 Acquaintance/stranger = 12
- ☐ Combination of different relationships to victim = 13
- ☐ Other = 14. Define:
- ☐ Relationship of victim(s) to perpetrator not known = 99
- ☐
- ☐

8. Number of months/years since index sexually abusive behaviour: (calculate backwards from Men's Group start date).

- ☐ 0 – <1 year = 1
- ☐ 1 year – <2 years = 2
- ☐ >2 years – <3 years = 3
- ☐ >3 years = 4
- ☐ not known = 99

9. Was participant interviewed by police in relation to index sexually abusive incident?

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

10. Did participant appear in court (or participant's case go to court) in relation to index sexually abusive incident?

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99
- ☐ Not applicable = 999

11. Legal outcome of index sexually abusive behaviour:

- ☐ Found unfit to plead = 1
- ☐ Community Rehabilitation Order (used to be probation order) = 2
- ☐ Community Treatment Order = 3
- ☐ Guardianship Order = 4
- ☐ Hospital Order = 5
- ☐ Prison/Custodial Sentences for Young Offenders = 6
- ☐ Cautioned = 7
- ☐ Acquitted/Absolute Discharge = 8
- ☐ Case Dropped = 9
- ☐ Fined/Payment of Damages = 10
- ☐ Conditional Discharge = 11
- ☐ Supervision Order = 12
- ☐ Community Punishment Order (used to be Community Service Order) = 13 Community
- ☐ Punishment and Rehabilitation Order (used to be Combination Order) = 14 Fully/Partly
- ☐ Suspended Sentence = 15
- ☐ Other (e.g. Attendance Centre Order, Care Order, Custody under Children and Young Persons Act, Curfew Order) = 16. Define:
- ☐ Not known = 99
- ☐ Not applicable = 999

12. If convicted, of what offence was the participant convicted?

- ☐ Buggery = 1
- ☐ Indecent assault on male/female = 2
- ☐ Gross indecency between males = 3
- ☐ Rape of a man/woman = 4
- ☐ Unlawful sexual intercourse with girl under 13. = 5 Unlawful
- ☐ sexual intercourse with girl under 16. = 6 Incest = 7
- ☐ Abuse of position of trust = 8
- ☐ Gross indecency with a child = 9
- ☐ Stalking = 10
- ☐ Indecent exposure = 11
- ☐ Sexual harassment = 12
- ☐ Other = 13 (e.g. procuration, abduction, bigamy, soliciting or importuning by a man. Define:
- ☐ Type of conviction not known = 99
- ☐ Not applicable = 999
- ☐
- ☐

Appendix 3: Mens Group Data Base I, II & III

25.7.03
30

13. Social outcome for participant of index sexually abusive behaviour: (Indicate all categories that apply) *(Code Yes = 1, No = 2, Not known = 99)*

- ☐ change of residential placement
- ☐ loss of job/change of work placement specialist
- ☐ treatment/therapy
- ☐ verbal reprimand
- ☐ loss of 'privileges' e.g. cigarettes or outings increased
- ☐ supervision
- ☐ medication. Define:
- ☐ nothing (i.e. there were no social outcomes) other.
- ☐ Define:
- ☐

None of the social outcomes is known = 99

☐

14. Relationship status at the time of index sexually abusive behaviour

single = 1

- ☐ married/cohabiting = 2
- ☐ divorced/separated = 3
- ☐

widowed = 4

in relationship but not living together = 5

not known = 99

15. Contact with family (e.g. parents/siblings) at time of index sexually abusive behaviour

lives with parents/siblings = 1

- ☐ frequent (once every week or two weeks) = 2
- ☐ medium frequency (twice every month) = 3
- ☐ occasionally (less than once per month, more than once per 6 months) = 4 rare (less than once every 6 months) = 5
- ☐ no contact = 6
- ☐ not known = 99
- ☐

16. Residential status at time of index sexually abusive behaviour

- ☐ own home (supported) = 1
- ☐ own home (unsupported) = 2
- ☐ with family (or close relative) = 3
- ☐ group/residential home = 4
- ☐ secure environment - low secure = 5
- ☐ secure environment - medium secure = 6
- ☐ secure environment - high secure = 7
- ☐ with support person in support person's home=8
- ☐ not known = 99

17. Employment status at time of index sexually abusive behaviour

- ☐ day centre = 1
- ☐ supported work experience = 2
- ☐ college/adult education = 3
- ☐ part time paid employment = 4
- full time paid employment = 5
- no day activity/employment = 6
- combination of employment types = 7
- not known = 99

18. Substance Abuse (include alcohol) at time of index sexually abusive behaviour

- ☐ Yes = 1. Define: No
- ☐ = 2
- ☐ Not known = 99

19. Please describe any life events that you would consider a trigger to the index sexually abusive behaviour. (Do not assume that it is a life event trigger unless it happened in the 3 months leading up to the index sexually abusive behaviour).

20. Please describe the amount of information available in the file to substantiate allegations that participant was the perpetrator of sexually abusive behaviour:

None: There was nothing but a passing mention of suspicion in the notes or there may be no documentation in the clinical notes that the participant was suspected of perpetrating sexually abusive behaviour = 1

- ☐ Some: There is some documentation of suspicions throughout the notes that the person had perpetrated sexually abusive behaviour. However, there may only be limited independent documentation to substantiate that the abuse occurred (e.g. staff observed participant and another person coming out of a bedroom, one or both looking dishevelled; person with intellectual disability says that they've been assaulted by participant, on further questioning person changes their account) = 2
- ☐ Much: there is documented evidence from a number of different sources that the participant engaged in sexually abusive behaviour, such as eye witness accounts, documentation regarding his conviction = 3

☐

Section 8: Background Information - History of Sexually Abusive Incidents (as Perpetrator)

1. **Has the participant engaged in any other sexually abusive behaviours in the past (do not include Index Sexually Abusive Incident.** If 'no' or 'not known' – there is no need to answer the rest of this section). *(In this situation, Code questions 2 - 17 as: Question not applicable = 999)*

Yes = 1
No = 2
Not known = 99

Please note:

Do not include *Index Sexually Abusive Incident* (i.e. the abusive incident described in Section 7) in calculations for the below questions, unless otherwise stated.

Please include any sets of sexual assaults when the perpetrator (participant) is a child.

'Sets of Assaults': Assaults on different identifiable victims even if they occur on the same day are coded as different sets of sexual assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time.

If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults.

If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults.

2. **How many different sets of sexual assault(s)* did the research participant perpetrate?**

#
Total number of sets of sexual assaults

3. Please indicate the number of sexually abusive behaviours that occurred for the set(s) of sexual assaults: (N.B. where man/research participant is perpetrator. Each set of sexual assaults may have more than one type of sexually abusive behaviour).

#	
	Perpetrator masturbates victim
	Perpetrator masturbates in public place* Perpetrator performs oral sex on victim Victim made to masturbate perpetrator
	Victim made to perform oral sex on perpetrator
	Perpetrator: attempted/actual anal/vaginal penetration of victim. Define type (if known):
	Victim made to penetrate other. Define type (if known):
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (unclothed)
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (through clothing)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (unclothed)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (through clothing)
	Perpetrator performs indecent exposure
	Victim shown pornography
	Victim photographed pornographically Verbal sexual harassment by perpetrator Sadomasochistic sex
	Stalking behaviour
	Other. Define type

4. What age was the participant when he first perpetrated each different set of sexual assault(s)*? (N.B. the total number should add to equal the total for question 2).

#	
	number of sets of sexual assaults when perpetrator aged >5 – <12 years old
	number of sets of sexual assaults when perpetrator aged >12 years, < 18 years of age
	number of sets of sexual assaults where perpetrator an adult
	number of sets of sexual assaults where perpetrator >60 years old
	number of sets of sexual assaults where age of perpetrator not known

Exact age of perpetrator when he first perpetrated each different set of sexual assaults (please list):

5. Please indicate the number of sets of sexual assault(s)*where the victim's gender is: (N.B. the total number should add to equal the total for question 2).

#	
	male
	female
	both (e.g. general public) gender
	of victim not known

6. Please indicate the number of sets of sexual assault(s)* where the victim's relationship to the perpetrator (participant) was: (N.B. The total number should add to equal the total for question 2)

#	
	Own son/step son
	Own daughter/step daughter
	Female sibling/step sibling
	Male sibling/step sibling
	Female parent; adopted/foster/step parent
	Male parent; adopted/foster/step parent
	Other relative (e.g. uncle/auntie, grandparents, including step relatives) Close friend of participant
	Close friend of participant's parents
	Other service user
	Staff member*
	Support person*
	Acquaintance/Stranger
	Other. Define:
	Number of sets of sexual assaults where relationship of victim to perpetrator not known

7. Please indicate the number of sets of sexual assault(s)* where the victim was aged: (N.B. The total number should add to equal the total for question 2)

#	
	<5 years old
	>5 – <12 years old
	>12 – <18 years old
	adult
	>60 years old
	range of ages (e.g. general public) age of
	victim not known

Exact age of victim for each of the sets of sexual assaults (please list):

8. Please indicate the number of times the perpetrator (participant) has been interviewed by the police/come to the attention of the police, in relation to sets of sexual assaults*: (N.B. If all interviews with the police are regarding one set of sexual assaults then please code as one interview. Two interviews would be coded if the participant was interviewed by the police/came to the attention of the police for two different sets of sexual assaults)

#

Numbers of interviews with police/times come to the attention of the police

☐ **9. Please indicate the number of times the perpetrator's (participant's) case has gone to court (N.B. each set of sexual assaults counts as only one court case if the case proceeded to court):**

#

Number of times perpetrator's case gone to court

10. Number of times legal outcome of court appearance for sets of sexual assaults* was:

#

Found unfit to plead
Community Rehabilitation Order (used to be Probation Order)

☐ Community Treatment Order
☐ Guardianship Order
☐ Hospital Order
☐ Prison/Custodial Sentences for Young Offenders
☐ Cautioned
☐ Acquitted/Absolute Discharge
☐ Case dropped
☐ Fined/Payment of Damages
☐ Conditional Discharge
☐ Supervision Order
☐ Community Punishment Order (used to be Community Service Order)
☐ Community Punishment and Rehabilitation Order (used to be Combination Order) Fully/Partly Suspended Sentence
☐ Other (e.g. Attendance Centre Order, Care Order, Custody under Children and Young Persons Act, Curfew Order). Define:
☐ Number of times legal outcome not known
☐

☐

11. If convicted for <u>sets of sexual assaults</u>*, please indicate the number of convictions for:

#	
	buggery
	indecent assault on male/female
	gross indecency between males
	rape of a man/woman
	unlawful sexual intercourse with girl under 13 unlawful sexual intercourse with girl under 16 incest
	abuse of position of trust
	gross indecency with child
	stalking
	indecent exposure
	sexual harassment
	other (e.g. procuration, abduction, bigamy, soliciting or importuning by a man. Define:
	number of times type of conviction not known

12. Number of times where the social outcome of a set of sexual assaults was: (N.B. each set of sexual assaults may have more than one social outcome associated with it).

#	
	change of residential placement
	loss of job/change of work placement
	specialist treatment/therapy e.g. psychology sessions verbal reprimand
	loss of 'privileges' e.g. cigarettes or outings increased supervision
	medication. Define:
	other. Define:
	nothing (i.e. there were no social outcomes)
	number of sets of sexual assaults where social outcome not known

13. If in question 12, participant receives specialist treatment (or participant has received treatment for perpetrating sexual abuse at any time in past, including following Index Sexual Assault), please give the number of different courses* of each type of treatment:

#	
	individual cognitive behavioural
	group cognitive behavioural (non SOTSEC-ID model). Define:
	group cognitive behavioural (SOTSEC-ID model)
	monthly maintenance group (or similar)
	number where type of previous therapy for sexually abusive behaviour not known
	other: Define:

☐ Question not applicable (i.e. participant has never received any treatment for perpetrating sexual abuse) **14. Number of times where relationship status at time of a <u>set(s) of sexual assault(s)*</u> was:**

#	
	single
	married/cohabiting
	divorced/separated
	widowed
	in relationship but not living together
	relationship status not known

15. Number of times where residence at time of <u>sets of sexual assault(s)*</u> was:

#	
	own home (supported)
	own home (unsupported)
	family (or close relative)
	group/residential home
	secure environment – low secure
	secure environment – medium secure
	secure environment – high secure
	with support person in support person's home residence
	not known

16. How often did participant (perpetrator) use illicit substances (include alcohol) at time of sets of sexual assault(s)* (N.B. average percentage of time that participant used illicit substances over the different sets of sexual assaults may need to be estimated)

- ☐ never/not known = 1.
- ☐ rarely (e.g. less than approximately 10% of time on average, over the different sets of sexual assaults) = 2
- ☐ sometimes (e.g. approximately 11 – 50% of the time on average, over the different sets of sexual assaults) = 3
- ☐ often (e.g. approximately 51 – 75% of the time on average, over the different sets of sexual assaults) = 4
- ☐ majority of the time (approximately greater than 75% of the time on average over the different sets of sexual assaults) = 5
- ☐

17. Please take the one set of sexual assaults, where the sexual assaults continued over the longest period of time, and state how frequently the perpetrator (participant) sexually assaulted the same victim:

- ☐ Once (includes numerous incidents with same victim if occur only on one day) = 1 several times (total of 2 – 4 times over different days) = 2
- ☐ continuously over months = 3
- ☐ continuously over years = 4
- ☐ not known = 99

18. Taking all sets of sexual assaults, does the participant predominantly perpetrate contact or non-contact sexually abusive behaviours? (Please cross only one of the two options below).

☐ Predominantly contact sexually abusive behaviours = 1 Predominantly non contact sexually abusive behaviours = 2

☐

Appendix 3: Mens Group Data Base I, II & III

MEN'S GROUP BACKGROUND INFORMATION AND DATA BASE SCHEDULE

PHASE TWO

Purpose

The purpose of the schedule is to provide a systematic way of gathering background information on each of the men who have agreed to participate in the SOTSEC-ID research. A further purpose of the schedule is to provide codes for entering data onto the database.

Introduction

The Men's Group Background Information and Data Base Schedule was designed to provide a way of coding information following a clinical interview or whilst reviewing a participant's medical or other health records. The Men's Group Background Information and Data Base Schedule is split into three phases:

- Phase One collects demographic and background information for participants prior to the beginning of the Men's Group.
- Phase Two collects information at the completion of the Men's Group
- Phase Three collects information at 6 months follow-up.

Phase Two contains 2 sections designed to obtain demographic information at completion of the Men's Group and to document any incidents of the participant perpetrating sexually abusive behaviour during the year duration that the Men's Group has been running.

Section 1: Demographic Data Phase Two: Gathers demographic information for the participant at the conclusion of the group.

Section 2: New Sexually Abusive Incidents (as Perpetrator): Gathers information on any incidents of sexually abusive behaviour perpetrated by the participant during the year that the Men's group runs.

Categories for some of the questions are based on findings in previous studies/publications including:

A. Kalinsky (personal communication July 24, 2003). The Offenders Index Codebook. November 2002.

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
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Appendix 3: Mens Group Data Base I, II & III

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Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

Appendix 3: Mens Group Data Base I, II & III

Definitions

Boyfriend is used in the schedule to refer to any man defined by the participant as their 'boyfriend.' The nature of this relationship would usually be more intimate than a plutonic friendship with the same sex, and may refer to a (presumed) consensual sexual relationship.

Child is someone who is 18 years or younger.

Close Relatives: refers to any relative or step relative. For example, auntie/uncle, grandparents/stepgrandparents, brother/sister, step brother/sister.

Course of Therapy refers to a block of therapy designed to help the individual with a specific problem.

Dissociative Disorders. In DSM-IV the 'essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment' (p. 477). Please refer to DSM-IV for further information on Dissociative Disorders.

Factitious Disorders in DSM-IV are 'characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role... [and] are distinguished from acts of Malingering. In Malingering, the individual also produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known. For example, the intentional production of symptoms to avoid jury duty, standing trial or conscription into the military would be classified as Malingering' (p. 471). Please refer to DSM-IV for further information on Factitious Disorders.

Formal Education includes attendance at primary school, secondary school/college and any further approved education course.

Girlfriend is used in the schedule to refer to any woman defined by the participant as their 'girlfriend.' Usually the nature of this relationship would be more intimate than a plutonic friendship with the opposite sex, and may refer to a (presumed) consensual sexual relationship.

Offence has been defined in this schedule as a behaviour that has resulted in a conviction through the courts.

Parent refers to primary adult responsible for caring for the individual. For example biological parents, adopted parents, same sex parents or anyone defined by the participant as their 'parent' as long as this does not include persons paid to look after the participant.

Public Place: Please note the following:

- If the participant engages in self only masturbation, whilst alone in a <u>public</u> place, but in <u>private</u> area (where others cannot gain access or accidentally come across him/discover

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

him) – this is NOT coded as a sexual assault (For example if participant goes to public place, e.g. sports centre, and masturbates in a locked private toilet cubicle).

- If the participant engages in self only masturbation whilst either alone or in presence of others, in a public place but not in a private area (where others may discover him, even if he thinks he is hiding) – this is CODED as a sexual assault regardless of whether there is/are identifiable victim(s). (For example, the following would be coded as a sexually abusive incident: 1) if participant goes to public place, e.g. sports centre, and masturbates in general toilet area, where there is the potential for him to be discovered by public. 2) if participant goes to public place, e.g. railway bridge/park, and masturbates by bridge/in park behind a tree where he thinks he is hiding but where could be discovered by public).

These definitions exclude behaviours such as voyeurism, where the participant may be masturbating in a locked private area following viewing nudity or sexual activity of another person without their knowledge and consent. This definition also excludes a perpetrator (participant) masturbating a victim, or masturbation in front of a victim in a private and locked area (e.g. bedroom). In addition, this definition excludes other illegal sexual behaviours that may occur in private areas.

Set of Sexual Assaults (Section 2) is/are defined as the participant being the perpetrator of any number of sexual assaults with a specific victim. Assaults on different victims, even if they occur on the same day, are coded as different 'sets' of assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time (e.g. months/years). If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults. If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexually Abusive Behaviour is defined as occurring when the other person is non-consenting and/or the behaviour(s) would be regarded as illegal if it came to the attention of the police. This term refers to behaviours that have resulted in a conviction as well as those behaviours that have not come to the attention of the police, the court, or resulted in a conviction through the courts but which meet the above criteria. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexual Relationship(s) refers to (presumed consensual) sexual experiences with a specific partner (of legal age). For example, where the individual has had a number of different sexual experiences with the same partner, the experiences are coded as one sexual relationship. Sexual contact could include such behaviours as genital touching, kissing, mutual masturbation, intercourse, oral sex etc.

Support Person refers to an individual who is paid to look after a person with intellectual disabilities in the support person's own home. This includes adult placements and adult foster arrangements.

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

Staff refers to employees of institution (e.g. residential facility, hospital) who are paid to care for the individual.

Type of Concurrent Therapy. Please indicate only one type of therapy under this section. Where the therapist is adopting an eclectic approach for working with the participant, please determine the predominant type of therapy that is being given.

Instructions for use

Please cross ☒ categories that apply, by clicking in the relevant box(es). Please only cross one box on questions requiring a Yes/No response. You may cross as many categories as are relevant for open-ended questions. Some questions require you to calculate the number of times a particular behaviour has occurred. Please put the number in the relevant box.

Please fill in as much information as possible for each of the questions. If there is no documentary information for a particular question then please state underneath the question that there is no information documented.

If the question does not have the response that is needed please use space underneath the question to document what is written in the file.

Questions/phrases with further explanations in the 'definitions' section are indicated by a *.

Please complete

Name of person filling out form:

Please indicate where information for filling out the schedule was obtained (more than one may apply):

- ☐ Clinical interview with individual
- ☐ Clinical interview with family/carer/key worker/doctor/probation officer
- ☐ Learning Disability Service clinical records
- ☐ Psychiatry clinical records
- ☐ Social services clinical records
- ☐ Other. Define:

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

Appendix 3: Mens Group Data Base I, II & III

Section 1: Demographic Data

The purpose of this section is to gather demographic data for the participant at the end of the Men's Group. Questions refer to all men (i.e. men who received treatment and those who were control participants) unless otherwise stated).

1. **Participant's first name**:

2. **Initial of participant's last name**

3. **Participant's date of birth**: (dd/mm/yyyy)

4. **Participant's research status: (Please cross only one of the options below).**

   ☐ Participating in research as treatment participant = 1
   ☐ Participating in research as control participant (i.e. is not receiving group CBT treatment according to SOTSEC-ID model) = 2

5. **Location of Men's Group**:

6. **Name of lead facilitator**:

7. **Group start date**: (dd/mm/yyyy)

8. **Group end date**: (dd/mm/yyyy)

9. **Date(s) that filling out this form:**

10. **Did the participant complete the Men's Group (Treatment participant only):**

    ☐ Yes = 1
    ☐ No = 2
    ☐ Question not applicable = 999

11. **If the man did not complete the Men's Group, what was the reason: (Treatment participant only)**

    ☐ Left following completion of statutory requirement to attend treatment (despite treatment not being complete) = 1
    ☐ Did not wish to continue (and no statutory requirement to continue) = 2
    ☐ Was asked to leave by facilitators because was not coping intellectually/socially with the demands of the group = 3
    ☐ Committed another offence and was unable to keep coming due to legal process = 4. Define legal processes e.g. put in prison:
    ☐ Other = 5. Define:
    ☐ Question not applicable = 999

Appendix 3: Mens Group Data Base I, II & III

12. Residential status at end of group:

- ☐ own home (supported) = 1
- ☐ own home (unsupported) = 2
- ☐ family (or close relative) = 3
- ☐ group/residential home = 4
- ☐ secure environment - low secure = 5
- ☐ secure environment - medium secure = 6
- ☐ secure environment - high secure = 7
- ☐ with support person* in support person's home = 8

13. Legal status at end of group:

- ☐ Informal = 1
- ☐ Under Mental Health Act = 2. Define Section
- ☐ Community Rehabilitation Order (used to be Probation Order) = 3. Define length and conditions:
- ☐ Guardianship Order = 4. Define conditions:

14. Level of security/escort required by participant when in community?

- ☐ no escort required = 1
- ☐ 1:1 escort required = 2
- ☐ 2:1 escort required = 3
- ☐ 3:1 escort required = 4
- ☐ no community outings regardless of number of escorts = 5

At the start of the Men's Group X was receiving (type of therapy) with (Name of therapist). Please indicate below if this therapy is continuing, or when the therapy ceased.

15. Therapy at start of (and concurrent to) the Men's Group continuing?

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99
- ☐ Not applicable = 999

If therapy has ceased, please write the date that the therapy finished:

Date therapy finished: (dd/mm/yyyy)

Appendix 3: Mens Group Data Base I, II & III

16. Has the participant received any new therapy during the year the Men's Group ran? (do not include that mentioned in question 15).

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

17. Reason for participant receiving new therapy during the year that the Men's Group ran: (N.B. Indicate all that apply) *(Code Yes = 1, No = 2, Not known = 99, Not Applicable = 999)*

- ☐ Perpetrating sexually abusive behaviour
- ☐ Other. Define:
- ☐ Not known
- ☐ Not applicable

18. Type of therapy. Please only complete if answer to question 17 is 'perpetrating sexually abusive behaviour':

- ☐ Individual cognitive behaviour therapy = 1
- ☐ Group cognitive behavioural therapy (excluding Men's Group) = 2
- ☐ 'Other' type of concurrent therapy = 3. Define:
- ☐ Not known = 99
- ☐ Not applicable = 999

19. Professional conducting therapy (N.B. Therapy is for 'perpetrating sexually abusive behaviour')

- ☐ Clinical psychologist = 1
- ☐ Social worker = 2
- ☐ Psychiatrist = 3
- ☐ Behaviourally trained nurse = 4
- ☐ Learning disability trained nurse = 5
- ☐ Counsellor = 6
- ☐ Probation officer = 7
- ☐ No formal qualification = 8
- ☐ Other = 9. Define:
- ☐ Not known = 99
- ☐ Not applicable = 999

Name of therapist:

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

20. Frequency of therapy (on average) (N.B. therapy is for 'perpetrating sexually abusive behaviour').

- ☐ ≥3 times per week = 1
- ☐ 2 times per week = 2
- ☐ once per week = 3
- ☐ once per fortnight = 4
- ☐ < once per fortnight = 5
- ☐ not known = 99
- ☐ not applicable = 999

21. Current Psychotropic Medications (please indicate all categories that apply). (Code Yes = 1, No = 2, Not known = 99)

- ☐ Stimulants e.g. amphetamine, methylphenidate
- ☐ Antidepressants: tricyclic antidepressants, serotonergic antidepressants SSRIs (e.g.fluoxetine), Monoamine oxidase inhibitors
- ☐ Lithium
- ☐ Neuroleptics: phenothiazines (e.g. chlorpromazine), butyrophenones (e.g.haloperidol), thioxanthenes (e.g. flupenthixol)
- ☐ Minor tranquillizers: anxiolytic and hypnotic drugs e.g. benzodiazepines and antihistimines
- ☐ Anticonvulsants e.g. carbomazepine
- ☐ Antilibidinal e.g. androcur

- ☐ On no medications
- ☐ Not known

Please list **ALL** medications that the participant is taking and dose:

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

22. Please document the <u>number</u> of 'other' convictions for offences (i.e. not including sexual offences) that occur during the year that the Men's Group runs. (N.B. convictions for other offences that occur **following** the completion of group will be coded in *Phase Three*).

#	
	Violence against the person e.g. murder.
	Burglary/robbery/theft and handling stolen goods.
	Fraud and forgery.
	Criminal damage e.g. arson.
	Drug offences.
	Motoring offences.
	Other. Define:

Appendix 3: Mens Group Data Base I, II & III

Section 2: New Sexually Abusive Incidents* (as Perpetrator)

1. **Has the participant engaged in any other sexually abusive incidents during the year that the Men's Group has been running?** If 'no' or 'not known' – there is no need to answer the rest of this section). *(In this situation, code questions 2 – 17 as: Question not applicable = 999).*

   ☐ Yes = 1
   ☐ No = 2
   ☐ Not known = 99

Please note:

All questions relate to sets of sexual assaults that were perpetrated during the year (not necessarily calendar year) that the Men's Group was running.

'Sets of Assaults': Assaults on different identifiable victims even if they occur on the same day are coded as different sets of assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time.

If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults.

If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults.

2. **How many different sets of sexual assault(s) did the participant perpetrate during the year that the Men's Group has been running?**

   #
   ☐ Total number of sets of sexual assaults

3. **Brief description of what is documented/alleged to have happened for each set of sexual assaults*:** (please include the dates of incident(s) if possible).

Description of set of sexual assaults:

Description of set of sexual assaults:

Description of set of sexual assaults:

Description of set of sexual assaults:

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

4. **Please indicate the number of sexually abusive behaviours that occurred for the set(s) of sexual assaults, perpetrated during the year of the Men's Group**: (N.B. where man/research participant is perpetrator. Each set of sexual assaults may have more than one type of sexually abusive behaviour).

#	
	Perpetrator masturbates victim
	Perpetrator masturbates in public place*
	Perpetrator performs oral sex on victim
	Victim made to masturbate perpetrator
	Victim made to perform oral sex on perpetrator
	Perpetrator: attempted/actual anal/vaginal penetration of victim. Define type (if known):
	Victim made to penetrate other. Define type (if known):
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (unclothed)
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (through clothing)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (unclothed)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (through clothing)
	Perpetrator performs indecent exposure
	Victim shown pornography
	Victim photographed pornographically
	Verbal sexual harassment by perpetrator
	Sadomasochistic sex
	Stalking behaviour
	Other. Define type

5. **Please indicate the number of sets of sexual assault(s)*where the victim's gender is:** (N.B. the total number should add to equal the total for question 2).

#	
	male
	female
	both (e.g. general public)
	gender of victim not known

Appendix 3: Mens Group Data Base I, II & III

6. **Please indicate the number of sets of sexual assault(s)* where the victim's relationship to the perpetrator (participant) was:** (N.B. The total number should add to equal the total for question 2)

#	
	Own son/step son
	Own daughter/step daughter
	Female sibling/step sibling
	Male sibling/step sibling
	Female parent; adopted/foster/step parent
	Male parent; adopted/foster/step parent
	Other relative (e.g. uncle/auntie, grandparents, including step relatives)
	Close friend of participant
	Close friend of participant's parents
	Other service user
	Staff member*
	Support person*
	Acquaintance/Stranger
	Other. Define:
	Number of sets of sexual assaults where relationship of victim to perpetrator not known

7. **Please indicate the number of sets of sexual assault(s)* where the victim was aged:** (N.B. The total number should add to equal the total for question 2)

#	
	< 5 years old
	≥5 – <12 years old
	≥12 – <18 years old
	adult
	≥60 years old
	range of ages (e.g. general public)
	age of victim not known

Exact age of victim for each of the sets of sexual assaults (please list):

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

8. **Please indicate the number of times the perpetrator (participant) has been interviewed by the police/come to the attention of the police, in relation to sets of sexual assaults* perpetrated during the year of the Men's Group:** (N.B. If all interviews with the police are regarding one set of sexual assaults then please code as one interview. Two interviews would be coded if the participant was interviewed by the police/came to the attention of the police for two different sets of sexual assaults)

#	
☐	Numbers of interviews with police/times come to the attention of the police

9. **Please indicate the number of times the perpetrator's (participant's) case has gone to court or is proceeding to court (N.B. if case is proceeding to court, each set of sexual assaults is coded as one court case):**

#	
☐	Number of times perpetrator's case gone to court/or is proceeding to court

10. **Number of times legal outcome of court appearance for sets of sexual assaults* was:** (In unusual circumstances a man (X) may have appeared in court for two different sets of sexual assaults that occurred on the same day (NB this equals two victims and two court appearances). When coding the legal outcome of court appearances, the outcome for each set of sexual assaults is coded separately (and then added together below). For example, X may receive a supervision order following his appearances in court. However, as this outcome relates to two sets of sexual assaults (i.e. two victims), two supervision orders are coded.

#	
☐	Found unfit to plead
☐	Community Rehabilitation Order (used to be Probation Order)
☐	Community Treatment Order
☐	Guardianship Order
☐	Hospital Order
☐	Prison/Custodial Sentences for Young Offenders
☐	Cautioned
☐	Acquitted/Absolute Discharge
☐	Case dropped
☐	Fined/Payment of Damages
☐	Conditional Discharge
☐	Supervision Order
☐	Community Punishment Order (used to be Community Service Order)
☐	Community Punishment and Rehabilitation Order (used to be Combination Order)
☐	Fully/Partly Suspended Sentence
☐	Other (e.g. Attendance Centre Order, Care Order, Custody under Children and Young Persons Act, Curfew Order). Define:
☐	Number of times legal outcome not known/awaiting outcome of court case

Appendix 3: Mens Group Data Base I, II & III

11. If convicted for sets of sexual assaults*, please indicate the number of convictions for: (If convicted for 1 victim, this = 1; if convicted for 2 victims, this = 2 etc).

#	
	buggery
	indecent assault on male/female
	gross indecency between males
	rape of a man/woman
	unlawful sexual intercourse with girl under 13
	unlawful sexual intercourse with girl under 16
	incest
	abuse of position of trust
	gross indecency with child
	stalking
	indecent exposure
	sexual harassment
	other (e.g. procuration, abduction, bigamy, soliciting or importuning by a man. Define:
	number of times type of conviction not known/awaiting outcome of court case

12. Number of times where the social outcome of a set of sexual assaults* was: (N.B. each set of sexual assaults may have more than one social outcome associated with it. Please add together social outcomes for all sets of sexual assaults).

#	
	change of residential placement
	loss of job/change of work placement
	specialist treatment/therapy e.g. psychology sessions
	verbal reprimand
	loss of 'privileges' e.g. cigarettes or outings
	increased supervision
	medication. Define:
	other. Define:
	nothing (i.e. there were no social outcomes)
	number of sets of sexual assaults where social outcome not known

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

13. Number of times where relationship status at time of a set(s) of sexual assault(s)* was:

#	
	single
	married/cohabiting
	divorced/separated
	widowed
	in relationship but not living together
	relationship status not known

14. Number of times where residence at time of sets of sexual assault(s)* was:

#	
	own home (supported)
	own home (unsupported)
	family (or close relative)
	group/residential home
	secure environment – low secure
	secure environment – medium secure
	secure environment – high secure
	with support person in support person's home
	residence not known

15. How often did participant (perpetrator) use illicit substances (include alcohol) at time of sets of sexual assault(s)* (N.B. average percentage of time that participant used illicit substances over the different sets of sexual assaults may need to be estimated)

- ☐ never/not known = 1.
- ☐ rarely (e.g. less than approximately 10% of time on average, over the different sets of sexual assaults) = 2
- ☐ sometimes (e.g. approximately 11 – 50% of the time on average, over the different sets of sexual assaults) = 3
- ☐ often (e.g. approximately 51 – 75% of the time on average, over the different sets of sexual assaults) = 4
- ☐ majority of the time (approximately greater than 75% of the time on average over the different sets of sexual assaults) = 5

Appendix 3: Mens Group Data Base I, II & III

Version 4 (Final Version)
1.12.03E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Two.doc

16. Please take the <u>one set</u> of sexual assaults, where the sexual assaults continued over the longest period of time, and state how frequently the perpetrator (participant) sexually assaulted the same victim:

- ☐ Once (includes numerous incidents with same victim if occur only on one day) = 1
- ☐ several times (total of 2 – 4 times over different days) = 2
- ☐ continuously over months = 3
- ☐ continuously over years = 4 not
- ☐ known = 99

17. How many sets of sexual assaults were:

#

- ☐ Predominantly <u>contact</u> sexual assaults
- ☐ Predominantly <u>non-contact</u> sexual assaults

Appendix 3: Mens Group Data Base I, II & III

17 Phase Two

Appendix 3: Mens Group Data Base I, II & III

MEN'S GROUP BACKGROUND INFORMATION AND DATA BASE SCHEDULE

PHASE THREE

Purpose

The purpose of the schedule is to provide a systematic way of gathering background information on each of the men who have agreed to participate in the SOTSEC-ID research. A further purpose of the schedule is to provide codes for entering data onto the database.

Introduction

The Men's Group Background Information and Data Base Schedule was designed to provide a way of coding information following a clinical interview or whilst reviewing a participant's medical or other health records. The Men's Group Background Information and Data Base Schedule is split into three phases:

- Phase One collects demographic and background information for participants prior to the beginning of the Men's Group.
- Phase Two collects information at the completion of the Men's Group
- Phase Three collects information at 6 months follow-up.

Phase Three contains 2 sections designed to obtain demographic information at 6 months follow-up. In this phase any incidents of the participant perpetrating sexually abusive behaviour during the six months follow-up from the end of the Men's Group are also documented.

Section 1: Demographic Data Phase Three: Gathers demographic information for the participant at 6 months follow-up.

Section 2: New Sexually Abusive Incidents (as Perpetrator): Gathers information on any incidents of sexually abusive behaviour perpetrated by the participant during the six months from the end of the Men's Group.

Categories for some of the questions are based on findings in previous studies/publications including:

A. Kalinsky (personal communication July 24, 2003). The Offenders Index Codebook. November 2002.

Appendix 3: Mens Group Data Base I, II & III

Appendix 3: Mens Group Data Base I, II & III

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders.* Forth Edition, American Psychiatric Association, Washington D.C.

Research Development and Statistics Directorate (1998). *The Offenders Index: Codebook.* Home Office.

Research Development and Statistics Directorate (2003). Home Office Counting Rules for Recorded Crime. Home Office. Retrieved 24 July 2003, from http://www.homeoffice.gov.uk/rds/countrules.html

McCarthy, M. & Thompson, D. (1997). A prevalence study of sexual abuse of adults with intellectual disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities*, 10(2), 105 - 124.

Thompson, D. (1997). Profiling the sexually abusive behaviour of men with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 10(2), 125 - 139.

Appendix 3: Mens Group Data Base I, II & III

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Parent refers to primary adult responsible for caring for the individual. For example biological parents, adopted parents, same sex parents or anyone defined by the participant as their 'parent' as long as this does not include persons paid to look after the participant.

Public Place: Please note the following:

- If the participant engages in self only masturbation, whilst alone in a <u>public</u> place, but in <u>private</u> area (where others cannot gain access or accidentally come across him/discover

Appendix 3: Mens Group Data Base I, II & III

him) – this is NOT coded as a sexual assault (For example if participant goes to public place, e.g. sports centre, and masturbates in a locked private toilet cubicle).

- If the participant engages in self only masturbation whilst either alone or in presence of others, in a public place but not in a private area (where others may discover him, even if he thinks he is hiding) – this is CODED as a sexual assault regardless of whether there is/are identifiable victim(s). (For example, the following would be coded as a sexually abusive incident: 1) if participant goes to public place, e.g. sports centre, and masturbates in general toilet area, where there is the potential for him to be discovered by public. 2) if participant goes to public place, e.g. railway bridge/park, and masturbates by bridge/in park behind a tree where he thinks he is hiding but where could be discovered by public).

These definitions exclude behaviours such as voyeurism, where the participant may be masturbating in a locked private area following viewing nudity or sexual activity of another person without their knowledge and consent. This definition also excludes a perpetrator (participant) masturbating a victim, or masturbation in front of a victim in a private and locked area (e.g. bedroom). In addition, this definition excludes other illegal sexual behaviours that may occur in private areas.

Set of Sexual Assaults (Section 2) is/are defined as the participant being the perpetrator of any number of sexual assaults with a specific victim. Assaults on different victims, even if they occur on the same day, are coded as different 'sets' of assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time (e.g. months/years). If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults. If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexually Abusive Behaviour is defined as occurring when the other person is non-consenting and/or the behaviour(s) would be regarded as illegal if it came to the attention of the police. This term refers to behaviours that have resulted in a conviction as well as those behaviours that have not come to the attention of the police, the court, or resulted in a conviction through the courts but which meet the above criteria. Please also refer to definition of *public place* for coding sexual incidents of public masturbation by participant.

Sexual Relationship(s) refers to (presumed consensual) sexual experiences with a specific partner (of legal age). For example, where the individual has had a number of different sexual experiences with the same partner, the experiences are coded as one sexual relationship. Sexual contact could include such behaviours as genital touching, kissing, mutual masturbation, intercourse, oral sex etc.

Support Person refers to an individual who is paid to look after a person with intellectual disabilities in the support person's own home. This includes adult placements and adult foster arrangements.

Appendix 3: Mens Group Data Base I, II & III

Appendix 3: Mens Group Data Base I, II & III

Staff refers to employees of institution (e.g. residential facility, hospital) who are paid to care for the individual.

Type of Concurrent Therapy. Please indicate only <u>one</u> type of therapy under this section. Where the therapist is adopting an eclectic approach for working with the participant, please determine the predominant type of therapy that is being given.

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version
24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

Appendix 3: Mens Group Data Base I, II & III

Instructions for use

- Please cross ☒ categories that apply, by indicating in the relevant box(es).
- Please only cross one box on questions requiring a Yes/No response.
- You may cross as many categories as are relevant for open-ended questions.
- Some questions require you to calculate the number of times a particular behaviour has occurred. Please put the number in the relevant box.
- Some questions are about status **at** 6 months after the end of the Men's Group and some refer to a period of time **during** the 6 months from the end of the Men's Group.

Please fill in as much information as possible for each of the questions. If there is no documentary information for a particular question then please state underneath the question that there is no information documented.

If the question does not have the response that is needed please use space underneath the question to document what is written in the file.

Questions/phrases with further explanations in the 'definitions' section are indicated by a *.

Please complete

Name of person filling out form:

Please indicate where information for filling out the schedule was obtained (more than one may apply):

☐ Clinical interview with individual
☐ Clinical interview with family/carer/key worker/doctor/probation officer
☐ Learning Disability Service clinical records
☐ Psychiatry clinical records
☐ Social services clinical records
☐ Other. Define:

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version
24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

Appendix 3: Mens Group Data Base I, II & III

Section 1: Demographic Data

The purpose of this section is to gather demographic data for the participant at 6 months follow-up. Questions refer to all men (i.e. men who received treatment and those who were control participants) unless otherwise stated.

1. **Participant's first name**:

2. **Initial of participant's last name**

3. **Participant's date of birth**: (dd/mm/yyyy)

4. **Participant's research status: (Please cross only one of the options below).**

   ☐ Participating in research as treatment participant = 1
   ☐ Participating in research as control participant (i.e. is not receiving group CBT treatment according to SOTSEC-ID model) = 2

5. **Location of Men's Group**:

6. **Name of lead facilitator**:

7. **Group start date**: (dd/mm/yyyy)

8. **Group end date**: (dd/mm/yyyy)

9. **Six month follow-up date**: (dd/mm/yyyy)

10. **Date(s) that filling out this form:**

11. **Did the participant complete the Men's Group:**

    ☐ Yes = 1
    ☐ No = 2
    ☐ Control Participant (question not applicable = 999)

Appendix 3: Mens Group Data Base I, II & III

12. If the man did not complete the Men's Group, what was the reason?: (Treatment participant only). Please continue to fill out the form even if the man dropped out of treatment.

- ☐ Left following completion of statutory requirement to attend treatment (despite treatment not being complete) = 1
- ☐ Did not wish to continue (and no statutory requirement to continue) = 2
- ☐ Was asked to leave by facilitators because was not coping intellectually/socially with the demands of the group = 3
- ☐ Committed another offence and was unable to keep coming due to legal process = 4. Define legal processes e.g. put in prison:
- ☐ Other = 5. Define:
- ☐ Question not applicable = 999

13. Residential status at 6 months follow-up:

- ☐ own home (supported) = 1
- ☐ own home (unsupported) = 2
- ☐ family (or close relative) = 3
- ☐ group/residential home = 4
- ☐ secure environment - low secure = 5
- ☐ secure environment - medium secure = 6
- ☐ secure environment - high secure = 7
- ☐ with support person* in support person's home = 8

14. Legal status at 6 months follow-up:

- ☐ Informal = 1
- ☐ Under Mental Health Act = 2. Define Section
- ☐ Community Rehabilitation Order (used to be Probation Order) = 3. Define length and conditions:
- ☐ Guardianship Order = 4. Define conditions:

15. Level of security/escort required by participant when in community at 6 months follow-up?

- ☐ no escort required = 1
- ☐ 1:1 escort required most or all of the time = 2
- ☐ 2:1 escort required = 3
- ☐ 3:1 escort required = 4
- ☐ no community outings regardless of number of escorts = 5

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version
24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

16. Therapy concurrent to the Men's Group continuing?

During the Men's Group X was also receiving (type of therapy) with (Name of therapist). Please indicate below if this therapy is continuing, or when the therapy ceased.

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99
- ☐ Not applicable = 999

If therapy has ceased, please write the date that the therapy finished:

Date therapy finished: (dd/mm/yyyy)

17. Has the participant received any new therapy during the 6 months following the end of the Men's Group? (do not include that mentioned in question 16).

- ☐ Yes = 1
- ☐ No = 2
- ☐ Not known = 99

18. Reason for participant receiving new therapy during the 6 months following the end of the Men's Group: (N.B. Indicate all that apply) *(Code Yes = 1, No = 2, Not known = 99, Not Applicable = 999)*

- ☐ Perpetrating sexually abusive behaviour
- ☐ Other. Define:
- ☐ Not known
- ☐ Not applicable

19. Type of therapy. Please only complete if answer to question 17 is 'perpetrating sexually abusive behaviour':

- ☐ Individual cognitive behaviour therapy = 1
- ☐ Group cognitive behavioural therapy (excluding Men's Group) = 2
- ☐ New Men's Group (SOTSEC-ID model) = 3
- ☐ Monthly maintenance Men's Group (or similar) = 4
- ☐ 'Other' type of concurrent therapy = 5. Define:
- ☐ Not known = 99
- ☐ Not applicable = 999

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final VersionE:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

20. Professional conducting therapy (N.B. Therapy is for 'perpetrating sexually abusive behaviour')

- ☐ Clinical psychologist = 1
- ☐ Social worker = 2
- ☐ Psychiatrist = 3
- ☐ Behaviourally trained nurse = 4
- ☐ Learning disability trained nurse = 5
- ☐ Counsellor = 6
- ☐ Probation officer = 7
- ☐ No formal qualification = 8
- ☐ Other = 9. Define:
- ☐ Not known = 99
- ☐ Not applicable = 999

Name of therapist:

21. Frequency of therapy (on average) (N.B. therapy is for 'perpetrating sexually abusive behaviour').

- ☐ ≥3 times per week = 1
- ☐ 2 times per week = 2
- ☐ once per week = 3
- ☐ once per fortnight = 4
- ☐ < once per fortnight = 5
- ☐ not known = 99
- ☐ not applicable = 999

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version

24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

22. Current psychotropic medications at 6 months follow-up (please indicate all categories that apply). (Code Yes = 1, No = 2, Not known = 99)

- ☐ Stimulants e.g. amphetamine, methylphenidate
- ☐ Antidepressants: tricyclic antidepressants, serotonergic antidepressants SSRIs (e.g.fluoxetine), Monoamine oxidase inhibitors
- ☐ Lithium
- ☐ Neuroleptics: phenothiazines (e.g. chlorpromazine), butyrophenones (e.g.haloperidol), thioxanthenes (e.g. flupenthixol)
- ☐ Minor tranquillizers: anxiolytic and hypnotic drugs e.g. benzodiazepines and antihistimines
- ☐ Anticonvulsants e.g. carbomazepine
- ☐ Antilibidinal e.g. androcur

- ☐ On no medications
- ☐ Not known

Please list **ALL** medications that the participant is taking and dose:

23. Please document the <u>number</u> of 'other' convictions for offences (i.e. not including sexual offences) that occurred during the 6 months following the end of the Men's Group:

#	
☐	Violence against the person e.g. murder.
☐	Burglary/robbery/theft and handling stolen goods.
☐	Fraud and forgery.
☐	Criminal damage e.g. arson.
☐	Drug offences.
☐	Motoring offences.
☐	Other. Define:

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version
24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

Section 2: New Sexually Abusive Incidents* (as Perpetrator)

1. **Has the participant engaged in any other sexually abusive incidents during the 6 months since the end of the Men's Group?** If 'no' or 'not known' – there is no need to answer the rest of this section). *(In this situation, code questions 2 – 17 as: Question not applicable = 999).*

   ☐ Yes = 1
   ☐ No = 2
   ☐ Not known = 99

Please note:

All questions relate to sets of sexual assaults that were perpetrated during the 6 months following the end of the Men's Group.

'Sets of Assaults': Assaults on different identifiable victims even if they occur on the same day are coded as different sets of assaults. Assaults on same victim are counted as one 'set' even if they occur over a period of time.

If multiple, but unidentifiable victims (e.g. general public) then code as one 'set' of sexual assaults.

If no identifiable victim(s) (e.g. it is known that perpetrator masturbated in public place but not known if this, or other sexual behaviours, were observed by others), code each known incident as one 'set' of sexual assaults.

2. **How many different sets of sexual assault(s) did the participant perpetrate in the 6 months following the end of the Men's Group?**

   #
   ☐ Total number of sets of sexual assaults

3. **Brief description of what is documented/alleged to have happened for each set of sexual assaults*:** (please include the dates of incident(s) if possible).

Description of set of sexual assaults:

Description of set of sexual assaults:

Description of set of sexual assaults:

Description of set of sexual assaults:

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version

24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

4. **Please indicate the number of sexually abusive behaviours that occurred for the set(s) of sexual assaults, perpetrated during the 6 months following the end of the Men's Group:** (N.B. where man/research participant is perpetrator. Each set of sexual assaults may have more than one type of sexually abusive behaviour. For example, where there have been two sets of sexual assaults:

   Set 1: perpetrator touches child on bottom. Child is naked.

   Set 2: perpetrator touches child on bottom and engages in anal intercourse

   This would be coded by placing a 2 under '*perpetrator touch of victim's genitals and/or bottom and/or breasts/chest* and a 1 would be placed under '*perpetrator: attempted/actual anal/vaginal penetration of victim*').

#	
	Perpetrator masturbates victim
	Perpetrator masturbates in public place*
	Perpetrator performs oral sex on victim
	Victim made to masturbate perpetrator
	Victim made to perform oral sex on perpetrator
	Perpetrator: attempted/actual anal/vaginal penetration of victim. Define type (if known):
	Victim made to penetrate other. Define type (if known):
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (unclothed)
	Perpetrator touch of victim's genitals and/or bottom and/or breasts/chest (through clothing)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (unclothed)
	Victim made to touch perpetrator's genitals and/or bottom and/or chest (through clothing)
	Perpetrator performs indecent exposure
	Victim shown pornography
	Victim photographed pornographically
	Verbal sexual harassment by perpetrator
	Sadomasochistic sex
	Stalking behaviour
	Other. Define type

5. **Please indicate the number of sets of sexual assault(s)*where the victim's gender is:** (N.B. the total number should add to equal the total for question 2).

#	
	male
	female
	both (e.g. general public)
	gender of victim not known

Appendix 3: Mens Group Data Base I, II & III

6. **Please indicate the number of sets of sexual assault(s)* where the victim's relationship to the perpetrator (participant) was:** (N.B. The total number should add to equal the total for question 2)

#	
	Own son/step son
	Own daughter/step daughter
	Female sibling/step sibling
	Male sibling/step sibling
	Female parent; adopted/foster/step parent
	Male parent; adopted/foster/step parent
	Other relative (e.g. uncle/auntie, grandparents, including step relatives)
	Close friend of participant
	Close friend of participant's parents
	Other service user
	Staff member*
	Support person*
	Acquaintance/Stranger
	Other. Define:
	Number of sets of sexual assaults where relationship of victim to perpetrator not known

7. **Please indicate the number of sets of sexual assault(s)* where the victim was aged:** (N.B. The total number should add to equal the total for question 2)

#	
	< 5 years old
	≥5 – <12 years old
	≥12 – <18 years old
	adult
	≥60 years old
	range of ages (e.g. general public)
	age of victim not known

Exact age of victim for each of the sets of sexual assaults (please list):

Appendix 3: Mens Group Data Base I, II & III

8. **Please indicate the <u>number</u> of times the perpetrator (participant) has been interviewed by the police/come to the attention of the police, in relation to <u>sets of sexual assaults</u>* perpetrated in the 6 months following the end of the Men's Group:** (N.B. If all interviews with the police are regarding one set of sexual assaults then please code as one interview. Two interviews would be coded if the participant was interviewed by the police/came to the attention of the police for two different sets of sexual assaults)

#
☐ Numbers of interviews with police/times come to the attention of the police

9. **Please indicate the number of times the perpetrator's (participant's) case has gone to court or is proceeding to court for <u>sets of sexual assaults</u>* perpetrated in the 6 months following the end of the Men's Group:** (N.B. if case is proceeding to court, each set of sexual assaults is coded as one court case):

#
☐ Number of times perpetrator's case gone to court/or is proceeding to court

10. **Number of times legal outcome of court appearance for <u>sets of sexual assaults</u>* was:** (In unusual circumstances a man (X) may have appeared in court for two different sets of sexual assaults that occurred on the same day (NB this equals two victims and two court appearances). When coding the legal outcome of court appearances, the outcome for each set of sexual assaults is coded separately (and then added together below). For example, X may receive a supervision order following his appearances in court. However, as this outcome relates to two sets of sexual assaults (i.e. two victims), two supervision orders are coded.

#
☐ Found unfit to plead
☐ Community Rehabilitation Order (used to be Probation Order)
☐ Community Treatment Order
☐ Guardianship Order
☐ Hospital Order
☐ Prison/Custodial Sentences for Young Offenders
☐ Cautioned
☐ Acquitted/Absolute Discharge
☐ Case dropped
☐ Fined/Payment of Damages
☐ Conditional Discharge
☐ Supervision Order
☐ Community Punishment Order (used to be Community Service Order)
☐ Community Punishment and Rehabilitation Order (used to be Combination Order)
☐ Fully/Partly Suspended Sentence
☐ Other (e.g. Attendance Centre Order, Care Order, Custody under Children and Young Persons Act, Curfew Order). Define:
☐ Number of times legal outcome not known/awaiting outcome of court case

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version

24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

11. If convicted for sets of sexual assaults*, please indicate the number of convictions for: (If convicted for 1 victim, this = 1; if convicted for 2 victims, this = 2 etc).

#	
	buggery
	indecent assault on male/female
	gross indecency between males
	rape of a man/woman
	unlawful sexual intercourse with girl under 13
	unlawful sexual intercourse with girl under 16
	incest
	abuse of position of trust
	gross indecency with child
	stalking
	indecent exposure
	sexual harassment
	other (e.g. procuration, abduction, bigamy, soliciting or importuning by a man. Define:
	number of times type of conviction not known/awaiting outcome of court case

12. Number of times where the social outcome of a set of sexual assaults* was: (N.B. each set of sexual assaults may have more than one social outcome associated with it. Please add together social outcomes for all sets of sexual assaults).

#	
	change of residential placement
	loss of job/change of work placement
	specialist treatment/therapy e.g. psychology sessions
	verbal reprimand
	loss of 'privileges' e.g. cigarettes or outings
	increased supervision
	medication. Define:
	other. Define:
	nothing (i.e. there were no social outcomes)
	number of sets of sexual assaults where social outcome not known

Appendix 3: Mens Group Data Base I, II & III

Version 4 Final Version
24.2.04E:\SOTSEC website local copy\sotsec\membersonly\docs\measures\MGDBS_Phase_Three.doc

13. Number of times where relationship status at time of a set(s) of sexual assault(s)* was:

#	
	single
	married/cohabiting
	divorced/separated
	widowed
	in relationship but not living together
	relationship status not known

14. Number of times where residence at time of sets of sexual assault(s)* was:

#	
	own home (supported)
	own home (unsupported)
	family (or close relative)
	group/residential home
	secure environment – low secure
	secure environment – medium secure
	secure environment – high secure
	with support person in support person's home
	residence not known

15. How often did participant (perpetrator) use illicit substances (include alcohol) at time of sets of sexual assault(s)* (N.B. average percentage of time that participant used illicit substances over the different sets of sexual assaults may need to be estimated)

- ☐ never/not known = 1.
- ☐ rarely (e.g. less than approximately 10% of time on average, over the different sets of sexual assaults) = 2
- ☐ sometimes (e.g. approximately 11 – 50% of the time on average, over the different sets of sexual assaults) = 3
- ☐ often (e.g. approximately 51 – 75% of the time on average, over the different sets of sexual assaults) = 4
- ☐ majority of the time (approximately greater than 75% of the time on average over the different sets of sexual assaults) = 5

Appendix 3: Mens Group Data Base I, II & III

16. Please take the <u>one set</u> of sexual assaults, where the sexual assaults continued over the longest period of time, and state how frequently the perpetrator (participant) sexually assaulted the same victim:

☐ Once (includes numerous incidents with same victim if occur only on one day) = 1
☐ several times (total of 2 – 4 times over different days) = 2
☐ continuously over months = 3
☐ continuously over years = 4
not known = 99

17. How many sets of sexual assaults were:

#	
	Predominantly <u>contact</u> sexual assaults
	Predominantly <u>non-contact</u> sexual assaults

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending- QACSO

Questionnaire on attitudes consistent with sex offences

Is this a pre- group, mid point, post- group or 6 month follow- up measure: _____
Name:

_____

Date:

_____

Tester:

_____

Other information:

_____

Notes for administration/ scoring:

- Scoring system: 0 = socialized response, 1 = Don't know, 2 = Unsocialised response
- Please score items strictly. If there is any indication of an 'unsocialised' response then Items should be scored as 2.
- Where an item has not been administered, please score 1.
- Bill Lindsay has indicated that Items B are for clinical interest and do not load statistically. Therefore we are scoring Items A only.

- Please also refer to: Broxholme, S.L., and Lindsay, W. R. (2003) Development and preliminary evaluation of a questionnaire on cognitions related to sex offending for use with individuals who have mild intellectual disabilities. *Journal of Intellectual Disability Research.* 47 (6): 472 – 482.

Topic One: Rape and attitudes to women

Directions:

1. Ask the question.
2. If the response is inappropriate or not full enough (must include words or variants of the words that are underlined) then give the answer below and repeat the question – continue in this manner until you are given an appropriate response.

Question:

- "What does it mean to rape a woman?"

Appropriate response:

- When someone is forced by another person to have sexual intercourse (sex)
- When a man forces (makes) a woman to have sex with him
- When a man makes a women have sex even when she says no

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1a	Is it possible for any woman to be raped?				0	1	2
b	Is it only women who wear tight clothes that can be raped?	2	1	0			
c	Could a woman wearing her Sunday best be raped?	0	1	2			
2a	Do you think that women who go around braless or in tight clothes want to have sex?	2	1	0			
2b	Is she asking for it?	2	1	0			
3a	Do you think that a woman can stop a man from raping her if she wanted to?	2	1	0			
b	Could a woman stop a man from raping her by shouting or fighting him off her?				2	1	0
c	If the rape goes ahead does that mean that she wants it?	2	1	0			
4a	Are women often partly to blame for the rape taking place?				2	1	0
b	Do some women lead men on?				2	1	0
5a	If a woman gets drunk at a party and has sex with a man there, is she fair game for anyone else?	2	1	0			
b	At a party a man sees a woman going into a bedroom to have sex with another man, would it be okay then for him to force her to have sex?				2	1	0
6	Are women just a load of bitches?	2	1	0			

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending
QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
7a	Can women who have had sex with a lot of men still be raped?	0	1	2			
b	Is she asking for it?	2	1	0			
8	Do women lie about being raped?				2	1	0
9a	Should a man stop touching and kissing a woman when she asks him to, even if he wants to carry on?				0	1	2
9b	If a woman lets a man touch and kiss her and then suddenly says she wants him to stop, is it okay for him to keep going?	2	1	0			
10a	Can you show a woman that you love her by forcing her to have sex with you?	2	1	0			
b	Is it okay to force a woman to have sex?				2	1	0
11	If a man rapes a woman is it just a bit of fun?				2	1	0
12a	Do men rape women to scare or frighten them?				0	1	2
b	Do men rape women to gain power over them?	0	1	2			
13	Do women make too much fuss about sexual assault?	2	1	0			
14	Do you think that if a woman is raped that it would cause her any harm?	0	1	2			
15	If a woman was raped do you think that it would take a few weeks or longer to get over it?	Week 2	DK 1	Longer 0			

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Topic Two: Voyeurism

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1	Do women who don't close their curtains when they are in their underwear want people to look at them?				2	1	0
2a	Do women like men to stare at their bodies?				2	1	0
b	Does it make them feel attractive?				2	1	0
3a	If a woman has a big pair of boobs is it only natural to have a good luck?				2	1	0
b	Is it right to have a good look?	2	1	0			
4	If a woman is wearing a short skirt does it mean that she wants men to look up it?	2	1	0			
5	Do some women make up stories about men looking through curtains at them?				2	1	0
6	Is staring at a woman's body a good way of showing her that you find her attractive?	2	1	0			
7	Do men stare at women to scare them?				0	1	2
8	If a man stares at a woman is he just having a bit of fun?	2	1	0			

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
9a	Is it okay to stare at a woman if you don't touch her?				2	1	0
b	Is there any harm in staring at a woman?	0	1	2			
10	If a woman sees a man staring at her do you think that she would only be upset about it for a few minutes or longer?				Few min's 2	DK 1	Longer 0

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Topic Three: Exhibitionism

Directions:

1. Ask the question.
2. If the response is inappropriate or not full enough (must include words or variants of the words that are underlined) then give the answer below and repeat the question – continue in this manner until you are given an appropriate response.

Question:

- "What does it mean to flash?"

Appropriate response:

- When a man shows (exposes) his private parts (penis) in public. Accept any appropriate or colloquial wording.

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1a	Do you think a woman has to look when a man flashes at her?				0	1	2
b	Could a woman walk away when a man flashes at her?				2	1	0

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
2a	If a woman looks at a flasher is it her fault?	2	1	0			
b	Is it the man's fault if a woman looks at him when he flashes?	0	1	2			
3a	Do women just pretend to be shocked when they see a penis?	2	1	0			
b	When a man shows his penis to a woman does it really turn her on?	2	1	0			
4a	Do most women laugh about being flashed at?	2	1	0			
b	Do women think that it is a bit of fun?	2	1	0			
5	Is flashing at someone a good way to show women that you want to have sex?	2	1	0			
6a	Do men flash to scare women	0	1	2			
b	Do men enjoy scaring women by flashing at them?	0	1	2			
7	Do you think that a woman would be harmed by a man flashing at her?	0	1	2			
8	Do you think that it would take a woman years or a few days to get over being flashed at?				Few days 2	DK 1	Years 0

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

Topic Four: Dating Abuse

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1	Is it okay to kiss in public, on the street?	0	1	2			
2	Do you think a woman should expect a man to try it on a date	2	1	0			
3	If you ask a girl out for a date should she know that you want to have sex?	2	1	0			
4	If a girl invites you back to her place for a coffee is she really offering to have sex?	2	1	0			
5a	Do you think its okay to expect sex on the first date?				2	1	0
b	If you are on the first date is it okay to expect the girl to have sex with you?	2	1	0			
6	If a girl makes out that she does not want to kiss is she playing a game?	2	1	0			
7a	Would a woman think that you found her ugly if you didn't ask her to have sex with you?	2	1	0			
b	If you don't ask a woman to have sex will she think you don't like her?	2	1	0			
8	Do you think a woman would get upset if her boyfriend kept trying to encourage her to have sex even though she has already said no?				0	1	2

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

Topic 5: Homosexual Assault

Directions:

1. Ask the question.
2. If the response is inappropriate or not full enough (must include words or variants of the words that are underlined) then give the answer below and repeat the question – continue in this manner until you are given an appropriate response.

Question:

- "What does it mean to be homosexual / gay?"

Appropriate response:

- When a man or woman is sexually attracted to members of the same sex. Also accept – when a man is attracted or has sex with another man.

Question:

- "What would it mean to rape a man?"

Appropriate response:

- When a man forces (makes) another man to have sex with him.

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1	Is it okay for men to have sex together?				0	1	2
2	If a man approached you for sex would you hit him or tell him you are not gay?				0	1	2
3	If a man does not want to have sex can he be forced to by another man?	0	1	2			
4a	If a man does not try to fight his way out of a rape does he want to have sex?	2	1	0			
b	Could a man stop another man from raping him?				2	1	0
5	Do men just say that they were raped because they are ashamed of being gay?	2	1	0			

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending

QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
6	If a man forced another man to have sex, would that be a good way of showing that he found him attractive?	2	1	0			
7a	Would a man rape another man to scare him?	0	1	2			
b	Would a man rape another man to get power over him?	0	1	2			
8	If a man tries to force another man or boy to have sex is he just having a bit of fun?	2	1	0			
9	If a man is raped by another man does it cause him harm?	0	1	2			
10	Would it take a man a few weeks or longer to get over being raped by another man?	Few weeks 2	DK 1	No 0			

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Topic Six: Offences against children

Directions:

1. Ask the question.
2. If the response is inappropriate or not full enough (must include words or variants of the words that are underlined) then give the answer below and repeat the question – continue in this manner until you are given an appropriate response.

Question:

- "What does it mean to masturbate?"

Appropriate response:

- When a person feels sexy (turned on) they may play with their private parts. Also accept – when a man plays with his penis or any other appropriate colloquial response.

Question:

- "What does it mean to have a period?"

Appropriate response:

- When girls are approximately 11 – 13 years of age, each month blood from their womb comes out through their vagina (between their legs etc). If does not state age, frequency or where the blood comes from then ask. If unable to answer then give the correct answer and ask the question again.

Question:
"What does it mean to sexually abuse a child?"

Appropriate response:

- When a child is touched or kissed inappropriately; made to have sexual intercourse or any other kind of sex. Accept any of the underlined answers and any other colloquial response.

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1	Do some children enjoy having sex with men?	2	1	0			
2	Do some children make up stories about being sexually abused?	2	1	0			
3a	Do children lead men on sexually?	2	1	0			
b	Do children do sexy things so that men will get turned on and want to have sex with them?	2	1	0			
4	Is it wrong to force a child to have sex?				0	1	2
5a	Can children be abused by people they know, as well as strangers?	0	1	2			
b	Can a child be abused my family members like their father, their mother or their uncle?	0	1	2			
6	Can you show you love a child by having sex with them?	2	1	0			

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
7	Do men have sex with children to scare them?				0	1	2
8	If a man has sex or masturbates in front of a child is it just a bit of fun?	2	1	0			
9	If a girl is old enough to have periods is she old enough to have sex?	2	1	0			
10a	Can a ten year old decide whether to have sex or not?	2	1	0			
b	If a child was ten years old would they be able to decide to have sex with a man?				2	1	0
11a	Do you think sex with children does harm if the adult is gentle?	0	1	2			
b	If the man was gentle would sex cause harm to the child?	0	1	2			
12	Does making a child watch you masturbate do them any harm?	0	1	2			
13a	After a few years would a child get over being sexually abused?	2	1	0			
b	Would a child ever fully get over being sexually abused or would it be okay in a few weeks or years?	Few weeks/ years 2	DK 1	Never 0			

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending QACSO

Topic Seven: Stalking and sexual harassment

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
1	Is following a woman a good way to show her you like her?	2	1	0			
2	Do some women make up stories about men following them?	2	1	0			
3a	Do men follow women because they want to scare them?	0	1	2			
b	Do men follow women because they think they have power over them?	0	1	2			
4a	Do some women like men to follow them?	2	1	0			
b	Does it make them feel attractive?	2	1	0			
5	Is it okay to follow women as long as you don't touch them?	2	1	0			
6	Is there any harm in following women?	0	1	2			
7	If a woman is wearing a short skirt and no bra does she want a man to follow her?	2	1	0			
8	Could a woman stop a man from following her if she wanted to?	2	1	0			
9	Is following a woman a good way of showing her you would like to have sex with her?	2	1	0			

Appendix 4: Questionnaire on Attitudes Consistent with Sex Offending

QACSO

No	Question	Scoring Items A			Scoring Items B		
		Yes	DK	No	Yes	DK	No
10	If a woman is walking around the town is it okay for a man to follow her?	2	1	0			
11	If a man follows a woman is he just having a bit of fun?	2	1	0			
12	If you followed a woman would it turn her on?	2	1	0			
13	Would a woman get upset if she saw a man following her?	0	1	2			
14	If she got upset how long would it take for her to get over it – a couple of days, a few weeks/ longer?	Days 2	DK 1	Weeks/ longer 0			

	Items A			Items B
Total Frequency	**2**	**1**	**0**	Please do not total Items B for the SOTSEC-ID research. Items A are scored only.
Total Score				

Summary of Results:

	Summary of results for Items A only
Total score from each topic:	
Topic One: Rape and attitudes to women	
Topic Two: Voyeurism	
Topic Three: Exhibitionism	
Topic Four: Dating abuse	
Topic Five: Homosexual assault:	
Topic Six: Offences against children	
Topic Seven: Stalking & sexual harassment	

Overall Total for Items A Only:

_____

Appendix 5: Sexual Attitudes and Knowledge Assessment SAKA

Client's name: _____

Date of birth: _____

Tester: _____

Is this a pre-group, post-group or six- month follow up measure? _____

THE SEXUAL ATTITUDES AND KNOWLEDGE ASSESSMENT (S.A.K)

This tool can be used to evaluate the individual's attitudes, knowledge and skills in the four main areas of:

1. Understanding relationships
2. Social interaction
3. Sexual awareness
4. Assertiveness

The participant is asked to respond to a series of questions, each accompanied by a picture (line drawing)

Procedure

Administering the tool

Using the questions from the SAKS and the corresponding pictures for each, read each question to the participant. Try to read the questions as closely as written. Use your own discretion in clarifying or simplifying the content as needed for the individual while preserving the essence of the question. When reading the questions, avoid giving cues like face gestures, or voice changes to direct the participant's answer. Mark participants answer in the proper blank space.

Scoring

1. After the assessment is completed mark the number of points correct for each question (except for attitude questions which are marked with *) in the blank to the left of each question on the SAKS question/ Answer Form.

2. Use the "Final Score Form" to figure the number of answers correct in each area. For each question, locate the number listed under the area. For example, find question number 1 which is located under "Understanding Relationships", on the Final Score Form. Then transfer the score (number of correct points) from the Question/Answer Sheet to the score form.

3. For attitude questions, summarise the person's answers in space under each category on the "Final Score Form".

SEXUAL ATTITUDES AND KNOWLEDGE SCALE (SAKS)
QUESTION / ANSWER FORM
(For individuals with the ability to answer open ended questions)

Questions marked with a * are to assess the person's attitudes and are not scored. Other questions are to be scored using the blanks to the left.

No of possible points	*No of points correct*		
	*	1.	Mary and John are coming home from a date. They like each other very much. Is it okay for them to hug?
1 point	_____	2.	Joe is home alone. Someone knocks at the door. What should he do? *(1 point)*
3 points	_____	3.	Mary is sitting on the couch with Jane, her cousin. Is it okay for Jane to touch Mary's breast? *(1 point)* If it is not okay who could she tell? *(1 point)* What should she do if the first person she tells does not listen? *(1 point?)*
1 point	* _____	4.	Jack is alone in his bedroom with the door closed. He is touching his penis. It feels good. Is this okay? Do you know another word fro this? *(1 point)*
1 point	* _____	5.	Jean is alone ion her bedroom with the door closed. She is touching her vagina. It feels good. Is this okay? Do you know another word for this? *(1 point)*
1 point	_____	6.	John is at work. He is rubbing his pants to make his penis feel good. Is this okay? *(1 point)*
1 point	_____	7.	John is hitchhiking (getting a ride from a stranger). Is this okay? *(1 point)*
	*	8.	Larry and Sam are homosexuals and love each other. Is it okay for them to touch each other's penis in private?
	*	9.	Jenny and Marie are lesbians and love each other. Is it okay for them to touch each other's vagina in private?
1 point	_____	10.	Kate does not want Mike to pull her shirt. What can she do? *(1 point)*
1 point	_____	11.	Mary lost her billfold (purse). Her bus money was in it. What should she do? *(1 point)*
1 point	_____	12.	John sees a new woman at his job. He wants to be friends with her. What could he do? *(1 point)*

No of possible points	*No of points correct*		
1 point	_____	13.	Mary is home alone and the phone rings. She answers the phone. The person on the phone starts saying nasty things to her. What could she do? *(1 point)*
1 point	_____	14.	Liz is at work. Her boss, Mr. Smith wants to kiss her. What could Liz do? *(1 point)*
1 point	_____	15.	These two people are boyfriend and girlfriend. They want to have sexual intercourse, but they don't want to have a baby. What should they do? *(1 point)*
1 point	_____	16.	This woman just found out she is pregnant and has told her husband. Tell me how she got pregnant. *(1 point)*
1 point	_____	17.	Scott is the only passenger on the bus. The bus driver stops the bus. He sits by Scott and tells him he is cute. Then he asks Scott to touch his penis. What should Scott do? *(1 point)*
1 point	_____	18.	What is this couple doing? *(1 point)*

19. Using the drawing of the nude male and female, ask the client to identify the following body parts.

No. of possible points:12

19a. First point to the body part and ask what the name is *(12 points)*

No. of possible points:12

19b. Second, name the body part and ask the person to point to it on the picture *(12 points)*

	19 a. Correct	19 a. Incorrect	19 b. Correct	19 b. Incorrect
Male				
Toes	_____	_____	_____	_____
Neck	_____	_____	_____	_____
Lips	_____	_____	_____	_____
Thigh	_____	_____	_____	_____
Penis	_____	_____	_____	_____
Testicles	_____	_____	_____	_____
Female	Correct	Incorrect	Correct	Incorrect
Chin	_____	_____	_____	_____
Hips	_____	_____	_____	_____
Eyebrow	_____	_____	_____	_____
Pubic Hair	_____	_____	_____	_____
Vagina	_____	_____	_____	_____

Breast _____ _____ _____ _____

Total of correct points for 19 a: _____
Total of correct points for 19 b: _____

Correct answers for individuals with the ability to answer open-ended questions

1. Attitude question*
2. Ask who it is before opening (1 point)
3. No (1 point). She could tell trustworthy significant other, like parent, teacher (1 point). Tell someone else she can trust (1 point)
4. Attitude question*. Masturbation (1 point)
5. Attitude question*. Masturbation (1 point)
6. No (1 point)
7. No (1 point)
8. Attitude question*
9. Attitude question*
10. Tell him "No" (1 point)
11. Talk to someone you trust like bus driver, store clerk or make a phone call (1 point)
12. Introduce himself or ask her name (1 point)
13. Hang up (1 point)
14. Tell him "No", walk away (1 point)
15. Use birth control, or name a specific type like condom, birth control pill (1 point)
16. They had intercourse (1 point)
17. Say "No" or leave the bus (1point)
18. Having intercourse or having sex (1 point)

Final Score Form

Directions: For each question locate the number listed below and transfer the score (number of correct points) from the "Question/Answer Sheet". For attitude questions summarise the person's answers in the blank under each category (except assertiveness where there are none).

Understanding Relationships			Social Interaction		
No. of possible points	**Question**	**No. of points correct**	**No. of possible points**	**Question**	**No. of points correct**
3 points	3		1 point	6	
1 point	12		1 point	10	
1 point	14		1 point	12	
1 point	17				
6 total points		Total:	3 total points		Total:

Summary of 'attitudes' (from questions 1, 8, and 9):

_____

_____

_____

_____

Sexual Awareness			Assertiveness		
No. of possible points	**Question**	**No. of points correct**	**No. of possible points**	**Question**	**No. of points correct**
			1 point	2	
3 points	3		3 points	3	
1 point	4		1 point	7	
1 point	5		1 point	10	
1 point	15		1 point	11	
1 point	16		1 point	13	
1 point	18		1 point	14	
24 points	19		1 point	17	
32 total points		Total:	10 total points		Total:

Summary of 'attitudes' (from questions 1, 4, 5, 8, and 9):

_____

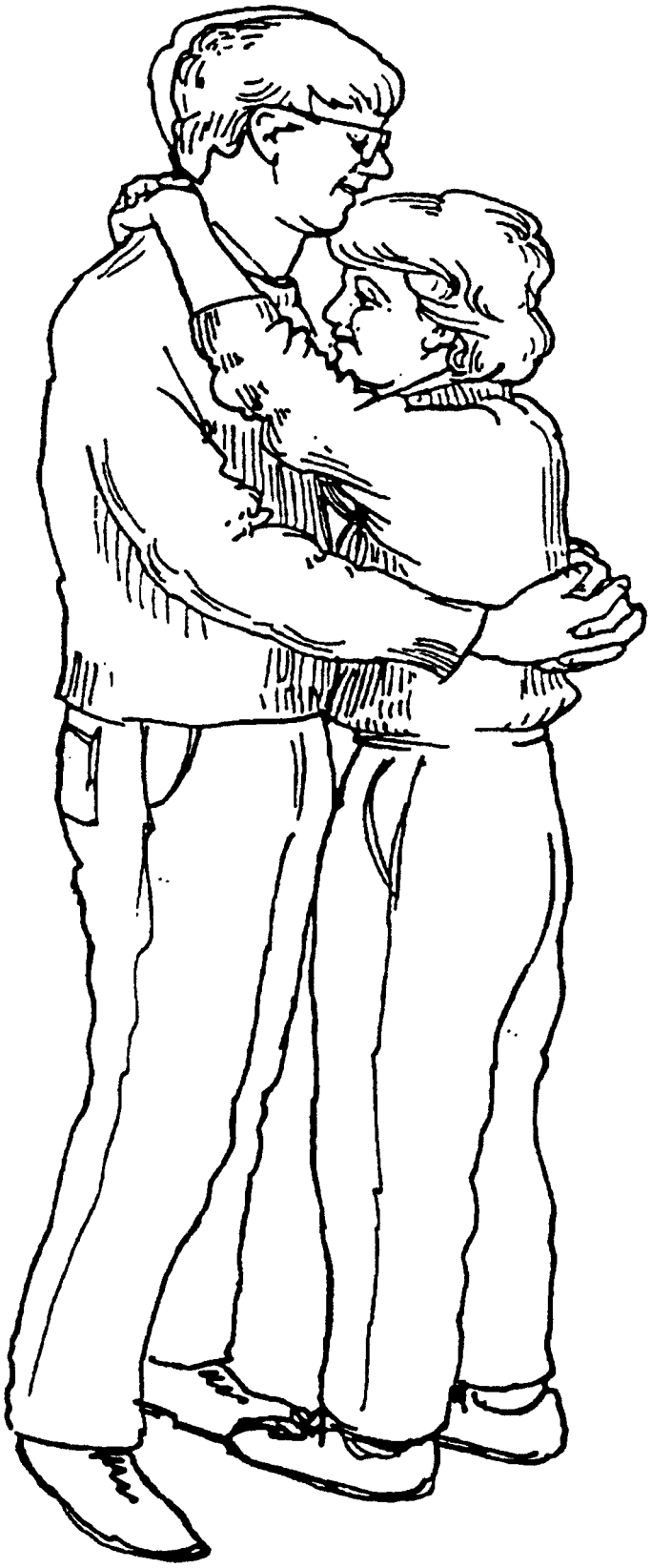
_____

_____

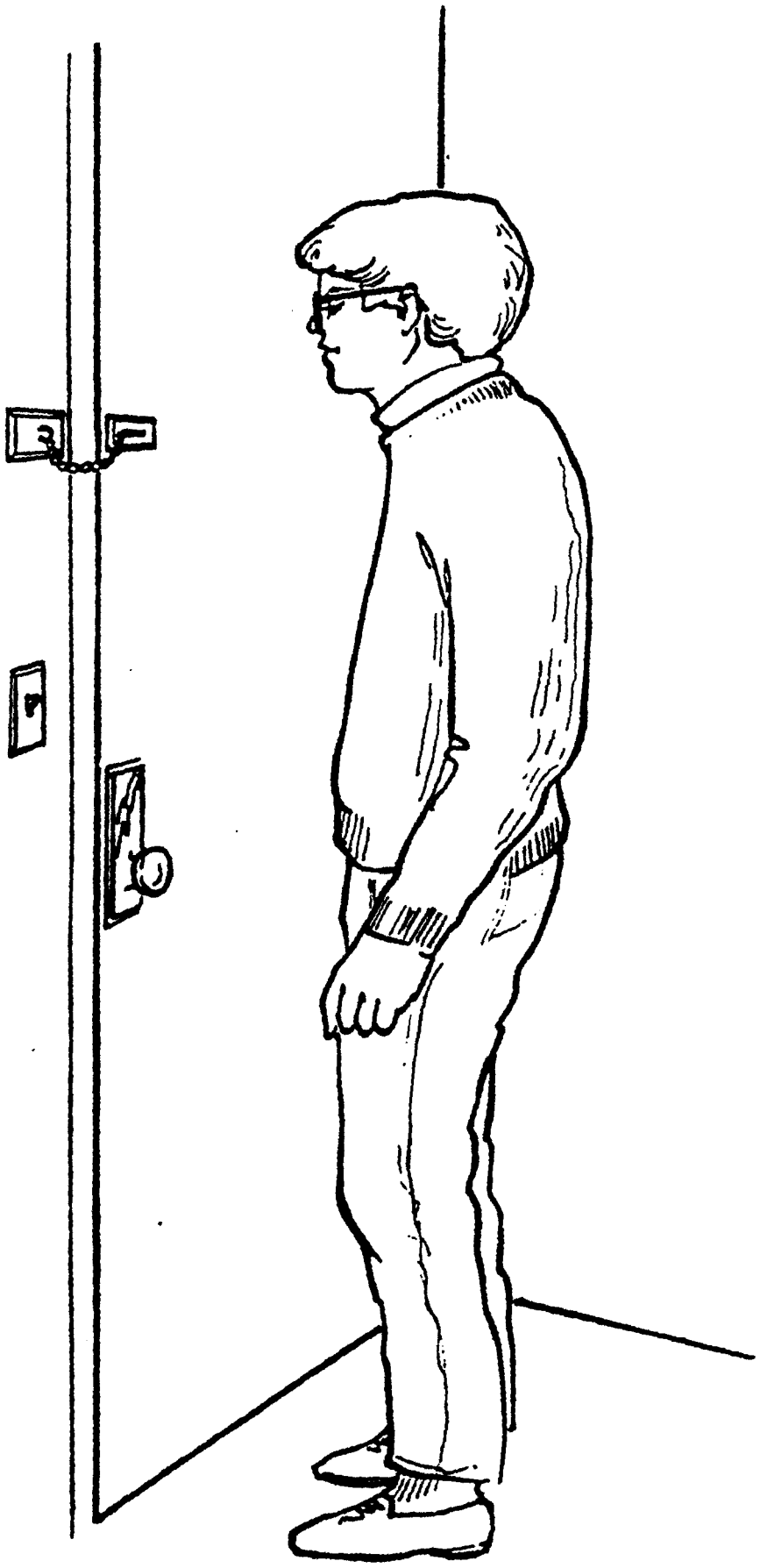
_____

Appendix 5: Sexual Attitudes and Knowledge Assessment SAKA

Question 1



Question 2



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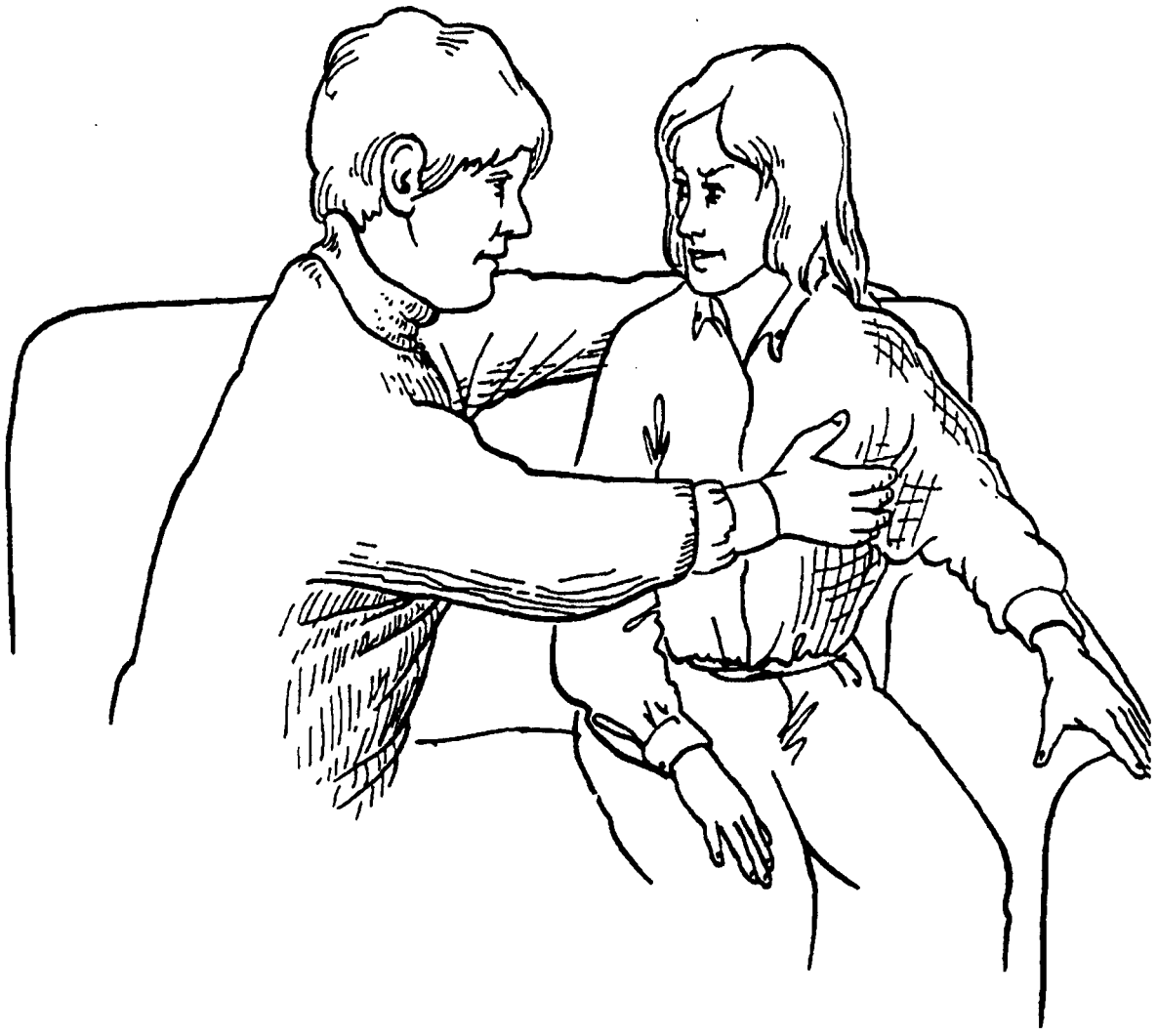

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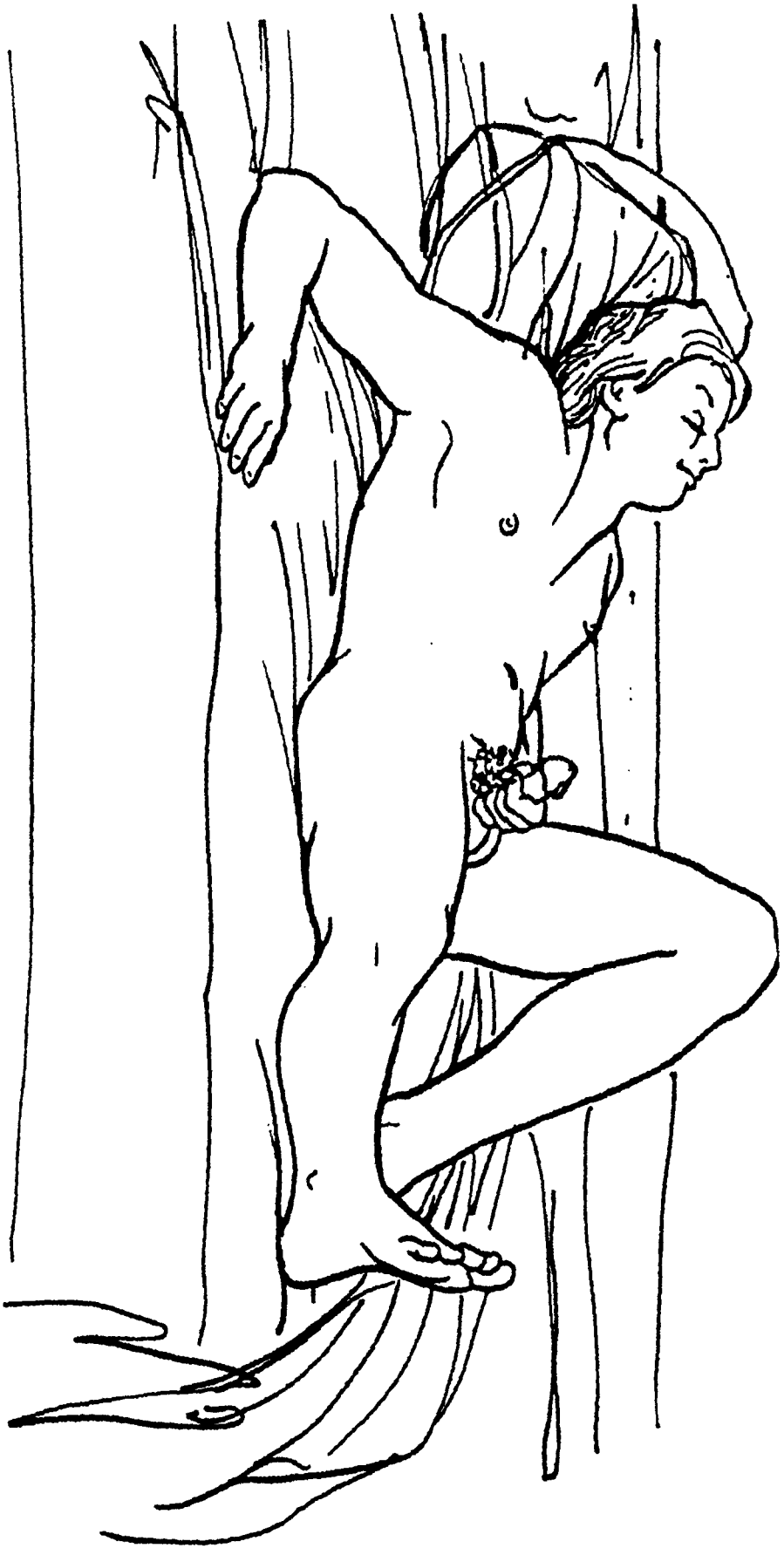

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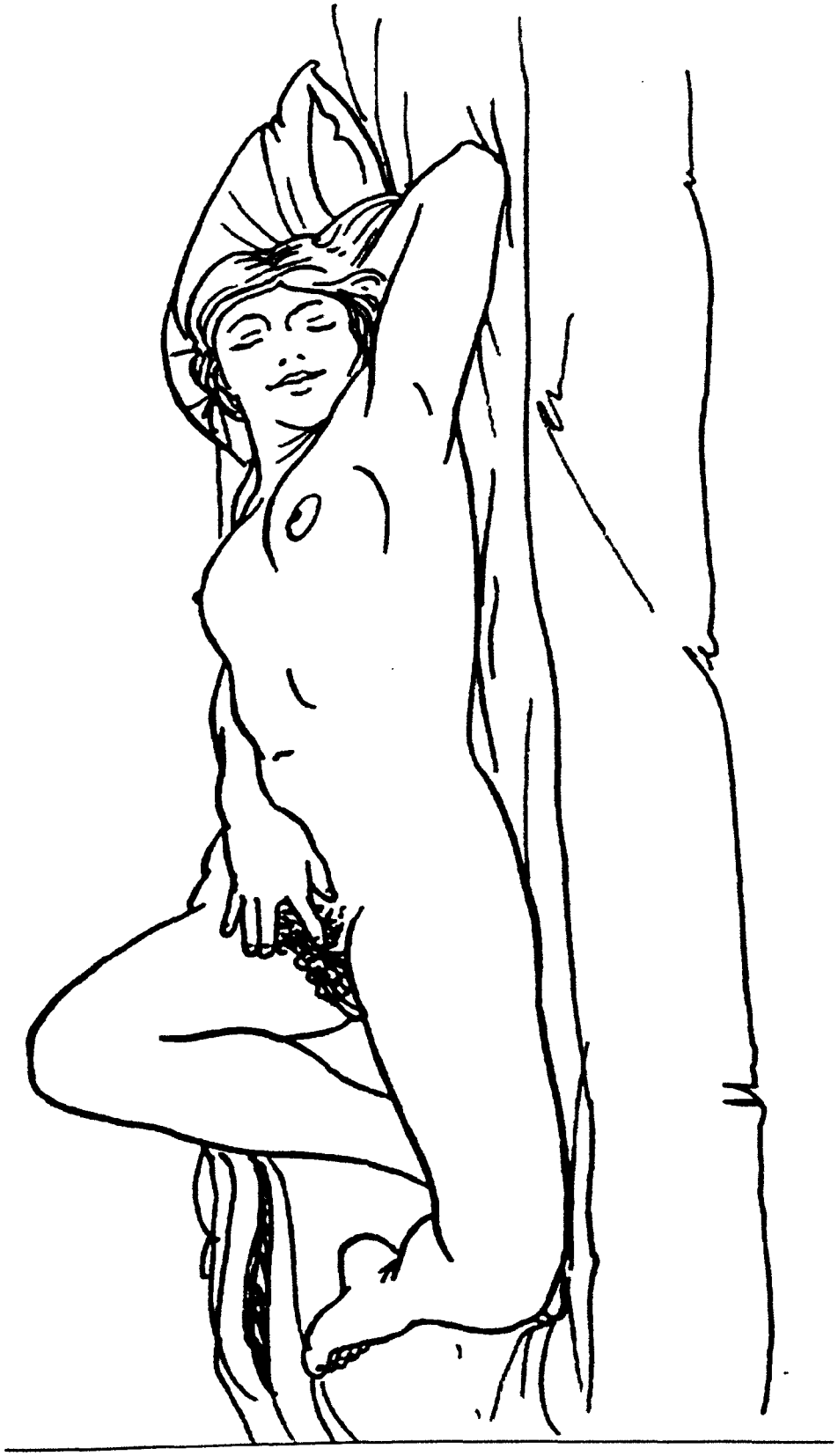

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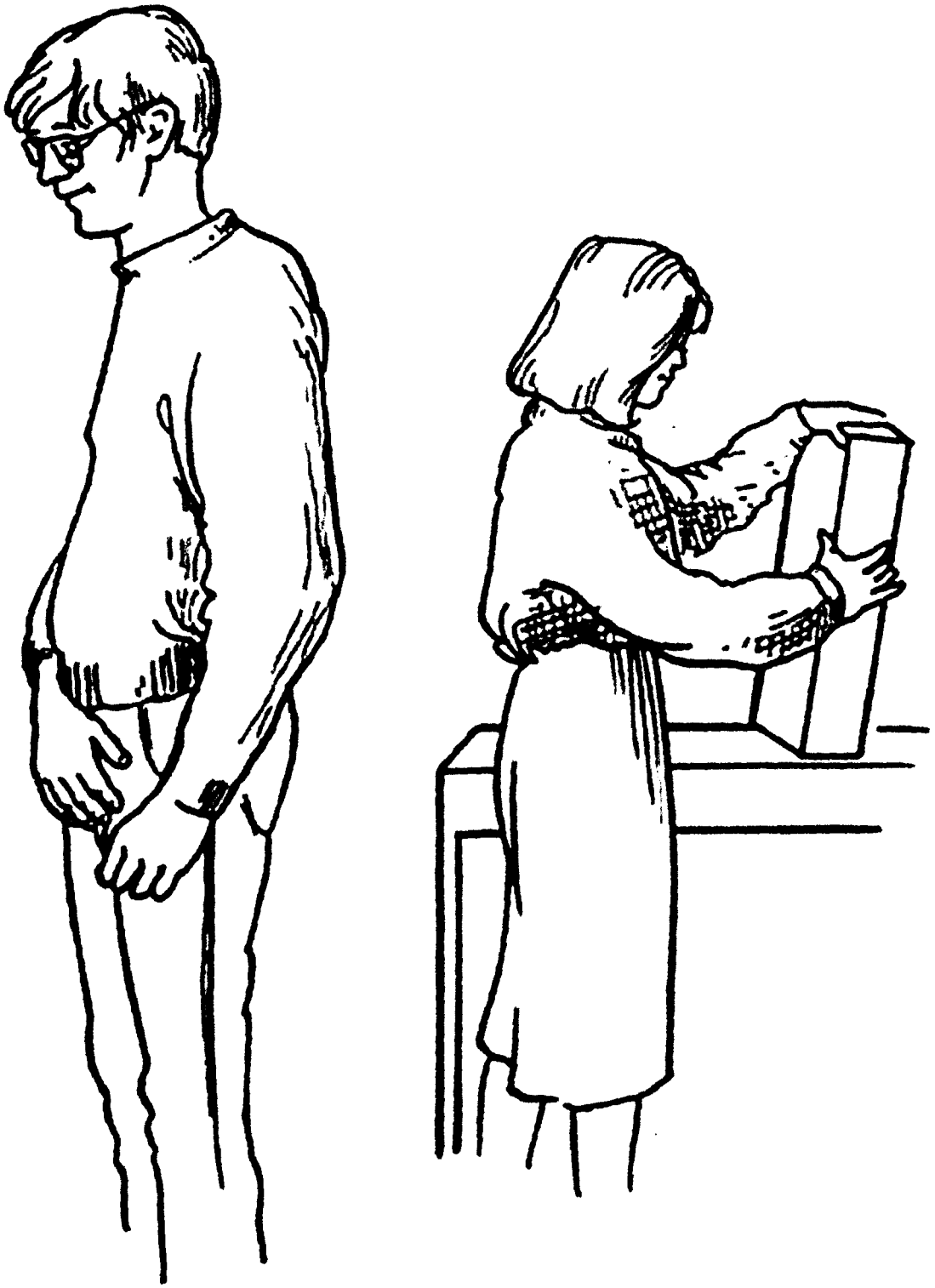
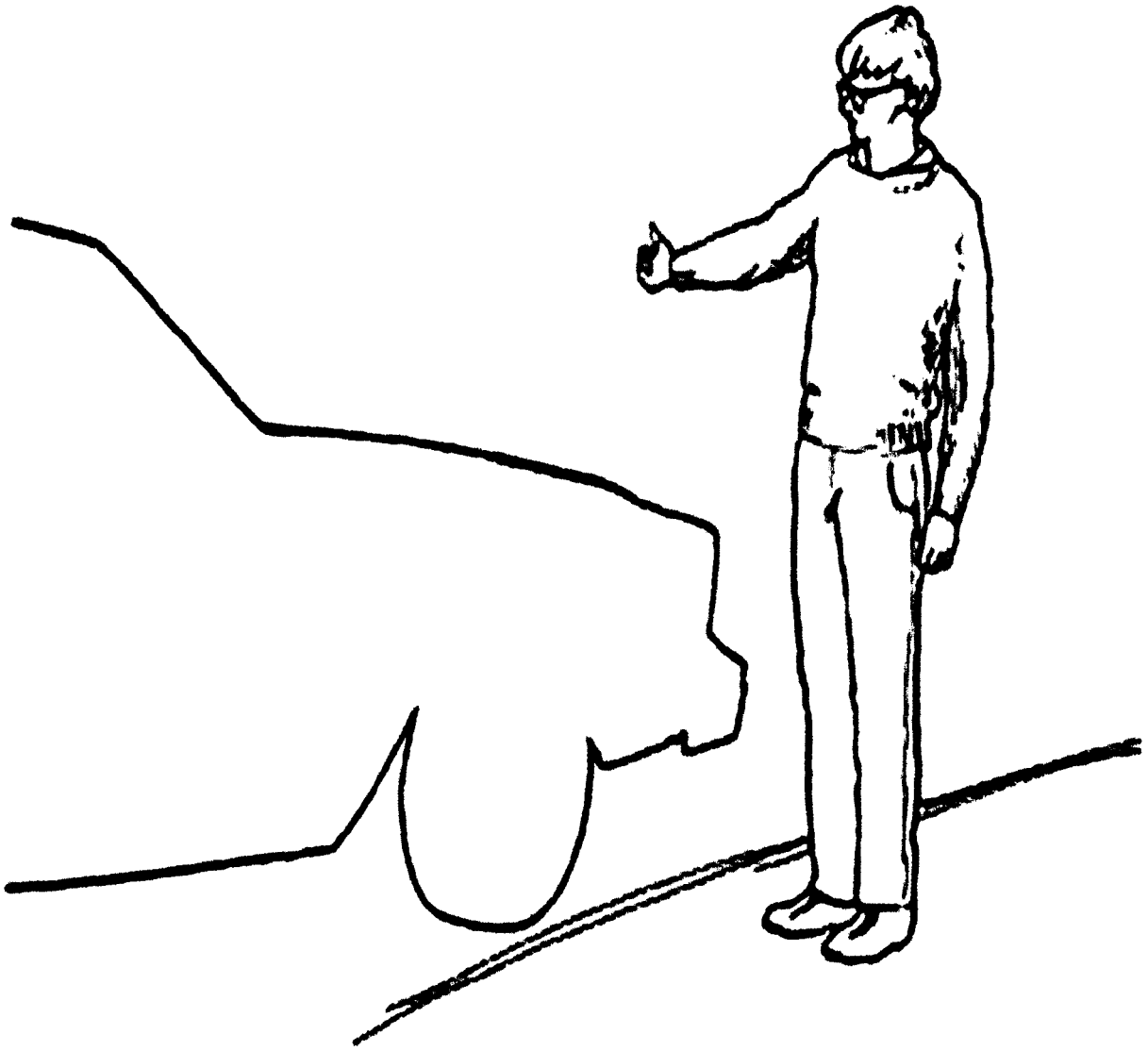
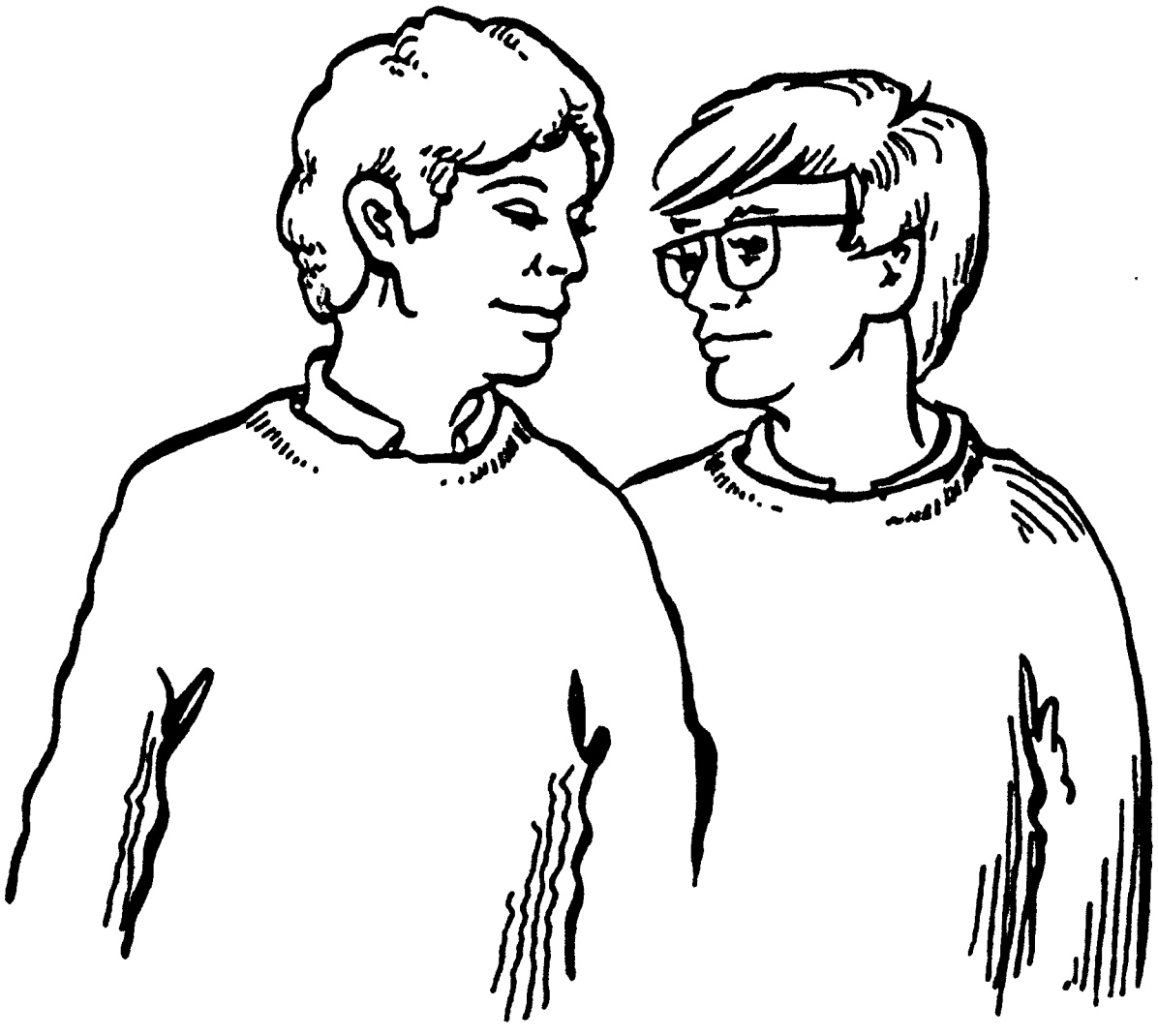


Question 7

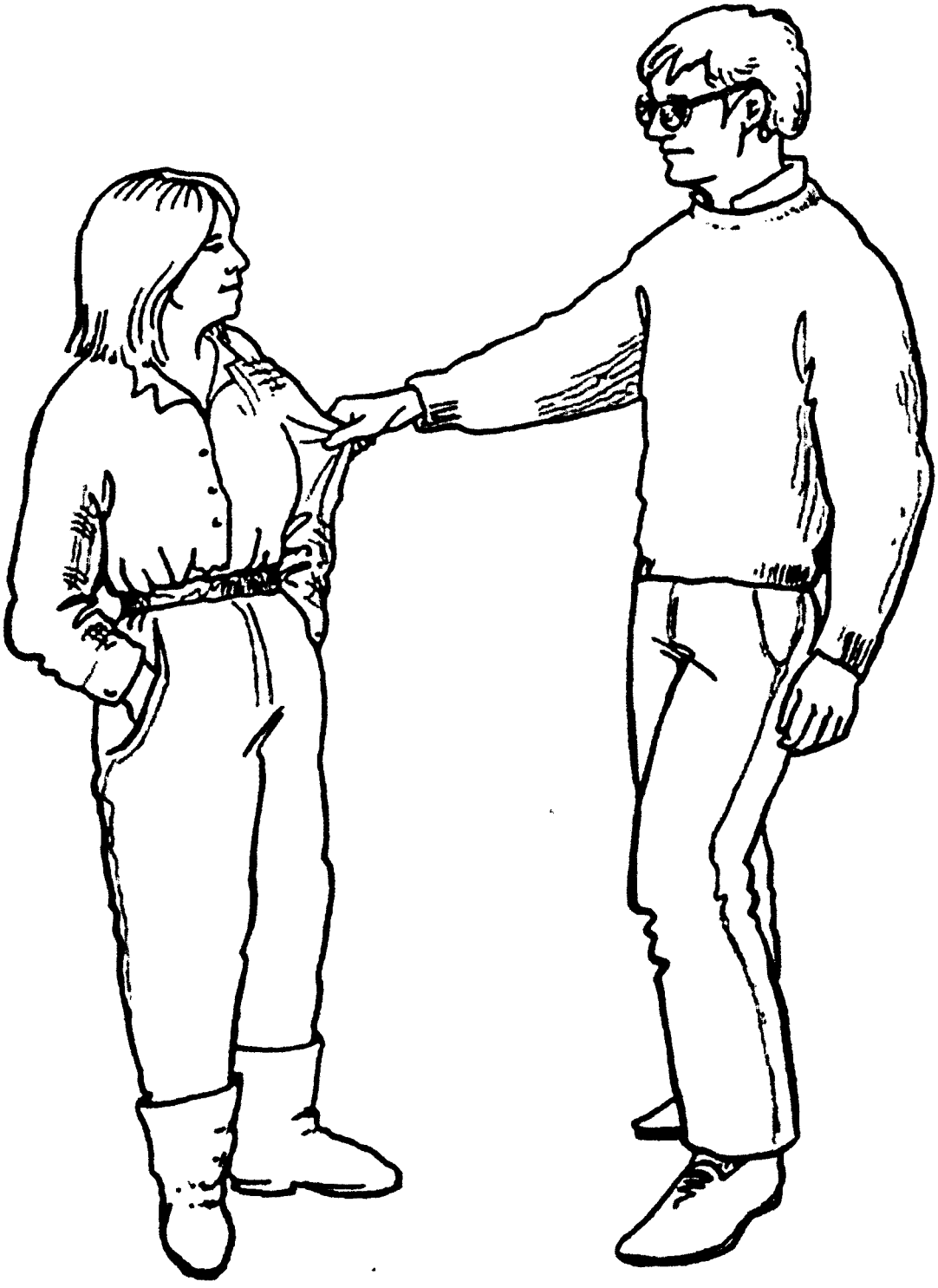


Question 8



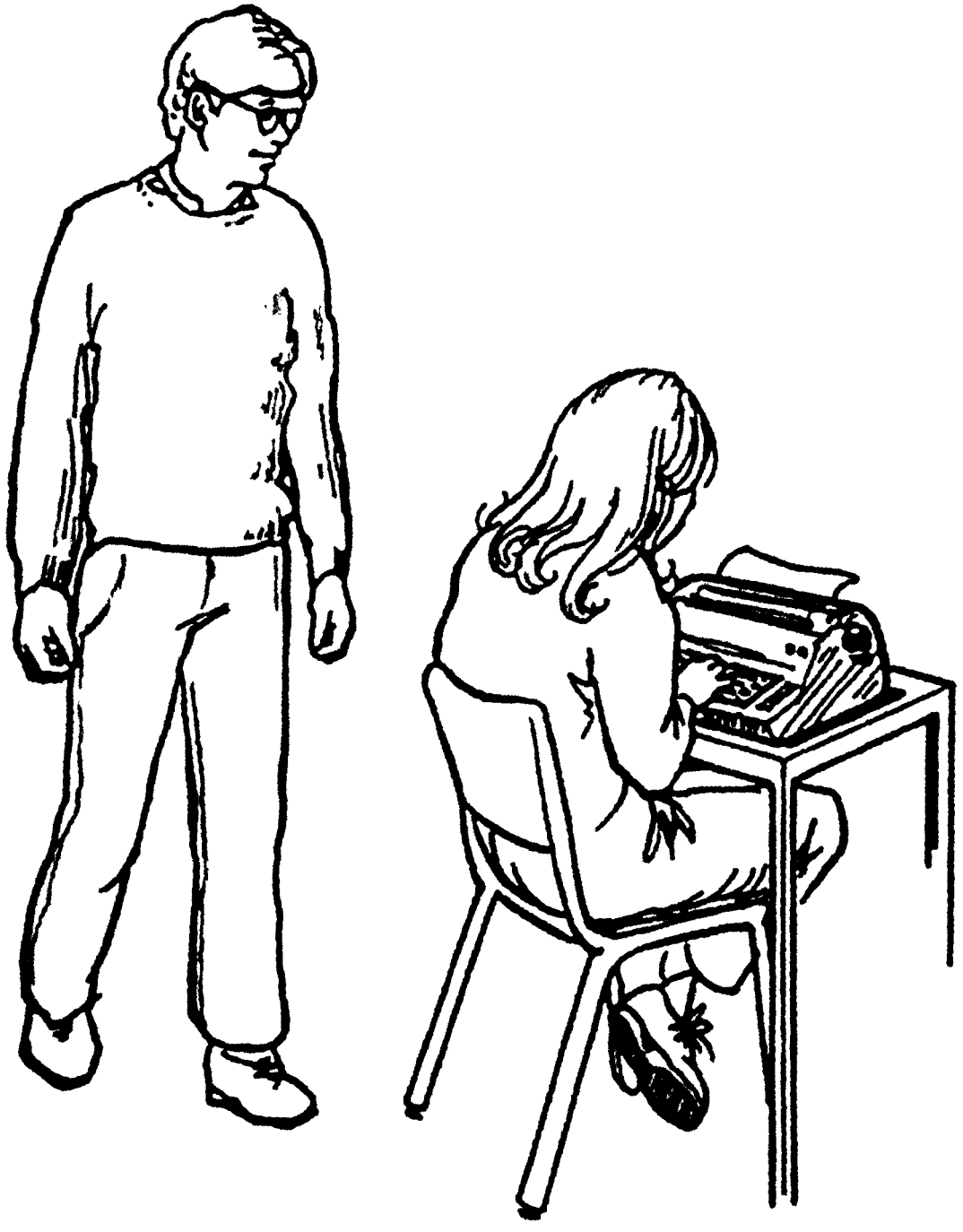
Question 9

Question 10



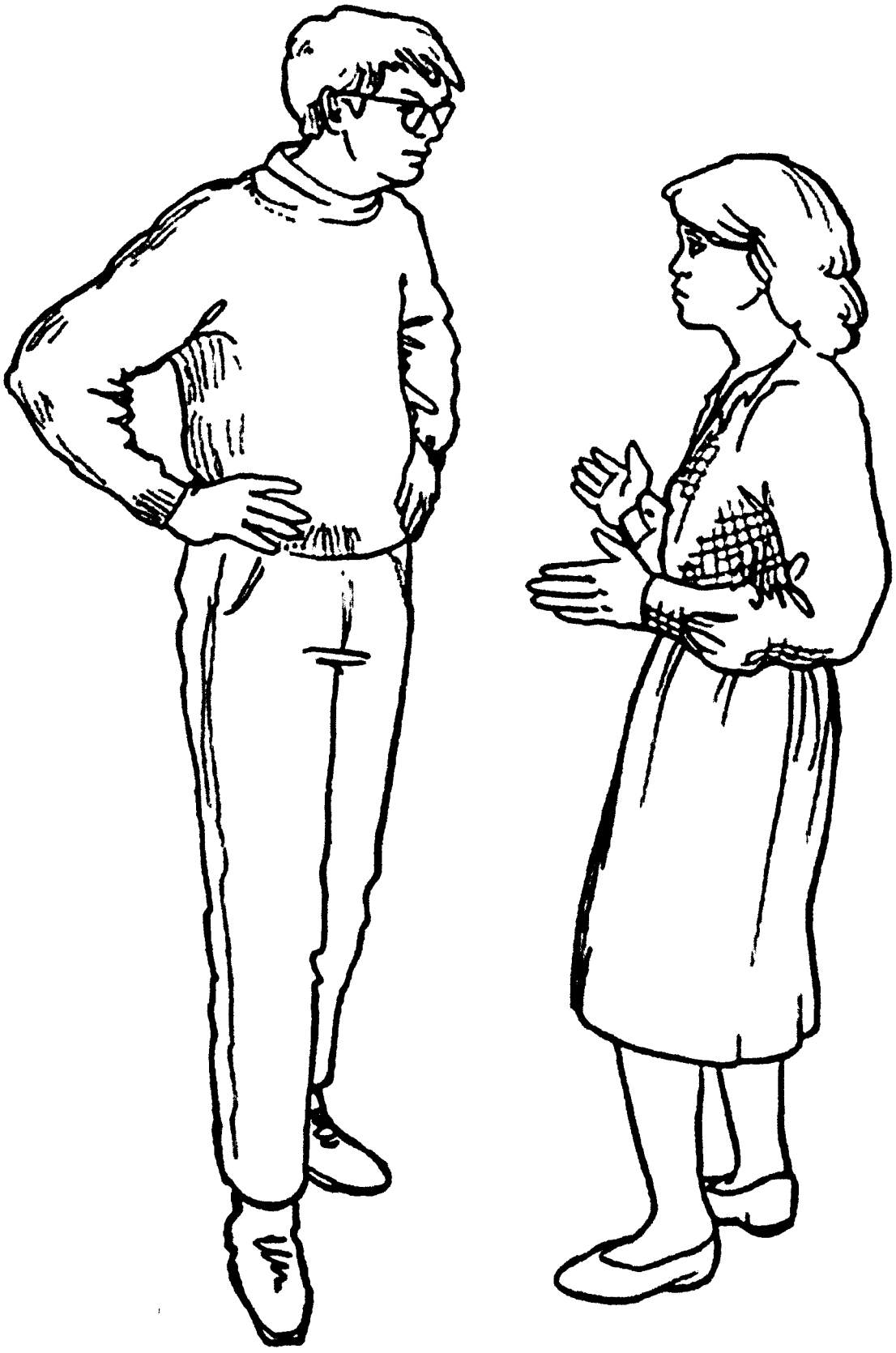
Question 11

Question 12



Question 13

Question 14



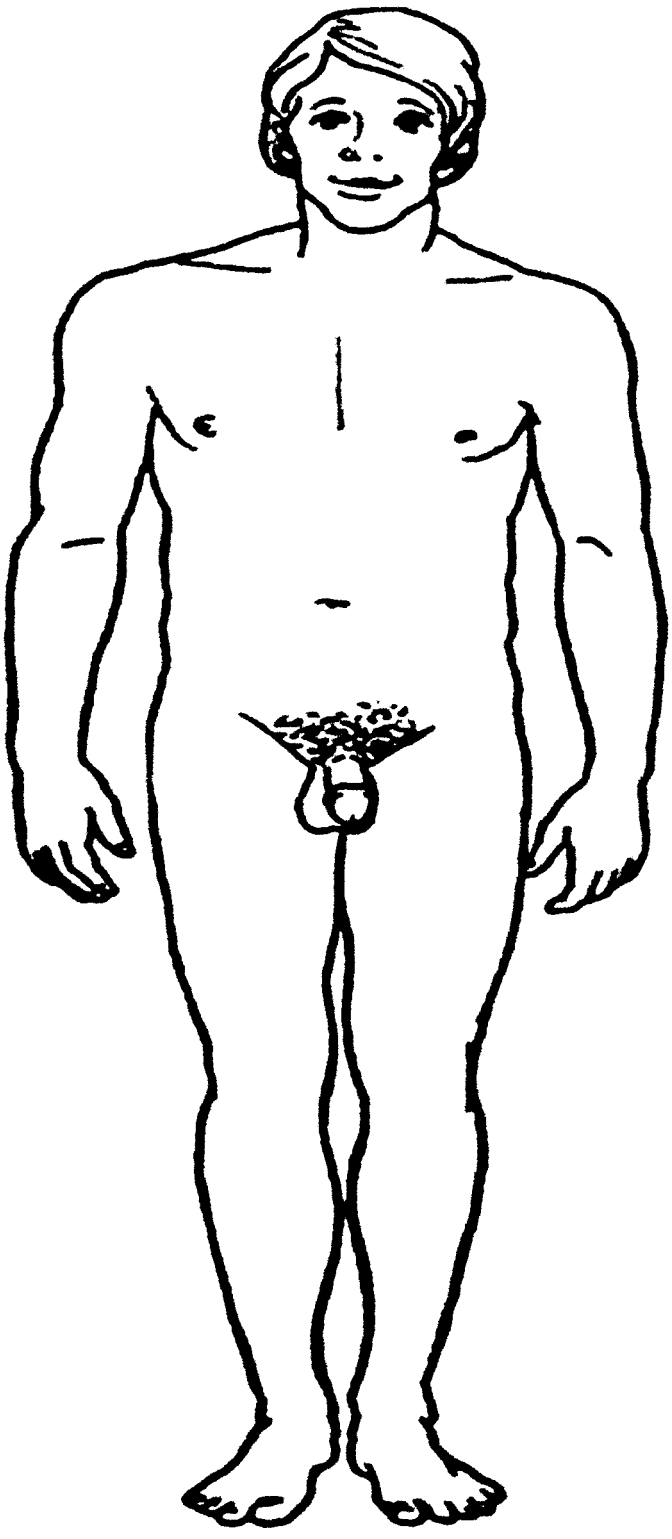
Question 15

Question 16

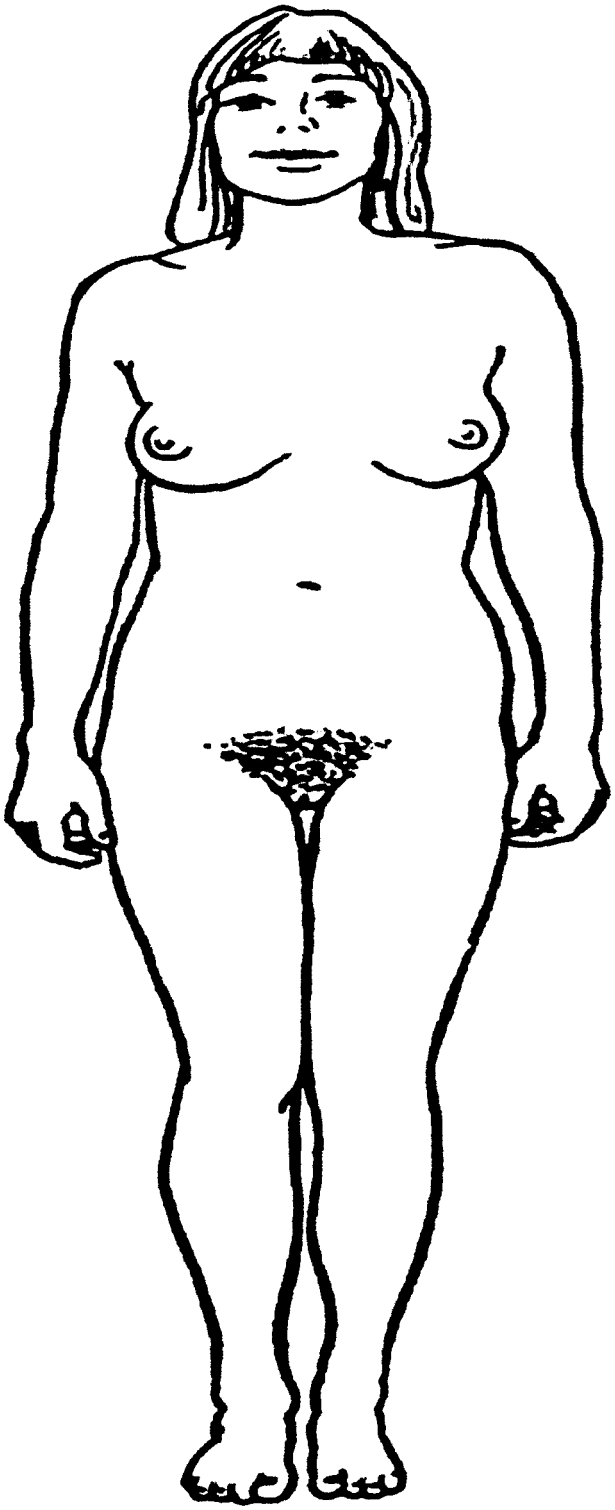
Question 17

Question 18

Question 19



Question 19



Appendix 6: Sex Offender's Self-Appraisal Scale SOSAS

SEX OFFENDER'S SELF-APPRAISAL SCALE
(S.O.S.A.S.)
Version 1.1
Adapted from the Prison Service "Sex Offence Attitude Questionnaire" by D. G. Bray et al, North Warwickshire NHS Trust.

Client's name:

_____

Tester's name:

_____

Date:

_____

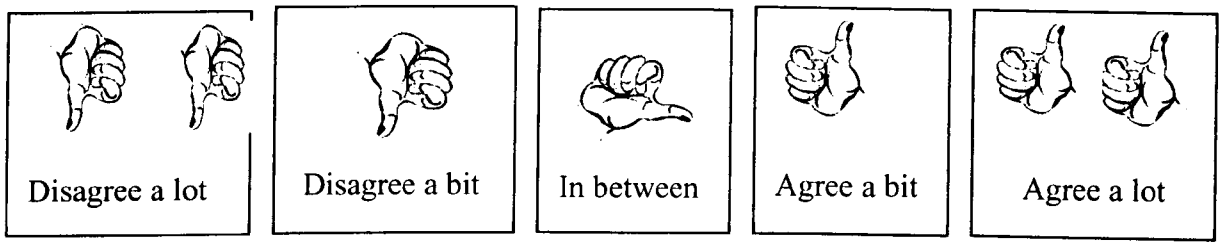
Pre, post or follow up measure?:

_____

Please send a full copy of the completed measure to the research team.

NOTES ON ADMINISTRATION

1. Enlarge font to an appropriate size and then print out.
2. Cut the statements out and stick each one on a card to make 24 cards, size x by y.
3. Arrange the boxes in the following patterns, within easy reach of the respondent:



4. Work through the examples a – d, making sure respondent understands the scale.
5. Get the respondent to shuffle the 20 statement cards.
6. Get the respondent either to read out the card or allow you to read it to him (with him still holding it).
7. The respondent "posts" a card into a box, according to their degree of agreement or disagreement with the statement on it.

8. After all 20 statements have been rated in this way, empty the box and record the degree of agreement/disagreement for each statement.

a.
I like chocolate cake.

_____
_____

b.
Cigarettes are good for my health.

_____
_____

c.
I have not seen a car this year.

_____
_____

d.
I will never eat worms.

_____
_____

1.
I did not do it.

_____
_____

2.
I am sure that I will never do sex offences again.

_____
_____

3.
I do not need help for my sexual behaviour.

_____
_____

4.
I have never done sex offences.

_____
_____

5.

I do not think I have a serious sexual problem.

_____

_____

6.
I couldn't control myself.

_____

_____

7.
He or She led me on.

_____

_____

8.
It happened because I wasn't getting enough sex.

_____

_____

9.
He or She turned me on so much, I couldn't help it.

_____

_____

10.
I did it because I had a lot of problems.

_____

_____

11.
He or She has got over it.

_____

_____

12.
It was just an accident.

_____

_____

13.
I only did it once.

_____

_____

14.
It was wrong, but I didn't hurt him or her.

_____

_____

15.
He or She enjoyed it.

_____
_____

16.
I think I might do a sex offence again.

_____
_____

17.
I planned things so that I could be alone with him or her

_____
_____

18.
I am going to need help for a long time to stop doing sex offences.

_____
_____

19.
I enjoyed having power over him or her.

_____
_____

20.
What I did was against the Law.

_____
_____

SEX OFFENDERS' SELF-APPRAISAL SCALE (S.O.S.A.S.) – Statements

Examples

a) I like chocolate cake.
b) Cigarettes are good for my health.
c) I have not seen a car this year.
d) I never eat worms.

Appendix 6: Sex Offender's Self-Appraisal Scale SOSAS

"Denial"

1) I did not do it.
2) I am sure I will never so sex offences again.
3) I do not need help for my sexual behaviour.
4) I have never done any sex offences
5) I do not think I have a serious sexual problem.

"Blame"

6) I couldn't control myself.
7) He/she led me on.
8) It happened because I wasn't getting enough sex.
9) He/she turned me on so much, I couldn't help it.
10) I did it because I had a lot of problems.

"Minimisation"

11) He/she has got over it.
12) It was just an accident.
13) I only did it once.
14) It was wrong but I didn't hurt him/her.
15) He/she enjoyed it.

"Real"

16) I think I might do a sex offence again.
17) I planned things so I could be alone with him/her.
18) I am going to need help for a long time to stop doing sex-offences.
19) I enjoyed having power over him/her.
20) What I did is against the Law.

S.O.S.A.S SCORING KEY

Agree + + = Agree a lot
Agree + = Agree a bit
In-between = In-between
Disagree + = Disagree a bit
Disagree + + = Disagree a lot

Items 1-15

Agree + + = 5
Agree + = 4
In-between = 3

	Disagree + = 2
	Disagree + + = 1
Items 17-20	Agree + + = 1
	Agree + = 2
	In-between = 3
	Disagree + = 4
	Disagree + + = 5
Item 16	**Deliberately ambiguous and not scored**
Item 17, 19, 20	Disagreement suggests possible 'desirability' motive
Items 7, 9, 15	Agreement suggestive of victim blaming

'Desirability' here means representing oneself in the least deviant light possible.

Appendix 6: Sex Offender's Self-Appraisal Scale SOSAS

S.O.S.A.S – Total Scores

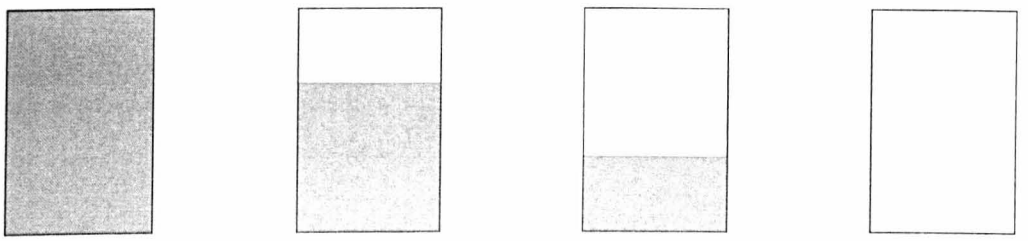
Item	Score	Total Score
1) I did not do it.		"Denial"
2) I am sure I will never so sex offences again.		
3) I do not need help for my sexual behaviour.		
4) I have never done any sex offences		
5) I do not think I have a serious sexual problem.		
6) I couldn't control myself.		"Blame"
7) He/she led me on.		
8) It happened because I wasn't getting enough sex.		
9) He/she turned me on so much, I couldn't help it.		
10) I did it because I had a lot of problems.		
11) He/she has got over it.		"Minimisation"
12) It was just an accident.		
13) I only did it once.		
14) It was wrong but I didn't hurt him/her.		
15) He/she enjoyed it.		
16) I think I might do a sex offence again.	*Not scored*	"Real"
17) I planned things so I could be alone with him/her.		
18) I am going to need help for a long time to stop doing sex-offences.		
19) I enjoyed having power over him/her.		
20) What I did is against the Law.		
		Overall Score

Appendix 7: Victim Empathy Scale Adapted VESA

VICTIM EMPATHY SCALE (Beckett & Fisher)

Administration:

First you will need to help the client understand the rating scale. Find out a couple of things he likes (e.g. ice cream and holidays) and a couple of things he dislikes (e.g. doing the washing up and going to the day centre). Then get him to rate statements about them using the scale below. Point out how the visual aid is a guide to how much he agrees with what you say. Make sure you use examples of statements he agrees with as well as statements he disagrees with. For example, ask him to respond to the statement 'I like ice cream' (he should agree) and 'I hate going to the day centre' (he should agree), as well as to 'I like washing up' (he should disagree) and to 'I hate holidays' (he should disagree)



3	2	1	0
YES VERY MUCH	YES MOSTLY	NO NOT MUCH	NO NOT AT ALL

Once you are sure the man understands how to use the scale, ask him to think about one particular NAMED victim, in answering the questions below. This should be the person involved in the most extreme offence committed. If he refuses to name them (or doesn't know their name) make it clear which victim you are talking about. If he claims they were not a victim, then say you still want to know how he thinks they feel about what happened. Make sure you use the SAME NAMED victim each time you rate his empathy (i.e. pre-group, post-group and follow-up).

Scoring:

a) Questions 17 and 18 are not scored.

b) Score following items as the scale suggests, i.e.
'Yes, very much' = 3, 'yes mostly' = 2, 'no, not much' = 1, & 'no not at all' = 0
Items 1 – 13 inclusive, 16, 19, 21, 24, 25, 27, 29

c) Score following items in reverse direction, i.e.
'Yes, very much' = 0, 'yes mostly' = 1, 'no, not much' = 2, & 'no not at all' = 3
Items: 14, 15, 20, 22, 23, 26, 28, 30

d) Add scores. Max score is 28 X 3 = 84. Express score as % of max. High scores mean low empathy.
Examples: if completed all 28 questions and got total score of 42, then final score = 42/84 X 100 = 50%
But if only did 26 of the 28 questions (i.e. could get no answer at all for 2 questions) & scored a total of 39 on these 26 questions, final score is 39 / 78 X 100 = 50%)

Appendix 7: Victim Empathy Scale Adapted VESA

Pre group, post group or 6 month follow up?:

_____

Date:

_____

Client's name:

_____

Tester:

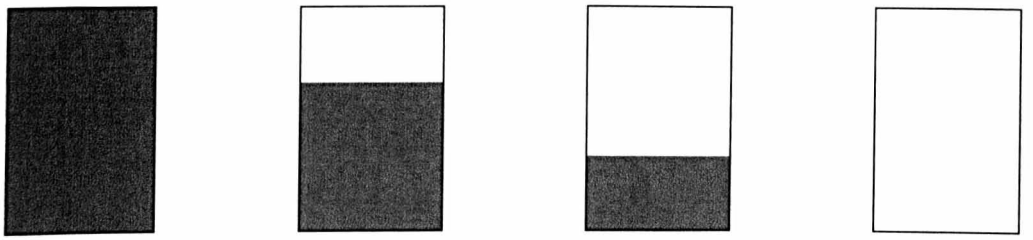
_____

Victim's name:

_____

Think about what (victim name throughout) thought. Do you think that (victim name)

1. Enjoyed what happened?



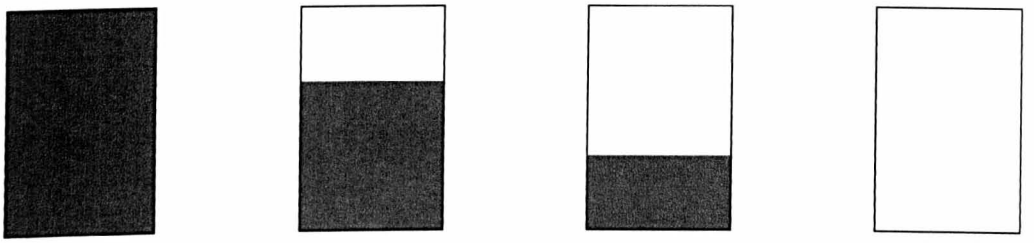
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

2. Thought you were sexy?



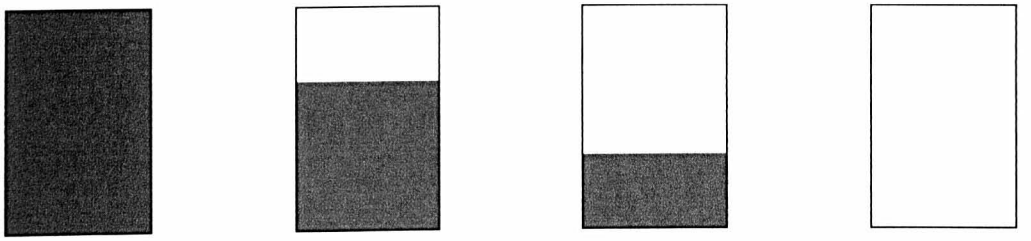
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

3. Took it all as a game?



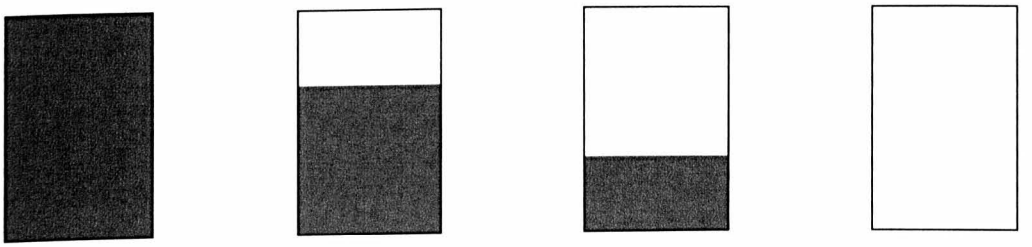
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

4. Had shown you that they didn't mind?



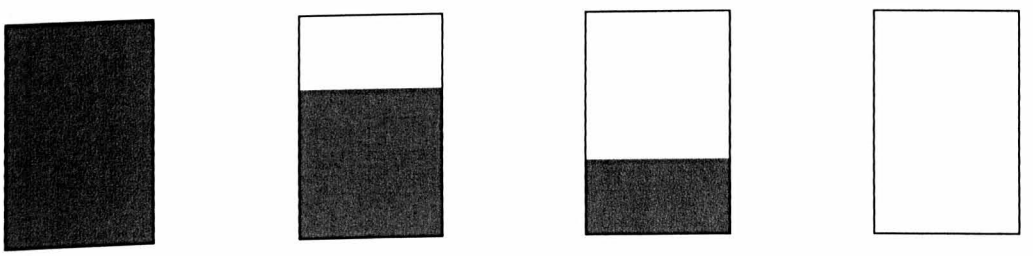
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

5. Could have stopped this happening if they wanted to?



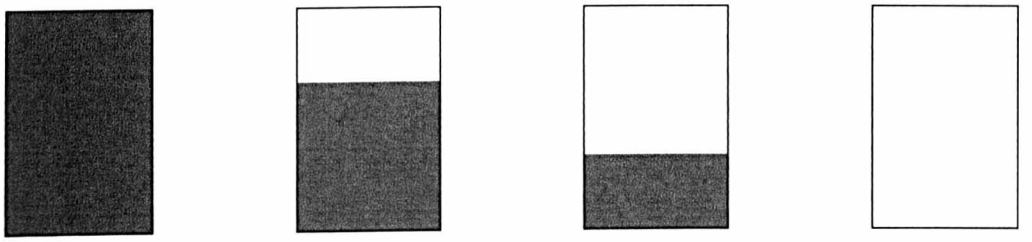
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

6. Was turned on by you?



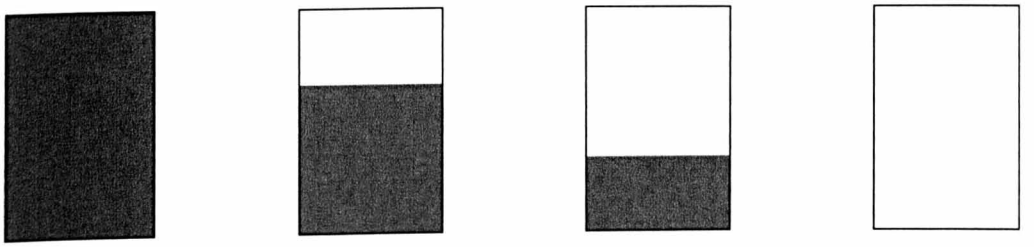
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

7. Wanted things to go further?



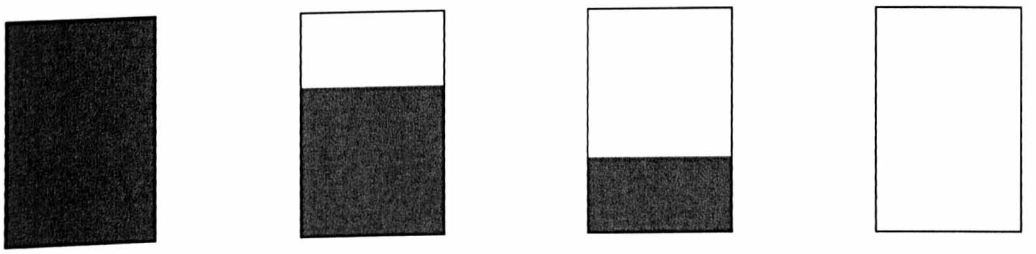
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

8. Was in charge of what happened?



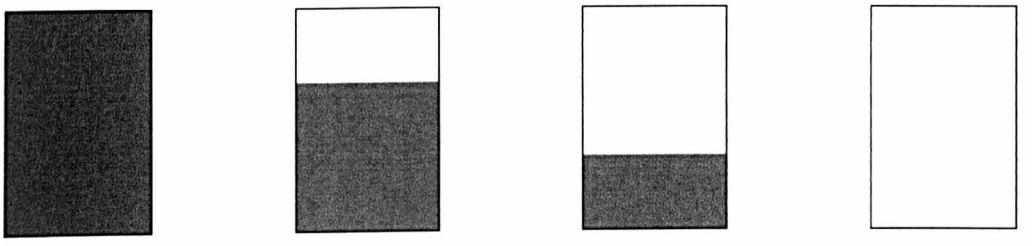
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

9. Felt good about what happened?



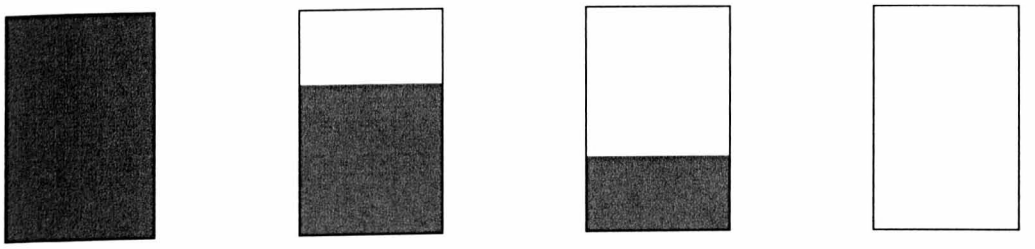
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

10. Felt okay in the situation?



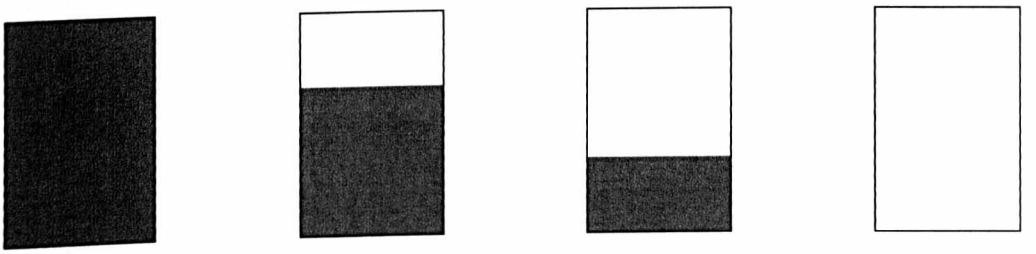
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

11. Was secretly excited by this?



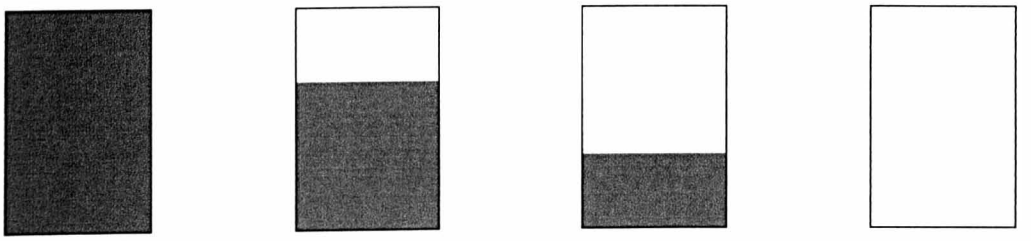
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

12. Had nice sexy thoughts about this afterwards?



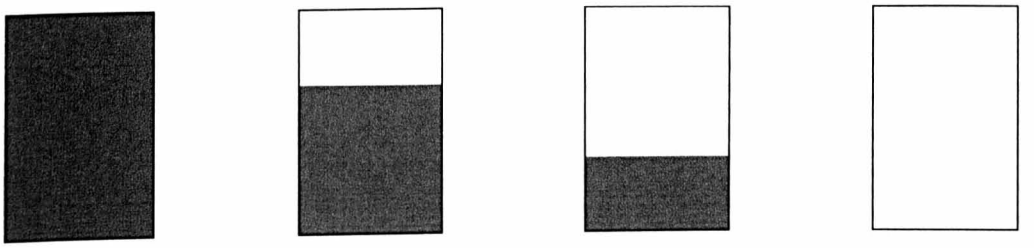
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

13. Felt guilty about how they had behaved?



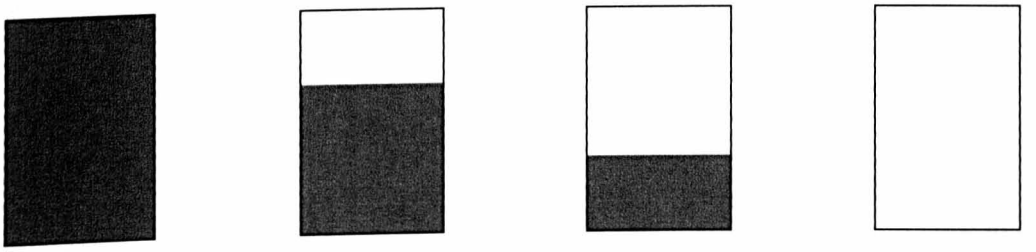
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

14. Was afraid?



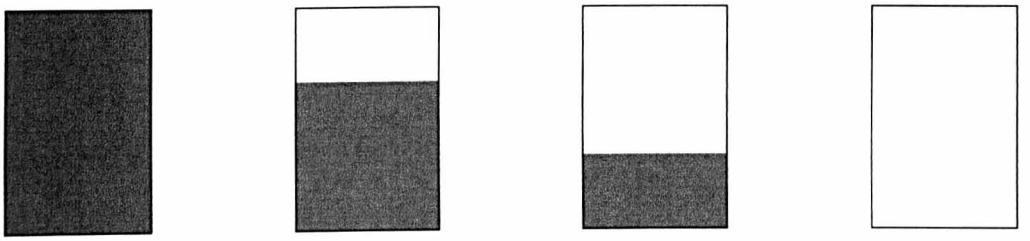
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

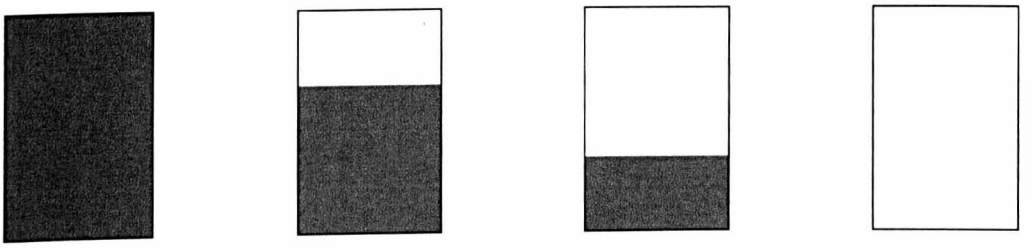
0
NO
NOT AT ALL

15. Thought about what happened afterwards?



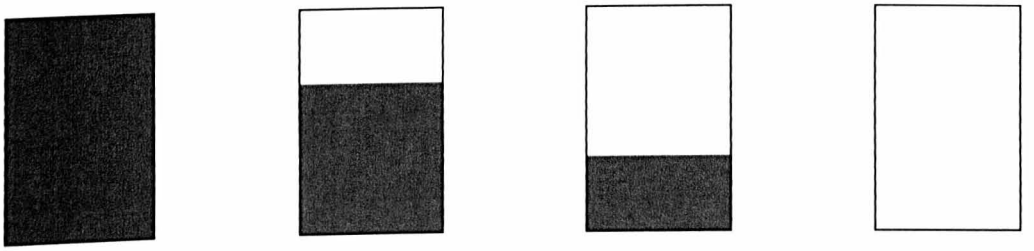
3	2	1	0
YES VERY MUCH	YES MOSTLY	NO NOT MUCH	NO NOT AT ALL

16. Hoped that it might happen again?



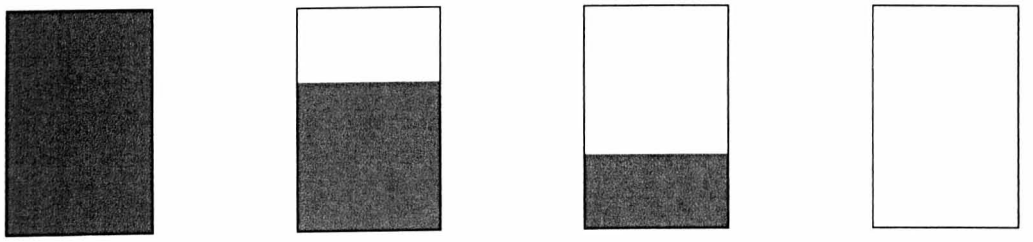
3	2	1	0
YES VERY MUCH	YES MOSTLY	NO NOT MUCH	NO NOT AT ALL

17. Did (victim name) feel sorry for themselves afterwards?



3	2	1	0
YES VERY MUCH	YES MOSTLY	NO NOT MUCH	NO NOT AT ALL

18. Did (victim name) feel sorry for you over what had happened?



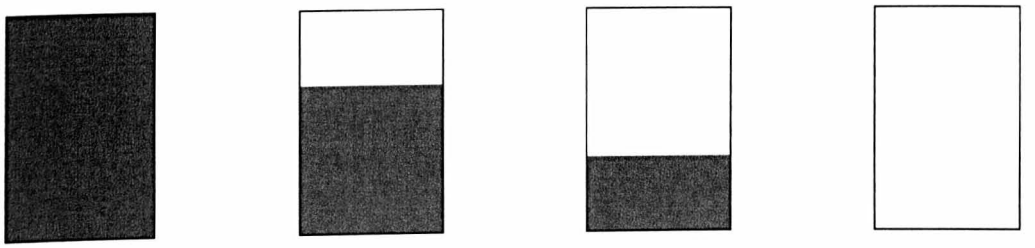
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

19. Had led you on?



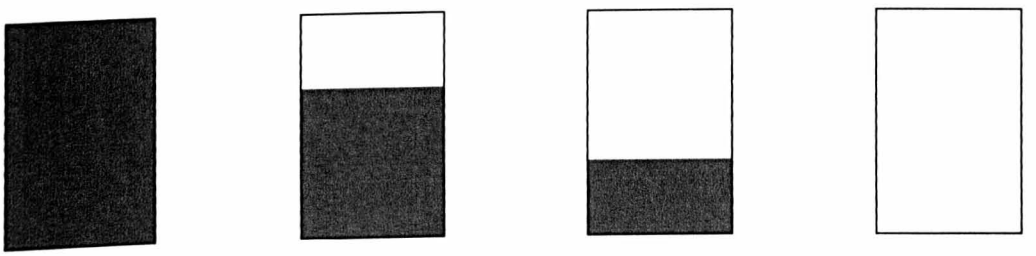
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

20. Felt angry about what happened?



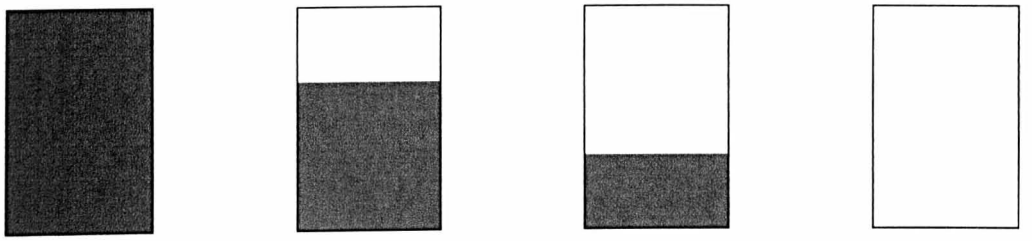
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

21. Had experienced something like that in the past?



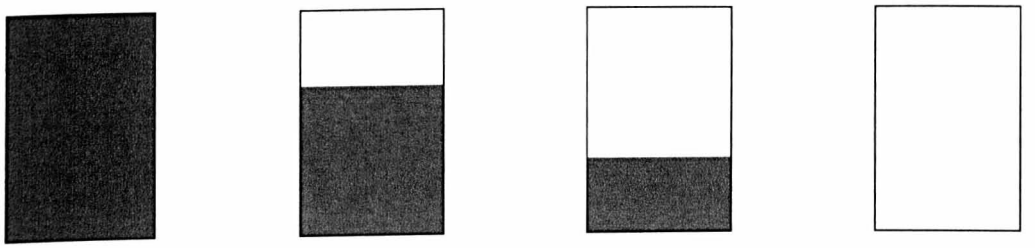
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

22. Felt picked-on by what happened?



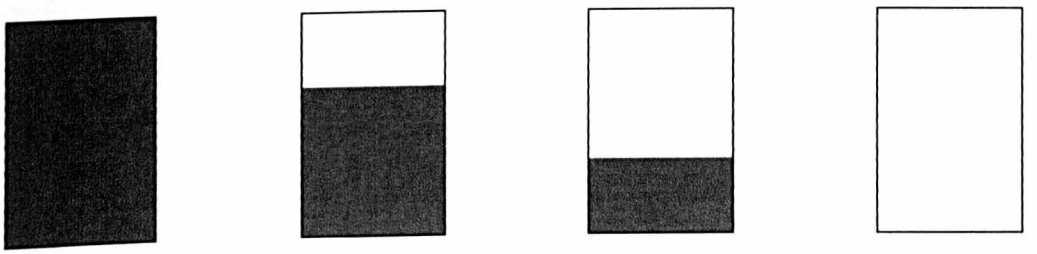
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

23. Worried that someone might find out what happened?



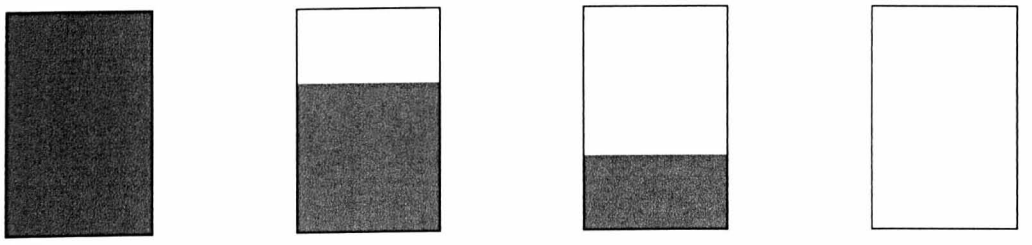
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

24. Would like to do it again if they had the chance?



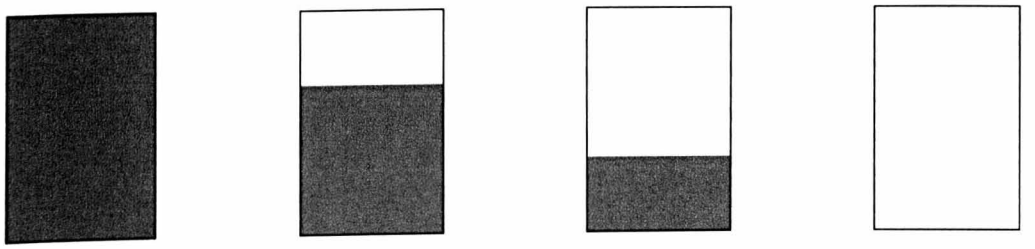
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

25. Had done more sexual things than other (children/ women/ men) their own age?



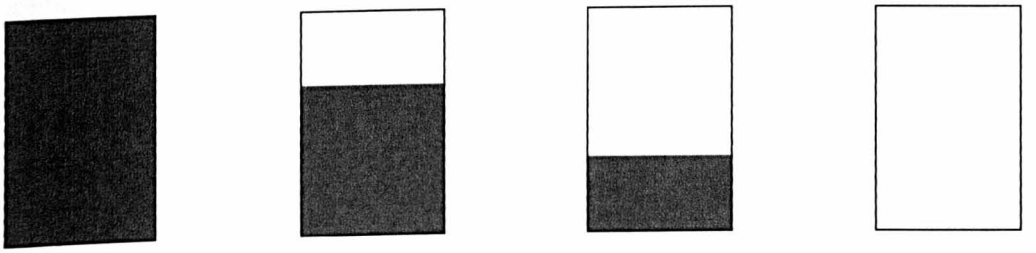
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

26. Had been led on by you?



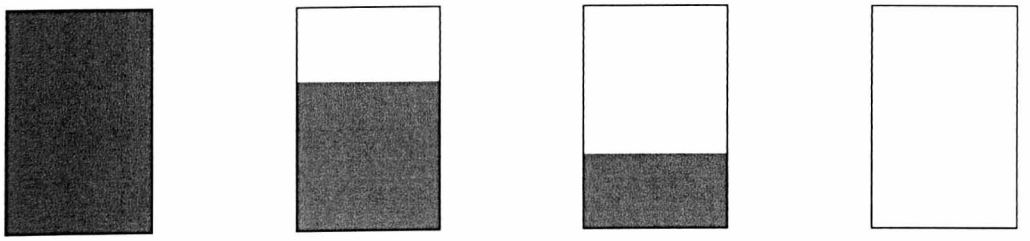
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

27. Wasn't sure what their feelings were?



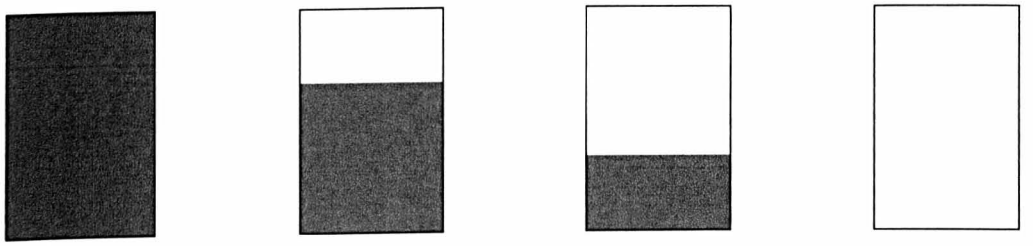
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

28. Felt dirty inside of themselves?



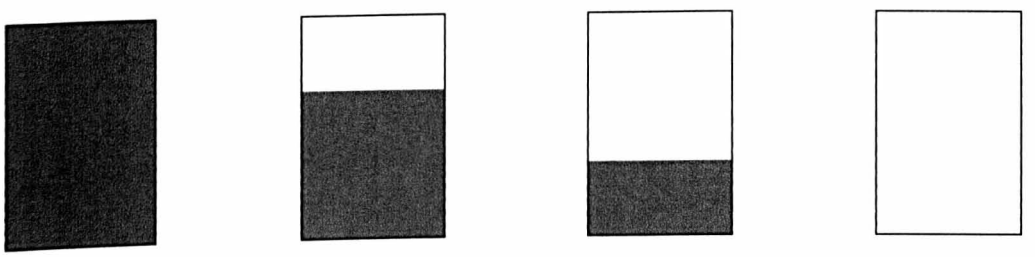
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

29. Was able to forget about it?



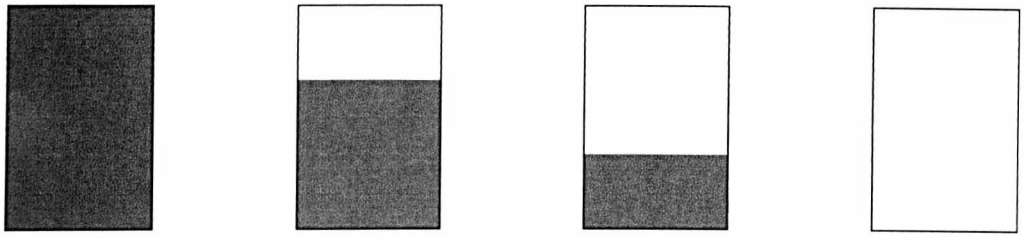
3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

30. Was harmed by what happened?



3
YES
VERY MUCH

2
YES
MOSTLY

1
NO
NOT MUCH

0
NO
NOT AT ALL

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Consent to Treatment for Informal Participants
[Local hospital/Trust headed paper]
Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM FOR TREATMENT

Men's Group

Name of Group Leaders: [Facilitator 1], [Facilitator 2], [Facilitator 3] and [Facilitator 4].

Please tick √ the 'YES' box if you agree. Put a X if you don't agree

	YES
I understand the information sheet	
I have asked any questions I wanted to	☐
I understand that I do not have to join the Men's Group	☐
I understand I can pull out of the Men's Group at any time	☐
I understand that it will not affect the services I get if I take part or not	☐
I agree for my Keyworker to know I am joining the Men's Group	☐
I agree for my Care Manager to know I am joining the Men's Group	☐
I agree for my Parents to know I am joining the Men's Group (they don't have to know if I don't want them to)	☐
I agree for my doctor to know I am joining the Men's Group	☐
I agree to join the Men's Group	☐

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

My name: _____

Date: _____

Signature: _____

Group leader: _____

Date: _____

Signature: _____

Sometimes the group leaders may need to talk to someone else if they think that you or someone else is in danger. Please give the name and telephone number of the person we can contact in this situation:

Name: _____

Who is my: _____(keyworker etc)

Telephone Number: _____

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Information Sheet for Participation in Treatment for Informal Participants
[Local hospital/Trust headed paper]

Men's Group

Some men with learning disabilities are being asked to join a Men's Group. The Men's Group is to help them stop sexually offending. You are being invited to join the Men's Group.

Background:
Some men with learning disabilities commit sexual offences like:

- Touching a child on the 'private parts' (genitals)
- Showing other people their 'private parts' in public.
- Forcing someone to have sex with them.

Doing these things is against the law and can get these men into trouble with the police.

The Men's Group
We are starting a group to help men stop doing these sexual offences. The group will teach men about:

- Their bodies
- Who it is OK to touch and who it is not OK to touch
- What can get you into trouble
- Feelings
- How to stop sexual offending

Joining the Men's Group

- The Men's Group is every week at [location] for [duration] hours.
- The group lasts for one year.
- There will be 5 – 10 men in the group.

Do I have to join the Men's Group?
No, you do not have to join the Men's Group.

What if I don't like the Men's Group?
If you want to leave the group at any time then that is OK.

Is there anything bad about joining the Men's Group?

- Sometimes the group may make you feel sad or upset. You can tell the group leader if you feel upset.
- The group will try to help you but it might not work

Is there anything good about joining the Men's Group?

- Yes, you may learn new things to help you
- You will meet new people
- The group may help you make safe choices and stay out of trouble

What happens at the end of the group?

- You may not need any more help
- If you do need more help, you may be asked to come to another Men's Group.

What if I don't like what happens in the Men's group?

- You can make a complaint to [hospital/Trust]
- You will be given information about how to complain
- You may want to ask a friend or staff member to help you make a complaint

Will things that I talk about in the group be private?

- One of the rules for the Men's Group will be: 'what's talked about in the group, stays in the group.'
- We will ask you the name of someone that helps you, so that we can talk to them about your progress in the group.
- We will only talk to other people if we think that you or someone else is in danger or you tell us about a new offence.

Will I find out about how I have done at the end of the group?

Yes. You will be told at the end of the group how you have done.

Contact name for further information:

You can talk to [Facilitator #] if you want more information. [His/Her] telephone number is [insert telephone number].

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Consent to Treatment for Legally Restricted Participants
[Local hospital/Trust headed paper]

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM FOR TREATMENT

Men's Group

Name of Group Leaders: [Facilitator 1], [Facilitator 2], [Facilitator 3] and [Facilitator 4].

Please tick √ the 'YES' box if you agree. Put a X if you don't agree

	YES
I understand the information sheet	☐
I have asked any questions I wanted to	☐
I understand that the court has said that I need to join the Men's Group	☐
I understand that it may affect the services I get if I take part or not	☐
I agree for my Key Worker to know I am joining the Men's Group	☐
I agree for my Care Manager to know I am joining the Men's Group	☐
I agree for my Parents to know I am joining the Men's Group, (they don't have to know if I don't want them to)	☐
I agree for my doctor to know that I am joining the Men's Group	☐

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

	YES
I agree for my probation officer to know I am joining the Men's Group	☐
I agree to join the Men's Group	☐

My Name: _____

Date: _____

Signature: _____

Group Leader: _____

Date: _____

Signature: _____

Sometimes the group leaders may need to talk to someone else if they think that you or someone else is in danger. Please give the name and telephone number of the person we can contact in this situation:

Name: _____

Who is my: _____(key worker, probation officer etc).

Telephone Number: _____

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Information Sheet for Participation in Treatment for Legally Restricted Participants
[Local hospital/Trust headed paper]

Men's Group

Some men with learning disabilities are being asked to join a Men's Group. The Men's Group is to help them stop sexually offending. You are being invited to join a Men's Group.

Background:
Some men with learning disabilities commit sexual offences like:

- Touching a child on the 'private parts' (genitals)
- Showing other people their 'private parts' in public.
- Forcing someone to have sex with them.

Doing these things is against the law and can get these men into trouble with the police.

The Men's Group
We are starting a group to help men stop doing these sexual offences. The group will teach men about:

- Their bodies
- Who it is OK to touch and who it is not OK to touch
- What can get you into trouble
- Feelings
- How to stop sexual offending.

Joining the Men's Group

- The Men's Group is every week at [location] for [duration] hours.
- The group lasts for one year.
- There will be 5 – 10 men in the group.
- You would need to go to the Men's Group each week

Do I have to take part in the Men's Group?
Yes, the court/your doctor/your probation officer has said you need to join the Men's Group. If you don't join the Men's Group then you may need to go back to court.

What if I don't like the Men's Group?
If you don't go to the Men's Group you may need to go back to court.

Is there anything bad about joining the Men's Group?
- Sometimes the group may make you feel sad or upset. You can tell the group leader if you feel upset.
- The group will try to help you but it might not work

Is there anything good about joining the Men's Group?
- Yes, you may learn new things to help you
- You will meet new people
- The group may help you to make safe choices and stay out of trouble

What happens at the end of the group?
- You may not need any more help.
- If you do need more help, you may be asked to come to another Men's Group.

What if I don't like what happens in the Men's Group?
- You can make a complaint to [hospital/Trust]
- You will be given information about how to complain
- You may want to ask a friend or staff member to help you make a complaint

Will things that I talk about in the group be private?
- One of the rules for the Men's Group will be: 'what's said in the group, stays in the group.'
- We will talk to some people that help you, like your (probation officer, Responsible Medical Officer) about your progress in the group.
- We will only talk to other people if we think that you or someone else is in danger or you tell us about a new offence.

Will I find out about how I have done at the end of the group?
Yes. You will be told at the end of the group how you have done.

Contact name for further information:
You can talk to [Facilitator #] if you want more information. [His/Her] telephone number is [insert telephone number].

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Covering Letter for Parents/Carers/Care Managers/Probation Officers and Doctors
[Local NHS/Private facility letterhead]

[Insert date], 2002

Dear [insert name]

Treatment for Men with a Learning Disability at Risk of Sexual Offending

I am writing to you because [name of client] has been invited to attend a group providing cognitive behaviour therapy for men with a learning disability at risk of sexual offending (the Men's Group). The treatment is designed to help men recognise when they are feeling like they may engage in sexually abusive behaviour ('warning signals'), providing strategies to help stop them from offending and to access help.

The group will be held at [location] on [day/s of week] at [meeting time] for one year. It is important that [name of client] attends all sessions of the group.

Please find enclosed an information sheet for the treatment, which outlines the treatment in more detail.

Please do not hesitate to contact myself [insert lead facilitators telephone number], [other facilitator name and telephone number] if you have any questions or concerns about the treatment, or if there are any difficulties with transport for [name of client] to the group.

Yours sincerely

Appendix 8: Treatment Consent Information Sheets and Forms
Studies 1 and 4

TREATMENT: Information sheet for Parents/Carers/Care Managers/Probation Officers and Doctors

[Local NHS/private facility headed paper]

Treatment for Men with a Learning Disability at Risk of Sexual Offending

A group treatment is being offered to men with learning disabilities that are at risk of sexual offending.

What does the treatment involve?

The treatment groups are based on an adaptation of mainstream sex offender treatment programmes. The general topic content will be:

- human relationships and sex education (especially social rules and legal and illegal behaviour)
- taking responsibility for offences
- empathy for the victim
- relapse prevention

The treatment groups will be run by clinicians in your local health service. Usually these people will be clinical psychologists, behaviour therapists or behaviourally trained nurses. The groups will be of 5 – 10 men, who will meet once or twice per week for a two-hour session. The group will run for a year.

Does it cost anything to receive the treatment?

The treatment is being offered by the NHS/private facility and therefore it will not cost anything to the individual, family or care provider.

How long is the treatment?

The treatment will last for one year. There will be one - two sessions per week each session lasting for 2 hours.

Does the individual have to take part?

Men are able to make their own decisions about taking part or not. However, given the seriousness of their behaviour it is important that men understand the possible consequences of them not taking part (e.g. getting into trouble with the police if their behaviour continues).

For some men, the court legally requires their attendance at the group. Refusal or absence from the group may have legal consequences (e.g. breaching a probation order/return to court).

What happens if the individual does not like the treatment?

All men are able to withdraw from the treatment at any stage. However, for those men who are legally required to attend treatment, there may be legal consequences from withdrawing from the treatment.

What are the benefits of receiving treatment?

Research with non-disabled populations has suggested that this type of group treatment is successful in preventing re-offending. Individual progress in treatment may result in changes in legal status or the level of security required by the individual.

What are the risks of receiving treatment?

The treatment groups will address sensitive issues such as attitudes to potential victims of abuse. This may create mild psychological distress or embarrassment. Levels of distress will be monitored constantly during the group by clinicians that are experienced in responding to distressed individuals.

The level of risk that the individual poses to others will be monitored carefully by the group facilitators. Facilitators will maintain active links with parents/carers/ probation officers and doctors etc. to discuss perceived increases or decreases in risk.

What happens at the end of the treatment?

There are a range of options which may be offered to the individual following treatment, such as:

- individual therapy
- another full group therapy programme
- a maintenance group which reviews content of the first group, but meets less regularly (e.g. once per month).

All men will be staying in touch with learning disability services after the end of the group. Further treatment and/or counselling will be available.

What happens if the individual or I want to complain?

The individual or yourself has the right to complain. Complaints can be made to the local NHS trust/service provider.

Will the content of treatment be kept private?

Yes, however there may be times when an individual has given information which the group facilitators believe someone else needs to know (for example if the individual or someone else is in danger). The individual is aware of this limit to confidentiality and

has given us details of a named person to contact in this event. The individual is also aware that if disclosures of offences that have been previously unknown are made then a (named) person will be contacted if the victim can be identified.

Will the individual get feedback at the end of the treatment?

The individual will be told about their progress in treatment. Feedback will also be given to the referring agent and other people involved in the individual's risk management.

What do I need to do?

You need to let us know if you have any concerns about [name] taking part in the treatment.

Contact name for further information:

For more information contact [group facilitators names and telephone numbers].

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

Consent to Research for Control group
(Hospital/Institution headed paper)
Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM FOR RESEARCH
Men's Group Research

Name of Researchers: Glynis Murphy, Neil Sinclair, Sarah-Jane Booth

Name of Group Facilitators: (Insert local names)

Please tick √ the 'YES' box if you agree. Put an X if you don't agree.

I have had understand the information sheet dated 27/1/03 (version 6) **YES**

explained to me by ..... (name) and ..... (my carer / advocate) ☐

I have asked any questions I wanted to ☐

I understand that I do not have to take part in the research ☐

I understand that I can pull out at any time without giving a reason ☐

If I pull out I understand that I can still go to the next Men's Group ☐

I agree for the research team to look at my medical notes
and other health records ☐

I agree for my Key Worker to know I am taking part ☐

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

I agree for my Care Manager to know that I am taking part ☐

YES

I agree for my parents to know that I am taking part (they don't have to know if I don't want them to) ☐

I agree for my doctor (GP, Psychiatrist) to know that I am taking part ☐

I agree for my Probation Officer to know that I am taking part ☐

I agree to take part in the research ☐

My name: _____

Date: _____

Signature: _____

My carer's /advocate's name: _____

Date: _____

Signature: _____

Researcher's Name: _____

Date: _____

Signature: _____

Sometimes the researchers may need to talk to someone else if they think that you or someone else is in danger. Please give the name and telephone number of the person we can contact in this situation:

Name: _____ Who is my:

_____ (Keyworker, Probation Officer etc)

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

Telephone Number: _____

Information Sheet for Participation in Research as a Control
(Local Hospital/Trust headed paper)

Does the Men's Group really help men?

Some men with learning disabilities do sexual offences. We have started a Men's Group to help them stop sexually offending. We want to find out if the Men's Group really helps men to stop sexual offending. This is research work. We are inviting you to take part in this work. Please read this information before you decide. You can talk to someone (like a carer or an advocate) to help you decide.

Why are we asking you?
We are asking you because you are waiting to join the next Men's Group.

Do you have to take part in finding out if the Men's Group really works?

- No, you do not have to take part in this research work.
- If you say "YES", it is still OK to change your mind later and say "NO." You do not have to give a reason.
- You will still be able to join the next Men's Group, even if you say "NO"

What do you have to do, if you say "YES" to this?

- (Name) or (Name), will talk to you and ask you some questions.
- They will ask you the questions before you start the Men's Group.
- The questions will take two or three visits to talk through. (Name) will see you either at home or at your day centre or at (name of local health centre), whichever you prefer

You need to answer the questions as honestly as you can. There might be some questions that you do not want to answer. That is OK. You do not have to give a reason.

If you say "YES" to the research, you will be part of this work for one and a half years.

There are 120 men with Learning Disabilities participating in this work.

Appendix 9: Research Consent Information Sheets and Forms Studies 1 and 4

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

What do we want to know?
We want to know whether the Men's Group helps men, by looking at your answers to the questions.

Is there anything bad about this work?

- Sometimes the questions may make you feel sad or upset. You can tell the person asking you the questions if you feel upset.
- Being part of this work may not help you.

Is there anything good about this work?
By saying "YES" to taking part, you will help other men because we will find out whether the Men's Group works.

What if you don't like the way this work is done?

- You can make a complaint to …….. (name)
- We will give you information about how to complain
- You may want to ask a friend or staff member to help you to make a complaint.

Will information kept about you be private?

- Yes. We will only tell someone else if we think that you or someone else is in danger, or if you tell us about a new offence.
- We will ask you if it is OK to tell your doctor about you being part of the research.
- We may need to look at your medical records and we will ask you if this is OK
- All of the results of this work will be kept locked away and only the research workers will be able to look at the files.
- If you pull out, the information about you will be destroyed.

What happens at the end?

- We will tell you whether the Men's Group really helps men
- You will be asked if you want to come to the next Men's Group, which is due to start on (insert date).
- The researchers will write about the work. No names or addresses will be given.

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

Who are the research workers?

- Glynis Murphy, Neil Sinclair and Sarah-Jane Booth are the research workers. They are all psychologists.
- The Department of Health is paying for the work.

Has the work been checked?

- People have looked at the work to check that it is safe.
- People have also checked that everyone gets good information before they start.

Further Information:

- Thank you for reading the information about this work
- You will be given a copy of the information sheet and consent form.
- If you want any extra information, you or your support person can call Glynis Murphy (01524 592771) or Neil Sinclair (01227 833 700). Or you can write to Glynis Murphy, Institute for Health Research, Lancaster University, Lancaster LA1 4YT

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

Consent to Research Treatment group
(Local Hospital/Trust headed paper)

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM FOR RESEARCH

Men's Group Research

Name of Researchers: Glynis Murphy, Neil Sinclair, Sarah-Jane Booth

Name of Group Facilitators: (insert local researchers)

Please tick √ the 'YES' box if you agree. Put an X if you don't agree.

	YES
I have had the information sheet dated 27/1/03 (version 6)	
explained to me by .....(name) and .....(my carer / advocate)	☐
I have asked any questions I wanted to	☐
I understand that I do not have to take part in the research	☐
I understand that I can pull out at any time without giving a reason	☐
If I pull out I understand that I can still go to the Men's Group	☐
I agree for the research team to look at my medical notes and other health records	☐
I agree to Sarah-Jane visiting my group sometimes	☐

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

I agree for my Key Worker to know I am taking part ☐ **YES**

I agree for my Care Manager to know that I am taking part ☐

I agree for my parents to know that I am taking part (they don't have to know if I don't want them to) ☐

I agree for my doctor (GP, Psychiatrist) to know that I am taking part ☐

I agree for my Probation Officer to know that I am taking part ☐

I agree to take part in the research ☐

My name: _____

Date: _____

Signature: _____

My carer's / advocate's name: _____

Date: _____

Signature: _____

Researcher's name: _____

Date: _____

Signature: _____

Sometimes the researchers may need to talk to someone else if they think that you or someone else is in danger. Please give the name and telephone number of the person we can contact in this situation:

Name: _____

Who is my: _____ (Keyworker, Probation Officer etc)

Appendix 9: Research Consent Information Sheets and Forms
Studies 1 and 4

Telephone Number: _____

Information Sheet for Participation in Research
(Local Hospital/Trust headed paper)
Does the Men's Group really help men?

It is great that you want to be part of the Men's Group. We want to find out if the Men's Group really helps men to stop sexual offending. This is research work. We are inviting you to take part in this work. Please read this information before you decide. You can talk to someone (like your carer or an advocate) to help you decide.

Why are we asking you?
We are asking you because you have said "YES" to joining the Men's Group.

Do you have to take part in finding out if the Men's Group really works?
- No, you do not have to take part in this research work.
- If you say "YES", it is still OK to change your mind later and say "NO." You do not have to give a reason.
- You will still be able to go to the Men's Group even if you say "NO"

What do you have to do, if you say "YES" to this?
As you know, the Men's Group lasts one year.

(Name) or (name), who run the Men's Group will talk to you and ask you some questions:
- before the first day of the group,
- halfway through the group and
- after the last day of the group
- and 6 months after the end of the group.

You need to answer the questions as honestly as you can. There might be some questions that you do not want to answer. That is OK. You do not have to give a reason.

The questions will take about two or three visits to talk through. (Name) will see you either at home or at your day centre or at (name of the local health centre), whichever you prefer.

There are 120 men with Learning Disabilities taking part in this work.

What do we want to know?

- We want to know whether the Men's Group helps men, by looking at your answers to the questions.
- Sarah-Jane Booth is one of the research workers. She may visit the group sometimes to see how the group is working.
- All the men in the group will be asked if this is OK, for her to visit
- If some men don't want Sarah-Jane to visit, then she won't come

Is there anything bad about this work?

- Sometimes the questions may make you feel sad or upset. You can tell the person asking you the questions if you feel upset.
- Being part of this work may not help you.

Is there anything good about this work?

- The group may help you to feel safer around other people.
- By saying "YES" to taking part, you will help other men because we will find out whether the Men's Group really works.

What if you don't like the way this work is done?

- You can make a complaint to (name).
- We will give you information about how to complain
- You may want to ask a friend or staff member to help you to make a complaint.

Will information kept about you be private?

- Yes. We will only tell someone else if we think that you or someone else is in danger, or if you tell us about a new offence.
- We will ask you if it is OK to tell your doctor about you being part of the research.
- We may need to look at your medical records and we will ask you if this is OK
- All of the results of this work will be kept locked away and only the research workers will be able to look at the files.

- If you pull out, the information about you will be destroyed.

What happens at the end?

- We will tell you how well you have done
- We will tell you whether the Men's Group helps men
- If you need more help (treatment or counselling) you can ask for some.
- The researchers will write about the work. No names or addresses will be given.

Who are the research workers?

- Glynis Murphy, Neil Sinclair and Sarah-Jane Booth are the research workers. They are all psychologists.
- The Department of Health is paying for the work.

Has the work been checked?

- People have looked at the work to check that it is safe
- People have also checked that everyone gets good information before they start.

Further information:

- Thank you for reading the information about this work.
- You will be given a copy of the information sheet and consent form.
- If you want any extra information, you or your support person can call Glynis Murphy (01524 592771) or Neil Sinclair (01227 833 700). Or you can write to Glynis Murphy at the Institute for \Health research, Lancaster University, Lancaster, LA1 4YT.

Appendix 9: Research Consent Information Sheets and Forms Studies 1 and 4

Covering Letter for Information Sheet for Parents/Carers/Care Managers/Probation Officers and Doctors
(Tizard Centre letterhead)

(Date)

Dear (insert name)

Do Men's Groups really help men with a learning disability at risk of sexual offending?

As you are aware, (name of participant) is attending a group designed to provide treatment for men with a learning disability at risk of sexual offending (the Men's Group). We are doing some research into whether this form of treatment works, in collaboration with (name of lead facilitators) who are running the Men's Group.

We are writing to you because (name of participant) has agreed to take part in the research. Please find enclosed an information sheet for the project, which outlines the reasons for doing the research, what the research involves and the risks and benefits of taking part.

Please do not hesitate to contact myself (01227 827989), Neil Sinclair (01227 833700) or (name of lead facilitator; telephone number) if you have any questions or concerns about the research.

Yours sincerely

Appendix 9: Research Consent Information Sheets and Forms Studies 1 and 4

Glynis Murphy
Professor of Clinical Psychology of Learning Disability

Information sheet for Parents/Carers/Care Managers/Probation Officers and Doctors (Local headed paper)

Do Men's Groups really help men with a learning disability at risk of sexual offending?

A research study is planned to look at whether Men's Groups really help men with a learning disability who are at risk of sexual offending.

The study is being led by Professor Glynis Murphy and Neil Sinclair (both clinical psychologists working with men with learning disabilities who sexually offend). .....(name) is the local investigator.

Why do this research?
Sex offending is a damaging and dangerous behaviour. The aim of the research is to see whether the treatment reduces future sexual offences.

The type of treatment being tested is called cognitive-behavioural treatment. It has been shown to work for non-disabled men who sexually offend. We want to know if it works for men with learning disabilities as well.

What does the research involve?

- The treatment is being offered to men in NHS/private institutions. Treatment groups run for one year. About 8 to 10 treatment groups will be asked if they want to take part. There will also be a comparison group of men who are waiting for treatment.
- The research involves assessments for the men
    - before they join the treatment group,
    - halfway through the year
    - at the end of the group
    - 6 months after the end of the group.

  These assessments will look at changes to the men's knowledge and beliefs about sexual issues.
- The researchers will collect information about re-offending for up to 6 months after the end of the group.

- One of the researchers (Sarah-Jane Booth) may visit the treatment groups to see how they are running (with the permission of the men in the group and the group facilitators).

Does it cost anything to receive the treatment?

- No, it is free.
- Carers may be asked if they want to come to a meeting about the groups. They will be able to get travel expenses for this.

How long is the research project?

- The research project will last for 1½ years.

Does the individual have to take part?

- No, they do not have to take part in the research. They do not have to give reasons for not taking part.

What happens if the individual does not like the research questions?

- The individual is able to withdraw from the research at any stage. They do not have to give reasons.
- If they do withdraw from the study, any information about them will be destroyed.

What are the benefits of taking part?

- Previous research with non-disabled men has suggested that this type of group treatment is successful in stopping re-offending.
- This research will show whether the treatment helps men with learning disabilities too.

What are the risks of taking part?

- The assessment questions touch on sensitive issues and may be a bit upsetting or embarrassing for the individual.
- We will only continue the questions when the men are in a calm and settled emotional state.
- The assessment questions will be asked by staff, like psychologists or nurses, who are familiar to the individual and who know how to help if men get upset.

The staff running the group will keep in contact with parents/carers and doctors (i.e. GP, psychiatrist) and will talk to them about difficulties the men may have in the group, if necessary.

What happens at the end of the research?

- The research project will end six months after the end of the group treatment programme.
- Depending upon the men's needs and local services, more treatment may be offered.
- All men will be staying in touch with learning disability services after the end of the group.

What happens if you or the individual wants to complain?

- We have a complaints form that we will send to everyone. It explains how to complain.
- The individual is able to withdraw from the research at any time.
- The research is only gathering information about whether the treatment works. The research itself is therefore very unlikely to harm anyone. However we need to tell you that:

> "If the subject is harmed by taking part in this research project, there are no special compensation arrangements. If the subject is harmed due to someone's negligence, then the subject may have grounds for a legal action but may have to pay for it. Regardless of this if you or the subject wish to complain about any aspect of the way the subject has been treated during the course of this study, the normal health service complaints mechanism may be available to you and the subject" (Central Office for Research Ethics Committees, 2001. Guidelines for Researchers).

Will the individual's results be kept private?

- Everyone's results will be kept private. They will be kept in locked filing cabinets that only the research workers can open.
- None of the men will be identified in any way in written papers afterwards.

There may be times when a man says something which the research workers believe someone else needs to know (for example, if the man or someone else is in danger). The individual is aware of this limit to his privacy and has given us the name of a person to contact if this happens. The men are also aware that if they talk about new offences then a (named) person will be contacted if the victim can be identified.

Will the men get feedback at the end of the project?

The individual men will be told of their own results and the overall group's results. The group's results will also be published but no names will be given.

What do you need to do?

You need to let us know if you have any concerns about (name) taking part in the research.

Contact name for further information:

For more information contact Glynis Murphy (01524 592771), Neil Sinclair (01227 833 700) or your local investigator .....

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Consent Form for Research: Supplement 1: Measurement

Men's Group Research

Name of Researcher: Neil Sinclair.

Name of Local Researcher:

Please tick the 'YES' box if you agree. Put an X if you don't agree.

I have had the Supplement 1 information sheet dated 18/06/07 (version 1) Explained to me by .....(my carer/advocate)	☐
I have asked any questions I wanted to.	☐
I understand that I do not have to take part in the research.	☐
If I pull out I can still go the Men's Group	☐
I agree for the assessments to be tape recorded provided that the tape is erased within 3 months.	☐
I agree for my key worker/named nurse to know I am taking part.	☐
I agree for my care manager to know I am taking part.	☐

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

I agree for my parents to know that I am taking part (they don't have to know if I don't want them to ☐

I agree for my doctor (GP, Psychiatrist) to know I am taking part. ☐

I agree for my probation officer to know I am taking part ☐

I agree to take part in the research. ☐

My name ----------

Date ----------

Signature ----------

My carer's/advocates name ----------

Date ----------

Signature ----------

Researcher's Name ----------

Date ----------

Signature ----------

Sometimes the researchers may need to talk to someone else if they think that you or someone else is danger. Please give the name and telephone number of a person we can contact in this situation.

Name: ----------

Who is my: ---------- (Keyworker, Probation Officer e

Telephone number: ----------

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Are the measures used in the research project any good?

We want to find out if the measures which we are using to see if the Men's Group really helps men to stop sexually offending are good ways of measuring. This is research work to see if the measures are useful. We are inviting you to take part in this work. Please read (or have somebody read to you) this information before you decide. You can talk to someone (like your carer or advocate) to help you decide.

Why are we asking you?
We are asking you because you have already said yes to being part of the Men's group and you are part of the overall research.

Do you have to take part in this extra research?
No, you do not have to take part in this extra piece of research. If you say "yes", it is still ok to change your mind later and say no. You do not have to give a reason. You will still be able to go to the Men's Group even if you say no.

What do you have to do if you say "yes" to this?
- We will give you the four standard measures one week and then again two – three weeks later.
- You have already completed these measures so you are familiar with them, and they will be given to you by staff that you know.
- There are about 30 men with learning disabilities who have been selected from the overall research project to take part in this extra research.

What do we want to know?
- Whether the measures really measure what we think they do.
- Whether the measures give us the same results when they are done at different times and with different people.

Is there anything bad about this work?
- It will take an extra one and a half to two hours of your time.
- It might be a little bit boring as you have been asked these questions before.

What good will this work do?
- It will help us and other researchers know what measures are good measures in in working outhow good the groups are.

What if you don't like the way this work is done?
- You can make a complaint to Cedar House or the Tizard Centre. We will give you information about how to complain.
- You may want to ask a friend or staff member to help you to make a complaint.

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Will information kept about you be kept private?

- Yes, we will only tell someone else if we think that you or someone else is in danger or if you tell us about a new offence.

Why are the assessments being tape recorded?

- We are recording the assessments so that another staff member can score the measures again using just the tape.
- The tapes will be erased as soon as they are rated again or within three months, whichever is sooner.

What happens at the end?

We will tell you whether the measures are good measures.

Who is the research worker?

Neil Sinclair. He is a clinical psychologist and works in private practice for Sinclair and Strong and at the University of Kent.

Has the work been checked?

People have looked at the work to check that it is safe.

Contact names for further information:

Neil Sinclair: Telephone on 01732 871018, mobile 07753985675 or at the Tizard Centre on 01227 827373.

Sinclair and Strong
23-27 Swan Street
West Malling
Kent ME19 6JU

The Tizard Centre
Beverley Farm
University of Kent at Canterbury
Canterbury
Kent CT2 7LZ

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Dear

Are the four change measures used in the research project valid and reliable?

As you are aware is or has been attending the group to provide treatment for men with learning disability and risk of sexual offending (the Men's Group). He has agreed to be a participant in the overall research project which has been ongoing for some time and is now approaching its conclusion.

We are collecting some additional information to help us understand the validity and reliability of the four main change measures which are being used in the research.

We are writing to you because has agreed to take part in the research. Please find an enclosed information sheet for the additional part of the research.

Yours sincerely

Neil Sinclair
Consultant Clinical Psychologist

Appendix 10: Measures Research Consent Information Sheets and Forms
Study 3

Are the measures used in the research project valid and reliable?

A supplementary piece of research is being carried out to examine whether the measures of change being used to evaluate effectiveness of the Sex Offender Treatment Programme are valid and reliable.

The study is being led by Neil Sinclair (a Consultant Clinical Psychologist working with men with learning disabilities who sexually offend).

Why are we doing this research?
There is no clear agreement at this stage amongst researchers about which measures of change are valid and reliable for assessing sex offender treatment for men with a learning disability. The aim of the research is to see whether the measures of change used in this project are good measures.

What does the research involve?

- Up to 30 participants who are already part of the overall research project will be asked to participate in additional measurement.
- The four measures of change will be administered on two separate occasions two to three weeks apart.
- The measures of change, which focus on the men's knowledge and belief about sexual issues are the questionnaire on attitudes consistent with sexual offending (QACSO), the sexual attitudes and knowledge scale (SAK), the sexual sex offenders self appraisal scale (SOASS) and the Victim Empathy Scale (VES). The Sexual Knowledge Interview Schedule (SKIS) will also be administered.
- Participants will be drawn from community and low and medium secure services and will include both NHS and private services.

Are there any costs associated with the research?

- No, apart from the time and effort of collecting the measures.

How long will this additional part of the research last?

- It should be concluded within 4-6 months of starting.

Does the individual have to take part?

- No, they do not have to take part in this additional part of the research. They do not have to give a reason for not taking part.

What happens if the individual refuses to undertake the additional assessment?

- The participant is able to withdraw from the research at any stage.
- They do not have to give reasons.

- If they do withdraw from the study, any information on them will be destroyed.

What are the benefits of taking part?

- The additional research will provide information on the reliability and on the validity of the measures that have been used; it will therefore help us know how much reliance we can place on the overall results.
- As there is no widespread agreement about which measures should be used in sex offender treatment for men with a learning disability, the research will help answer this question.

What are the risks of taking part?

- The men may become bored by going through the same set of tests again.
- However, the test will be given by people who are already well known to the men and the men may withdraw or delay completion of the assessments at any point.

What happens at the end of the research?

- The research will be written up and an easy read version will be made available for participants and others interested.

What happens if the individual wants to complain?

- Firstly, we have a complaints form we send to everyone. It explains how to complain. The individual is able to withdraw at any time.
- The research is only gathering additional information about the assessment tools used in the research. All participants have already been given these assessment tools a number of times. They are therefore extremely unlikely to harm them. However, we need to tell you that:
  "If the subject is harmed by taking part in this research project, there are no special compensation arrangements. If the subject is harmed due to someone's negligence, then the subject may have grounds for legal action but may have to pay for it. Regardless of this if you or the subject wish to complain about any aspect of the way the subject has been treated during the course of this study, the normal health service complaints mechanism may be available to you and the subject". (Central Office for Research Ethics Committees 2001. Guidelines for Researchers).

Will the individual's results be kept private?

- Everyone's results will be kept private. They will be kept in locked filing cabinets that only the research workers can open.
- None of the men will need to be identified in any way in written paperwork afterwards.

Please do not hesitate to contact me if you have any questions or concerns on 01732 871018, mobile 07753985675 or at the Tizard Centre on 01227 827373.

Yours sincerely

Neil Sinclair
Consultant Clinical Psychologist

Appendix 11: Qualitative Research Consent Information Sheets and Forms

Study 2

Consent Form for Research: Supplement 2: Qualitative Study

Men's Group Research

Name of Researchers: Neil Sinclair.

Name of Local Researcher:

Please tick the 'YES' box if you agree. Put an X if you don't agree.

I have had the Supplement 2 information sheet dated 18/06/07 (version 1) explained to me by .....(my carer/advocate)	☐
I have asked any questions I wanted to.	☐
I understand that I do not have to take part in the research.	☐
If I pull out I can still go the Men's Group	☐
I agree for the assessments to be tape recorded provided that the tape is erased within 3 months at the longest.	☐
I agree for my key worker/named nurse to know I am taking part.	☐
I agree for my care manager to know I am taking part.	☐
I agree for my parents to know that I am taking part (they don't have to know if I don't want them to	☐
I agree for my doctor (GP, Psychiatrist) to know I am taking part.	☐
I agree for my probation officer to know I am taking part	☐
I agree to take part in the research.	☐

Appendix 11: Qualitative Research Consent Information Sheets and Forms
Study 2

Date ----------

Signature ----------

My carer's/advocates name ----------

Date ----------

Signature ----------

Researcher's Name ----------

Date ----------

Signature ----------

Sometimes the researchers may need to talk to someone else if they think that you or someone else is danger. Please give the name and telephone number of a person we can contact in this situation.

Name: ----------

Who is my: ---------- (Keyworker, Probation Officer e

Telephone number: ----------

Appendix 11: Qualitative Research Consent Information Sheets and Forms
Study 2

Consent Form for Research: Qualitative Study.

We want to find out what it has really been like for you to be in the Men's Group. We would like to ask you questions about the groups you took part in, the staff you worked with, the things you did in the group, and how they have affected you. We also want to ask you questions about your personality and previous offending and risk of offending.

Why are we asking you?
We are asking you because you are already part of the Men's Group research and we are asking up to ten men so that we have a better understanding of what it is like to be part of the group and of how your personality works.

Do you have to take part in this additional research?
- No, you do not have to take part in this additional piece of research.
- If you say, "yes", it is still ok to change your mind later and say no.
- You do not have to give a reason.
- You will still be able to go to the Men's Group even if you say no.

What do you have to do if you say "yes" to this?
- We will make a time with you to ask you some detailed questions about your experience in the Men's Group, what you thought and felt about the group and all the things you did in the group, and how it has affected you. There are some questions, but it will be a bit like a conversation.
- We would like to tape record this conversation so that we can get the full details of what you say.
- We will also meet with you once or twice to do a personality assessment called the Repertory Grid.
- This is a way to help us understand your personality. This part will not be recorded.
- The total amount of time should be between three to four hours, and should take three to four different appointments.

What do we want to know?
- Information about the Men's Group you attended.
- Your thoughts and feelings about the Men's Groups you attended.
- How the Men's Groups have affected you.

- Any suggestions you have to make the Men's Groups better.
- How we can make sense of your previous sexual offending when we understand more about your personality.

Is there anything bad about this work?

- It will take three to four appointments and three to four hours of your time.
- Some of the questions will be hard to answer and will require you to think hard about what you think and how you feel.

What good will this work do?

- We will get to know lots of detailed information about you personally and your thoughts and feelings about the Men's Groups, and sexual offending.
- We will write what is called a case study which brings all this information together along with the results of your assessments in the Men's Groups. The case study will not include your name or anything that will identify you.

Is there anything good about this work?

- The work may help you understand yourself and previous sexual offending better.
- We will show you the finished case study before it goes to anyone else and you will be free to stop your agreement and we will give you all the information back.
- This work should help us and others to understand what it's really like to be part of the Men's Treatment Group from the patient's (client's) point of view.

What if you don't like the way this work is done?

- You can make a complaint to Cedar House or the Tizard Centre. We will give you information about how to complain.
- You may want to ask a friend or staff member to help you to make a complaint.

Will information kept about you be kept private?

- Yes, we will only tell someone else if we think that you or someone else is in danger or if you tell us about a new offence.

What happens at the end?

- We will show you the results and show you the final case study.
  /e will show you an easy to read version of the final report.
  /hen we write up the work, no names or addresses will be given, and we will make sure that eople cannot guess who the case study is about.

. the research worker?

ıclair. He is a clinical psychologist and works in private practice for Sinclair and Strong :he University of Kent.

e work been checked?

- People have looked at the work to check that it is safe.

Contact names for further information:
Neil Sinclair: Telephone on 01732 871018, mobile 07753985675 or at the Tizard Centre on 01227 827373.

West Malling Clinic
23-27 Swan Street
West Malling
Kent ME19 6JU

The Tizard Centre
Beverley Farm
University of Kent at Canterbury
Kent CT2 7LZ

Appendix 11: Qualitative Research Consent Information Sheets and Forms
Study 2

Dear

What is it like to participate in Sex Offender Treatment as a participant with a learning disability?

As you are aware, is attending a group designed to provide treatment for men with a learning disability at risk of sexual offending (the Men's Group). We are undertaking some additional research to help us understand what this treatment feels like from the point of view of a participant in the treatment, as well as a personality assessment using the repertory grid to help us develop a detailed case study of a small number of the men participating in the overall research project.

We are doing this in collaboration with who is running the Men's Group.

We are writing to you because has agreed to take part in the research.

Please find enclosed an information sheet for the project, which outlines the reasons for doing the research, what the research involves and the risks and benefits of taking part.

Please do not hesitate to contact me on 01732 871018, mobile 07753985675 or at the Tizard Centre on 01227 827373.

Yours sincerely

Neil Sinclair
Consultant Clinical Psychologist

What happens if the individual does not like the research questions?

- The individual is able to withdraw from the research at any stage. They do not have to give reasons.
- If they do withdraw from the study, any information on them will be destroyed.

What are the benefits of taking part?

- The questions are open-ended and the interview style will be conversational rather than question and answer, and both the interview and the repertory grid assessment are reasonably pleasant experiences in themselves.
- The research will provide a detailed picture of the experiences of the Men's Group from a participant's point of view, and the case study approach will provide detailed information about a number of men participating in treatment.

What are the risks of taking part?

- Some of the questions will be challenging and some may be slightly sensitive, though probably less sensitive than much of the content of the Men's Group they have already completed.
- The sessions may be somewhat demanding, so we will time the sessions to avoid existing commitments and spread appointments over several sessions so they are not too tiring.
- The interview questions and the repertory analysis will be undertaken by staff that the men are already familiar with.
- The qualitative interview will be audio-recorded. We will destroy the audio tape within three months of the interview or as soon as it has been transcribed. We are happy to do this in front of the men if they wish, and we raise this point specifically with the men in the consent form and check with them again before we turn on the audio tape during the interview.

What happens at the end of the research?

- The research project will end six months after it has started.
- The results of the interviews and repertory grid assessment will be written up together in a series of case studies. The case studies will not include names or identifying information.
- The men's participation in the supplementary part of the research programme will not affect their participation in the overall research programme or the treatment programme.

What happens if the individual wants to complain?

- We have a complaints form we send to everyone. It explains how to complain. The individual is able to withdraw from the research at any time.
- This research consists of one to two open-ended qualitative interviews and a repertory grid assessment over one to two sessions. The interviews and the

Appendix 11: Qualitative Research Consent Information Sheets and Forms
Study 2

What is it like to participate in Sex Offender Treatment as a participant with a learning disability?

In addition to the main research study assessing effectiveness of sex offender treatment for men with a learning disability and at risk of sexual offending, this supplementary project aims to find out what it is like for the men to be in such treatment programmes. This will be done by using an open ended qualitative interview, and a personality assessment called the repertory grid. Information will be combined in case studies on selected participants from the overall project. The study is being led by Neil Sinclair (a Consultant Clinical Psychologist working with men with a learning disability and at risk of sexual offending).

Why do this research?

- Most of the research on men with a learning disability who sexually offend focuses on quantitative information such as how much sexual knowledge has been gained and what changes there have been in cognitive distortions or victim empathy, but very little of this research provides an understanding of what it is like for a man with a learning disability to be part of a sex offender treatment programme.
- Some research has provided case study information, but few have combined detailed qualitative and quantitative results. That is what this research aims to do.

What does the research involve?

- Up to ten participants will be selected from NHS and private services both in the community and in secure settings.
- The project should be concluded within 6 months of commencement.
- The project involves two main elements, firstly an open ended qualitative interview, which may last up to two hours and will be offered over one to two appointments. The second part is a personality assessment called the repertory grid. This will take up to two hours over one or two appointments.
- It doesn't cost anything to participate in the project.

How long is the research project?

- The research project lasts for about 6 months.

Does the individual have to take part?

- No they do not have to take part in the research.
- They do not have to give a reason for not taking part.

repertory grid assessment are likely to be positive experiences for the men on the whole, and sensitive topics will be less common than they have been in the Men's treatment groups themselves, so the research is very unlikely to harm anyone. However, we need to tell you that:
"If the subject is harmed by taking part in this research project, there are no special compensation arrangements. If the subject is harmed due to someone's negligence, then the subject may have grounds for legal action but may have to pay for it. Regardless of this if you or the subject wish to complain about any aspect of the way the subject has been treated during the course of this study, the normal health service complaints mechanism may be available to you and the subject". (Central Office for Research Ethics Committees 2001. Guidelines for Researchers).

Will the individual's results be kept private?

- Everyone's results will be kept private. They will be kept in locked filing cabinets that only the research workers can open.
- None of the men will need to be identified in any way in written paperwork afterwards.

There may be times when a man says something which the research workers believe someone else needs to know about (for example, if the man or someone else is in danger). The individual is aware of this limit to confidentiality, and has given us the name of a person to contact if this happens. The men are also aware that if they talk about new offences then a (named) person will be contacted if the victim can be identified.

Will the men get feedback at the end of the project?
Each of the men who participate in the supplementary project will be shown his individual results from the interview, the personality assessment and the case study write up. The results will be published although no names will be given and the results will be anonymous.

What do you need to do?
You need to let us know if you have any concerns about .....
taking part in this research.

Contact name for further information:
For more information contact Neil Sinclair on on 01732 871018, mobile 07753985675 or at the Tizard Centre on 01227 827373.

Appendix 12: Collaboration Agreement- Research Participants

Collaboration Agreement

We the facilitators of the Men's Group at *(please give full address)*

..... (NHS service/private

treatment facility) agree to administer the entire set of core SOTSEC-ID

measures and follow the guidelines set out in the treatment manual.

We agree to endeavour to collect at least some control participants (i.e.

people referred after the commencement of the group).

We will discuss any substantial deviations from the treatment manual, with the

SOTSEC-ID group including Professor Murphy and Neil Sinclair.

We agree to share the data with the collaborative SOTSEC-ID group, in return

for being able to access the collaborative data.

We understand that the data will be published collaboratively.

Appendix 12: Collaboration Agreement- Research Participants

Please sign if you are a lead facilitator, * other facilitators need not sign.

Facilitator 1 (Please print name)	Signature of Facilitator 1	Date

Address: _____

Email : _____

Facilitator 2 (Please print name)	Signature of Facilitator 2	Date

Address: _____

Email : _____

Facilitator 3
(Please print name)

Facilitator 4
(Please print name)

Facilitator 5
(Please print name)

Facilitator 6
(Please print name)

* All e-mails and information regarding SOTSEC-ID will be sent to lead facilitators only. Please forward them to your colleagues as necessary.

Appendix 13: Collaboration Agreement- Comparison Participants

Appendix 13: Collaboration Agreement

We at *(please give full address)* ....

..... (NHS service/private treatment facility)

agree to administer the entire set of core SOTSEC-ID measures and to collect control participants (i.e. people who are suitable for but are unable to complete a treatment group).

We agree to share the data with the collaborative SOTSEC-ID group, in return for being able to access the collaborative data.

We understand that the data will be published collaboratively.

Please sign if you are a lead data collector, [2] other data collectors need not sign.

[2] All e-mails and information regarding SOTSEC-ID will be sent to lead data collectors only. Please forward them to your colleagues as necessary.

Appendix 13: Collaboration Agreement- Comparison Participants

Lead data collector 1 (Please print name)	Signature of data collector 1	Date

Address: _____

Email : _____

Lead data collector 2 (Please print name)	Signature of data collector 2	Date

Address: _____

Email : _____

Data collector 3
(Please print name)

Data collector 4
(Please print name)

Data collector 5
(Please print name)

Data collector 6
(Please print name)

Appendix 14: Case Studies

Case Study 1 (Roger)

Background.

Roger (not his real name) is a man who looks younger than his thirty-odd years, and usually bears a smile and a friendly demeanour in most situations despite an upbringing in which he has no recall of his mother or father, and was brought up by his grandparents from a year old. File reports suggest that his mother, who may have had a learning disability, died while he was an adolescent, but little is known other than these basic facts. Whether his primary schooling was mainstream or special is uncertain, but it is known that he attended secondary special schooling until he was 17 years old. He remained with his grandmother throughout his adolescence and into adulthood, but shifted into respite care and then into residential care when his grandmother died shortly after having been moved into a nursing home whilst Roger was in his 20's. He has limited family left, but retains contact with one or two extended family members. Individual sessions with Roger explored the issues of grief and loss in connection with his parents and his grandparents, especially his grandmother, but there was limited affect in relation to these losses, and no apparent sense of loss or grief. There is no confirmed history of Roger being a victim of child sexual abuse, although there is likely to have been periods when he was in vulnerable circumstances. There is no record of him committing any childhood offences of any type. Roger had a girlfriend, but he reported no sexual contact as part of this relationship.

Reports of his sexually abusive behaviours began after his grandmother died and Roger moved into formal residential services. Over a three year period prior to his index offence, Roger's sexually abusive behaviour developed from non-specific concerns and discomfort reported by female staff members, to masturbation in front of female staff, assault of fellow service users and assault of a stranger on the street. His index sexually abusive behaviour (i.e. the one that immediately preceded his

entry into the treatment group) was a penetrative sexual assault on an adult male who was the most vulnerable in the residential service where Roger lived at the time. No charges were brought as there was insufficient evidence or reliable witness accounts to sustain a prosecution. Prior to the index incident, there were at least six sets of sexually abusive behaviour including public masturbation (2), incidents of penetrative assault on both male (at least 1) and female (at least 1) vulnerable adults in residential services- one of whom had communication problems, and assault by genital touching of a woman in a shopping area and a male within his service.

Victims were all adult, mainly from service settings, and both male and female. The initial service response, often seen in such cases (Brown & Thompson, 1997), was to offer a personal relationship course focusing on interpersonal and social skills, human relations and sex education, but the problematic behaviours persisted. Other incidents were suspected, especially within his service setting. Roger's assaults seemed to increasingly focus on individuals who were both vulnerable in terms of physical and intellectual disability, and who had communication difficulties which made summoning help during an assault and reporting it afterwards more difficult. Reports on his offences both from file notes and his own later accounts during treatment indicate a degree of planning as he would commit offences at night when staff numbers were low and clients less able to attract staff attention. He committed a retaliatory assault (hair pulling and face scratching) after one of his victims made a report, but there were no other reports of violent or illegal activities outside the sexual assaults. Securing convictions for any of these incidents proved difficult, although he received a formal caution on one occasion, and he was shifted to other services and subject to increased supervision in an attempt to manage the risk. No systematic treatment to address the sexually abusive behaviours occurred prior to the SOTSEC ID group. Roger was eventually detained under the Mental Health Act (1983) following the index incident and admitted to a secure hospital which offered the SOTSEC-ID treatment programme. He remained at the hospital for a little over two years, completing two cycles of the programme, and was discharged back to his local area with a relapse prevention plan.

Roger's pre-treatment scores are shown in Table One below. Roger was assessed as having an IQ in the range 53 – 61 on the WAIS III (Wechsler, 1997), and scored an age-equivalent in the range 8years 10 months to 10 years 9 months on the British Picture Vocabulary Scale (BPVS) (Dunn, Dunn, Whetton, & Burley, 1997). This is above the level of 7 years which was the necessary level for being able to complete component skills for cognitive therapy found by Joyce et al. (2006, p. 22). On the Vineland Scales of Adaptive Behaviour (Sparrow, Balla, & Cicchetti, 1984) Roger obtained an age-equivalent of 4 years 2 months on the *Communication Domain*. This is different to the BPVS age equivalent, but probably reflects an imbalance between items in the *Receptive* and *Expressive* subdomains and the low ceiling in the *Receptive* subdomain of the Vineland, rather than a genuine difference in communication performance (for a more detailed discussion of the Vineland in reference to people with an intellectual disability see Beail, 2003). The age equivalent scores of a little over 8 years on *Living Skills* and *Community living skills* domains are more consistent with the BPVS. Consistent with some of the features of Roger's sexually abusive behaviour described above and the lack of emotion he displayed over his grandmother's death, his overall score on the P-Scan was 26, which the manual describes as raising moderate concern for the presence of psychopathy (Hare & Herve, 1999). This is notable in the slightly elevated scores on *Interpersonal* and *Affective* facets, which are consistent with Roger's offending history and empathy and remorse deficits respectively. His low score on lifestyle is positively reflective of his acceptance and engagement with social norms and rules.

Table 1

Roger's Pre-Treatment Scores

Assessment		Score (95% Confidence Limit)	Comment
	Measure		
WAIS III	Full Scale IQ	53-61	These scores are consistent with a moderate to mild intellectual disability.
	Verbal IQ	58-68	
	Performance IQ	53-66	
Vineland	Communication	RS: 251 PR: 0.1	Communication and Socialisation scores are markedly lower at percentile ranks of 0.1 than Daily Living score at a percentile rank of 45.
	Daily Living AE	RS: 380 PR: 45	
	Socialization AE	RS: 219 PR: 0.1	

In summary, then, Roger was a man who seemed to have had minimal difficulties whilst living with his grandmother, but developed sexualised and then sexually abusive behaviour quite rapidly once he entered formal services. The presence of a mild learning disability in combination with parental disruption and loss is likely to have had an effect on attachment and the development of social and relationship skills (Bowlby, 2005) despite Roger not being able to articulate this affect. This is perhaps most noticeable in the lack of empathy for significant others in his life such as his grandmother, and in his offending style, in which he selected very vulnerable victims who were least able to summon help during the offence or report it afterwards.

Roger completed two year-long cycles of the SOTSEC-ID treatment programme, and themes from the summary notes made at the end of each session are presented in the table below. The notes are organised into groups which correspond to the thematic headings from the IPA reported above. The purpose of this analysis is to demonstrate from contemporaneous clinical notes while the treatment was being delivered that the experience of the group as described in such notes fits the framework which emerged from the IPA analysis.

Towards the end of each treatment group a relapse prevention plan (RPP) is developed for each participant. The RPP from the first treatment groups for Roger is shown below in Table Three without change apart from the name.

Appendix 14:Case Studies

Table 2. Sample of themes taken from weekly progress entries for 'Roger' in his first treatment group

Superordinate Theme Examples from contemporaneous notes
Background to Offending • *acknowledged he had a sexual problem because of things he had done in the past* • *never had a consensual sexual relationship*
1. Memory of Treatment *Human relations and sex education:* • *basic knowledge of contraception and reproduction* • *little apparent knowledge of menstruation* • *unsure about whether people appeared to be consenting or not* o *e.g.if one person consented, the other one didn't have to consent* *Cognitive Model:* • *distorted thoughts confusing lust and love* • *able to do a cognitive analysis (thoughts, feelings actions) for his problem situation from the week* • *applied to problem from the week but found it difficult to access his feelings and thoughts, and to come up with alternative thought* *Sexual offending model:* • *disclosed that he was thinking/fantasizing about his previous offences during the week* • *disclosed that he had had a "not OK" sexual fantasy about previous offending* • *able to disclose a number of not OK sexy thoughts with prompting* • *able to discuss a 'turn-off' fantasy (aversive imaginal consequence)* *Victim empathy:* • *able to describe the thoughts and feelings of someone being stared at* • *high level of participation in victim empathy exercises (scenarios)though limited affect* • *able to name various emotions that his victim may have felt, though level of affect seemed minimal*
2. Experience of Group Processes • *Reluctance to disclose: could not think of anything negative that had happened in the last week* • *Confidentiality: Upset about another client breaching confidentiality* • *Sexual attraction arising during treatment: When challenged over staring at facilitator, apology forthcoming and behaviour disappeared when challenged by both facilitators* • *Difficulty of treatment: he had found the previous week very difficult.* • *Roger said that he finds it difficult to discuss his sexual offences* • *initially angry about the level of reaction to offending behaviour at the time-but then became more thoughtful and less angry after cognitive restructuring*[1]
3. Impact of Treatment • *Relapse prevention plan: went through his Relapse Prevention Plan* • *Impact of intellectual disability on treatment: had problems retaining the information for the duration of the session*
4. Fear of Reoffending • *Treatment motivation: said would like to change because he wanted to stop getting into trouble* • *Risk management: afraid that staff would cancel his trips if he told them that he was having not OK sexy thoughts. We worked through this in terms of working together on risk*

1. This may be an example of the 'nature of harm' implicit theory described by Thakker, Ward and Navathe (2007, p.22).

Table 3.

Roger's Relapse Prevention Plan

Four stage model	Offending:	Non- Offending
Not ok sexy thoughts/films/fantasy	Having sex against their will, 16-19 year old female.	*Distractor fantasy:* Relaxing on a beach, chilling out, sunny and hot, sea war, and calm. Having a nice, relaxing swim. *Legal fantasy:* –adult, but agreeing to have sex. Read signs/body language to tell. *Aversive (Turn off) fantasy:* Female turns into 65 year old women or female karate kicking me to the ground.
Making it ok/ Lying	She wants it. ⟷ She enjoyed it. ⟷ I got hurt so they should get hurt. ⟷ Short skirts ⟷	No one wants to be raped she doesn't enjoy it She is actually scared and thinks it is horrible. Hurting her won't help me – makes things worse for her and me. Just about fashion and dressing up. Doesn't mean she wants to have sex.
Planning	Wait for no one to be around/not looking/at night/secretly/looked around. Pick victims who can't call for help Go wandering at night	Being observed – staff/video/door alarm. Keep away from handicapped especially people who can't talk. Staff at night must know where I am at all times.
Offending	Snuck out and found someone – entered bedroom – molested – hand over mouth	Get into trouble. Hurt the victim.

Roger was assessed on a range of measures and the overall result for each measure are shown below in Table 4 and then in graphical format in Figure 2. The dates of the two groups (deliberately transformed to preserve anonymity) completed by Roger were June 00 to June 01, and August 01 to August 02. Start and finish dates of the SOTSEC ID Programmes which he completed are shown on the graphs as Group1 and Group2.

Table 4

Appendix 14: Case Studies

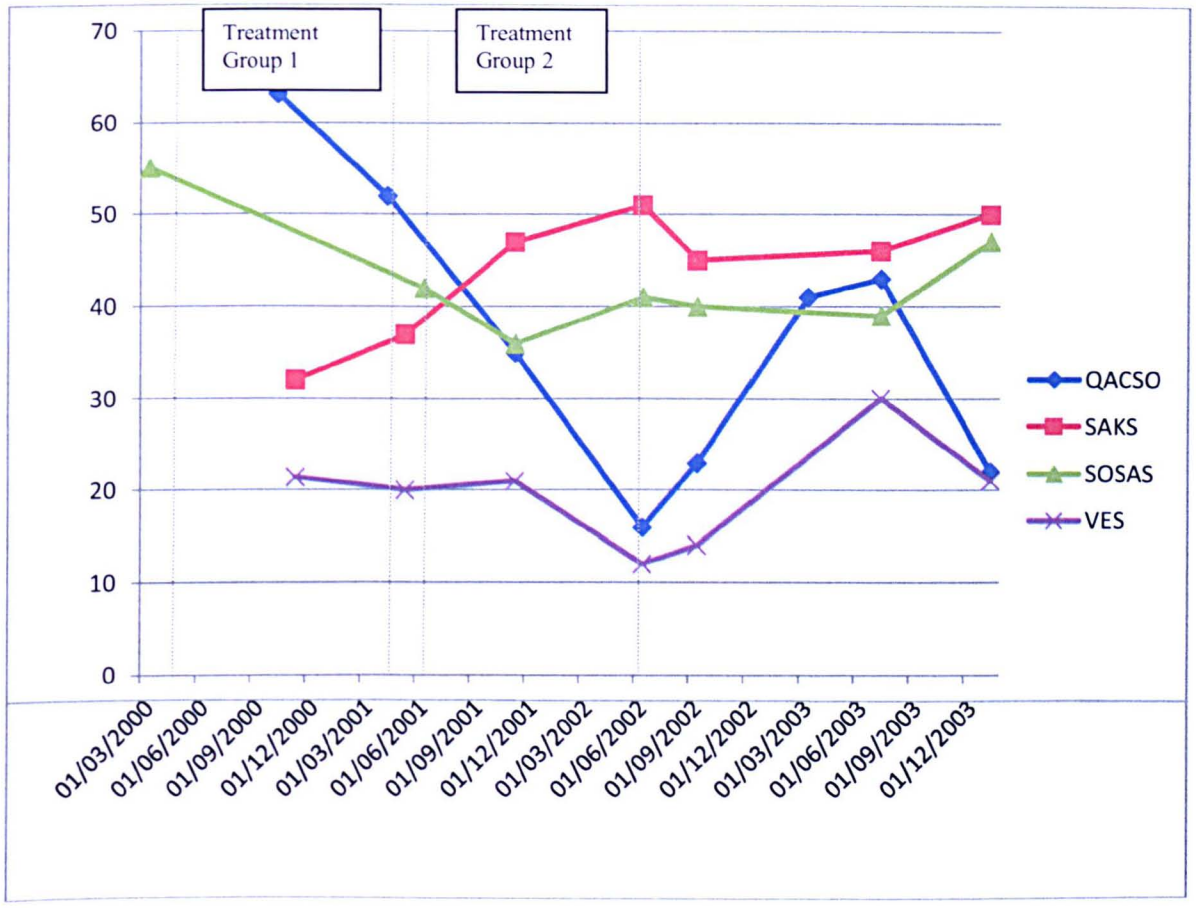
Roger's Overall QACSO, SAKAS, SOSAS and VESA results over both treatment groups

Assessment	Mar[1] 2000	Oct 2000	Nov 2000	Apr 2001	May 2001	Jun 2001	Nov 2001	Jun 2002	Sep 2002	Mar 2003	Jul 2003	Jan2 004
		First treatment group					Second treatment group					
QACSO Total Score		63		52			35	16	23	41	43	22
SAKAS Total score			32		37		47	51	45		46	50
SOSAS Total score	55					42	36	41	40		39	47
Victim Empathy Total Score			21.4		20		21	12	14		30	21

1. Dates of assessment transformed uniformly to preserve anonymity.

Figure 2.

Roger's Overall QACSO, SAKAS, SOSAS and VESA results over both treatment groups



The data show a mixed pattern over the four measures. The SAKAS, a measure of sexual attitudes and knowledge, shows a steady improvement (increases go with improvements in sexual knowledge) over the four occasions on which it was assessed prior to and during treatment, with a small sudden drop at the conclusion of treatment and a gradual improvement to immediate post-treatment levels thereafter. This shows good maintenance over a considerable period of time. The QACSO, which measures cognitive distortions related to sexual offending, and is the best researched and supported of our measures (References), also shows a steep improvement (decreases in scores go with

reductions in cognitive distortions supportive of offending) over the four assessments during treatment as cognitive distortions decrease, but then shows a steep relapse in cognitive distortions post treatment, followed by a recovery to post-treatment levels. The SOSAS, which also purports to measure cognitive distortions related to sexual offending, similarly shows a strong treatment effect (decreases in scores go with less offence – supporting cognitive distortions) which maintains for about a year and then declines. The VESA, which measures victim empathy, shows very little response for the first eighteen months of treatment, but then shows an improvement in victim empathy (lower scores indicate higher victim empathy) half way through the second treatment group. This seemed to correspond to a change in victim empathy and then more genuine engagement with the treatment as reflected in his emotional response to the victim empathy exercises and reflections on his cognitive distortions, although the VESA scores increased sharply again immediately treatment finished. They returned to half their pre-treatment level before dropping again.

There were no sexual assaults committed during the treatment period whilst in a secure hospital, which is not insignificant given his previous pattern of offending within service settings, and at the time of writing there have been no further offences three and a half years after discharge into the community, although follow-up assessments completed post treatment and as a result of visits to his local area show all scores increasing after treatment finished, especially the QACSO and the VESA. What this means for his risk of reoffending is not clear, but it would certainly suggest and increased risk. His residential supervision arrangements included 24 hour supervision, so his risk was constantly managed.

Case Study 2 (Peter)

Peter (not his real name) is a forty-three year old man who came from a large family with four other siblings and lived with his family for his childhood and adolescence. Peter's childhood is described as disrupted and unhappy as a result of family problems. He did not attend a special school in primary school but did so for high school, and has a long history of involvement with the police. He has a diagnosis of Autism. He reports an attempted sexual assault by an older man while Peter was in his early 20's which still troubles him. Peter was convicted of four offences in childhood, two for Robbery, Theft and Handling Stolen Goods and two for sexual offences. Peter has a total of thirteen convictions as an adult for other offences apart from sexual offences which include one conviction for Violence Against a Person, two for Burglary / Robbery, two for Theft Offences, four for Criminal Damage, two for Drunk and Disorderly, one for Possessing an Offensive Weapon in Public, two for Disorderly Behaviour and one for Breach of Conditional Discharge. Peter says that he had one girlfriend previously and that he had sexual relationships as part of that relationship. Peter was also married for a short time but now has only hostile interactions with his ex-wife whenever they have accidental contact as they live in the same area. He is sexually interested in adult females and younger females (he denies being attracted to female children but staff reports point to this remaining an issue), and his index offence involved assault of an unknown young female in a public setting. He attempted to touch her breasts. This is a similar offence to previous offences as a minor when he attempted to touch unknown females either genitally or on their breasts. Peter was transferred from a prison setting where he was on remand, to a secure hospital setting where he received the SOTSEC ID Sex Offender Treatment Programme. He remained at the secure hospital for a little over two years and was then transferred to a step-down service and then to a community residential service, followed by return to a step-down service when there were increased risk concerns about the possibility of future offending (there were no actual breaches).

Appendix 14: Case Studies

Peter's pre-treatment scores are shown below in Table 5. He has a mild learning disability with an IQ score in the range 53-61, and obtained low scores in the communication and socialisation domains of the Vineland Adaptive behaviour scales, although he obtained an comparatively high score for daily living skills. He has lived independently and is able to use advanced daily living skills such as budgeting and day to day living in general, but struggles with communication and socialisation, as would be expected given his diagnosis of autism.

Table 5.

Peter's Pre-Treatment Scores

Assessment	Score		Comment
WAIS III	Measure	95% Confidence Limit	These scores are consistent with a moderate to mild intellectual disability.
	Full Scale IQ	53-61	
	Verbal IQ	58-68	
	Performance IQ	53-66	
Vineland	Communication	RS: 251 PR: 0.1	Communication and Socialisation scores are markedly lower at percentile ranks of 0.1 than Daily Living score at a percentile rank of 45.
	Daily Living AE	RS: 380 PR: 45	
	Socialization AE	RS: 219 PR: 0.1	

Appendix 14:Case Studies

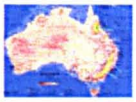
Table 6.

Sample of themes taken from weekly progress entries for 'Peter' in his second treatment group

Superordinate Theme and examples from contemporaneous notes
1. Background to Offending
• *Showed some understanding of the cognitive model. Appeared to feel more positive about the bullying problem raised earlier after a facilitator discussed it with him in the context of the cognitive model.*
• *Peter completed thoughts, feelings and actions on being a victim of violence from his father, and was quite insightful about the effects of this throughout his life*
2. Memory of Treatment
• *Showed a competent knowledge of relevant parts of the anatomy. Was also able to distinguish the anatomical differences between young, adolescent, young adult and older adult males and females.*
• *Had good general knowledge of contraception*
• *Showed a good understanding of the topic covered and was aware of the importance of the use of condoms during sexual activities.*
• *Found it difficult to identify difference between ok and not-ok sexy thoughts.*
• *Participated in discussions, remembered 4 stage model.*
• *Completed thoughts, feelings, actions on not-ok sexy thoughts. Showing some mysogynistic ideas, finding it difficult to reframe these. Has good insight into what others would think of him for offending, and participated in further discussions about 4 stage model.*
3. Experience of Group Processes
• *Became upset over an issue, but restructured thoughts with support*
• *Peter completed thoughts, feelings, and actions on forcing someone to have sex, but needed prompts to reframe thoughts.*
• *Continues to find it difficult to say what is not acceptable about his "not-OK sexy thoughts", but is willing to share his sexual fantasies with the group so that they can be discussed. A bit distracted in early parts of the group, engaging when prompted. More engaged in discussions about 4 stage model, remembered details well and contributed appropriately to group work.*
• *Became upset when another participant talked about child sex offending and he then left the room on 2 occasions, but was able to re-engage following 1:1 discussion with the facilitator.*
• *Found it very difficult during the thoughts, feelings, actions section to name feelings other than anger, and needed a lot of help to be able to identify thoughts that he had. However, it was quite a breakthrough when he finally opened up.*
• *Initially finding it difficult to disclose not-ok sexy thoughts due to a misunderstanding about target group at his placement and anger/fear about the effect it would have on his moving on. Peter calmed when this was addressed with him and he disclosed fantasy material appropriately.*
• *Limited contributions unless asked*
• *Minimal contribution unless encouraged by the facilitator*
• *Still reluctant to participate without prompting, although would respond willingly when invited.*
• *Quiet during the group, and still reluctant to contribute until asked to do so*
4. Impact of Treatment
• *Facilitator had written victim's account, Peter did not see a problem with his offending behaviour, and found it difficult to empathise with victim when asked what he thought.*
• *Became somewhat frustrated in the session about an issue raised in the group from the previous week*
• *Becoming angry at times in the session. found it difficult to participate in the session thereafter, joining in discussions only towards the end of the session with prompts.*
• *Becoming angry in discussions about alcohol and offending: kept angrily saying "... the offence occurred because I was drunk". Not wanting to talk about offence but did give a brief account*
5. Fear of Reoffending
• *He participated in discussions about relapse prevention and was happy with the idea that he would complete maintenance work at his placement.*
• *Able to recall the issues discussed in the previous week's session*
• *He was able to retain the information that he learnt and able to answer questions at the end of the session.*

Appendix 14:Case Studies

Table 7 Peter's Relapse Prevention Plan

Four stage model	Offending:	Non- Offending
1. Fantasy - Not okay sexy thought	Woman in twenties – long black skirt/boots. Put arms around her, hold tight – call her a slut – touch her between legs.	**Pink Elephant:** Visit uncle in Australia. Swimming, Pool.  **Legal fantasy:** Having sex female over age of 16 – she agrees & is enjoying.  **Turn off:** Boyfriend walks in & beats me up – calls the police.
2. Making it okay - Lying	"It's okay to go & round women / touch them". "She won't tell the police". "It's the drink that makes me do it". "She's asking for it wearing those boots/skirt". "They're all tarts".(and therefore it is for me to do what I want. "If my wife hadn't have left, I wouldn't have done it".	"It's not okay to grab women & touch them". "I don't want to scare her". "She did tell the police". "It's my fault – I use the drink to get confidence to offend". "They're not asking for it – they just want to look good". Everyone is entitled to respect and consent. "It's my fault – not my wife's".
3. Planning	Go & have a drink. Go to a nightclub. Hang around outside, wait for woman on her own	Avoid drinking – have a soft drink. Avoid nightclubs – go to pictures/bowling or go home & listen to music. Contact a friend, have them with you.
4. Offending	Go & grab her	Don't want to go to prison. 

Peter was also assessed on a range of change measures before and after the treatment groups, and the results of these are shown below in Table 8 and then in graphical format

in Figure 3. The dates of the two groups and the measures (deliberately varied to preserve anonymity) completed by Peter were June 01 to June 02, and August 02 to August 03. Start and finish dates of the SOTSEC ID Programmes which he completed are shown on the graphs as Group 1 and Group 2.

Figure 3

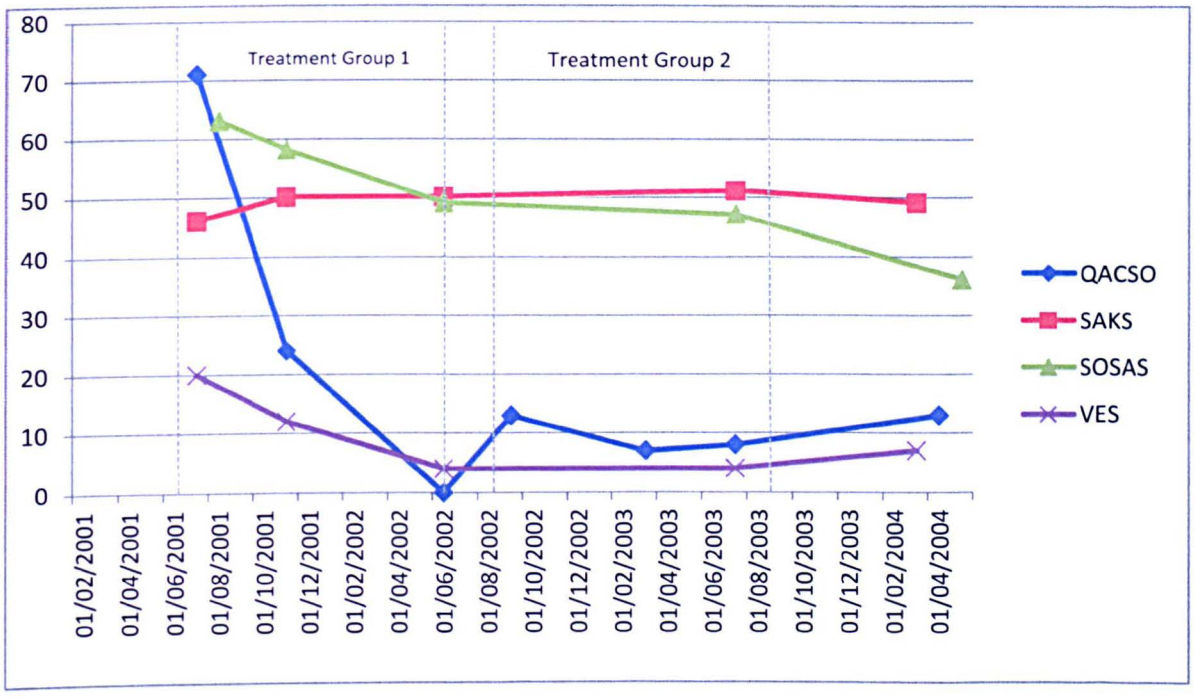
Peter's Overall QACSO, SAKAS, SOSAS and VESA results over both treatment groups

Table 8:

Peter's Overall QACSO, SAKS, SOSAS and VES results over both treatment groups

Assessment	Jul 01	Aug 01	Nov 01	Jun 02	Sep 02	Mar 03	Jul 03	Mar 04	Ap 04	May 04
QACSO	71		24	0	13	7	8		13	
SAKS	46		50	50			51	49		
SOSAS		63	58	49			47			36
VES	20		12	4			4	7		

Appendix 14: Case Studies



The graph shows a dramatic drop in QACSO scores after the first treatment group, with little change thereafter. The SOSAS also shows a drop during the first group and then again after the second group, while the VESA shows a drop during the first group and little change thereafter. Although the SAKA shows little change across the groups, this is due to the ceiling effect, as he improved slightly between the first and second administrations, but then did not have much further room to progress within the scoring range of the SAKA.

Appendix15: Themes and Sub-themes from the IPA Analysis of the first three Qualitative Interviews

Appendix15: Themes and Sub-themes from the IPA Analysis of the first three Qualitative Interviews

1) Personal experience of offending,
   a. As a victim
   b. As an offender
   c. Family disruption

2) Memory of practical details, content and experience of the groups,
   a. Incidentals
   b. Content
   c. Experience of treatment,
      i. Disclosure
      ii. Confidentiality
      iii. Difficulty
      iv. Comfort of group
      v. Group serious
      vi. Adjust to sex offending label and treatment

3) Impact of the treatment,
   a. Group helping
   b. Massive change
   c. Responsibility for offence
   d. Likelihood of apprehension
   e. Risk/supervision balance

4) Fear of re-offending,
   a. Urge to offend still present
   b. Deep dark hole
   c. Resentment of freedom and 'hold' of objects of desire

5) The future,
   a. Self
   b. Men's group

Appendix 16: Qualitative Interview Guide

(Taken from approved amendment application)

Check that the information sheet has been read with an advocate or carer, that the consent form has been completed, and that consent is still valid and freely given. Check consent for audio taping before turning on the audio tape. Check time availability and willingness, (usually 30-45 minutes for 1 to 2 interviews).

Suggested Preamble:
"*I am interviewing some of the men who have been through the sex offending treatment or men's group here at ..... name of facility or area if a community group. We are trying to find out what its like to be in the men's group and what affect it has had on you*".

Open-Ended Question Guides

1. Previous Treatment Experience – Practical Details
   Probe for:
   - Number of groups
   - Location(s)
   - Where and when held
   - Facilitators

2. Previous Treatment Experience – Knowledge
   Probe for:
   - What was learnt from the group(s)
   - Sexual knowledge, consent, legal understanding
   - Group and interpersonal skills and group rules
   - Cognitive (thoughts,, feelings and actions) model
   - 4 stage sexual offending model
   - Victim empathy
   - Relapse prevention model

3. Previous Treatment Experience – Opinions & Feelings
   Probe for opinions and feelings about:
   - Start and finish of the group, and now
   - The group and treatment as a whole
   - Different parts of the group, such as disclosure, talking v doing activities, group v individual treatment, presence of challenging behaviour

- Has the group helped

4. Previous Life Experiences
Probe for:
   - Family structure, including siblings, parent surrogates, absence of either parent.
   - Significant experiences including sexual victimisation during any stage of the participants life, but in particular the early years.

5. Previous Sexual Offending
(provide a warning to the participant at this stage that the interview cannot guarantee confidentially over any new offences which are disclosed. Any offences which are disclosed which have not been disclosed before will need to be reported to the Police.)

Probe for:
   - previous sexual offences (use historical record if necessary).
   - acknowledgement of offending, responsibility and blame.

6. Re-offending and Risk
Probe for:

   - response to an opportunity to offend again without getting caught
   - effect of completing the men's group
   - understanding of and acceptance of the relapse prevention plan and risk management measures
   - understanding of the balance between risk to others and rights of the participant.

7. "How do you see your future?"
   - Probe for the impact which treatment has had on this future.

8. "Should we keep running the men's group for other men like yourself?"

9. "How should we change the men's group to make it better?"

9. "Anything else you would like to say?"

Appendix 17: Risk Assessment and Management
(previously Chapter Four in main dissertation)

Introduction

Given the devastating impact of sexual offences already outlined in Chapter One, and the effectiveness of sexual offending treatment programmes to reduce the probability of future offending as discussed in Chapters Two and Three, this chapter explores risk assessment and management as approaches to further reducing the risk of sex offending. Terms, definitions, and approaches to risk assessment and management in general are reviewed, and a four factor model proposed which draws together the disparate pressures on the risk assessment and management process. The literature on risk assessment and risk management for people with an intellectual disability is also reviewed, and a further model proposed for understanding the way in which different risk assessment approaches can lead to risk management in conjunction with clinical assessment and treatment programmes.

Definitions

Two features most commentators (Allen, 1997; Health and Safety Executive, 1994; Taylor, 2001; Turner, 1998) (Snowden, 1997) agree are essential to an understanding of risk, are the probability of the risk occurring, and the magnitude or severity of damage or injury should the adverse event occur. Taylor and Halstead (Taylor, 2001)use the example of flying a plane or riding a bicycle for the first time, to illustrate that two events with a similar probability of an adverse event occurring (falling off the bike or crashing the plane) nonetheless have very different magnitude or severity of damage, and that both factors must be taken into account when risk is considered for any particular adverse event. A final, perhaps obvious, element of risk is the adverse event itself. One definition of risk that includes these features suggests that risk is, "...the probability of an adverse future event multiplied by its magnitude." (Adams, 1995; cited in Allen, 1997, p.370). Some definitions also include reference to the frequency of the presence of the hazard, or factors that make the adverse event more likely. For example, if a person who cannot ride a bike and is therefore at risk of injury from riding a bike is kept in an environment where there are no bikes, the risk is lower than if the person lives in an environment where access to bikes is freely available. Although this example may seem trivial, the extension to secure and community settings, where potential victims are available or not, illustrates the differences in risk assessment that a consideration of frequency of presence of the hazard can make.

The definition of risk assessment follows logically as entailing three key features, namely the specification of the adverse event(s), the assessment of the probability of that event occurring, and the assessment of the severity of the

consequences if the event occurred. Most assessments seem to incorporate frequency of hazard presence within the probability assessment, or hold this factor constant by specifying the range of circumstances for which the risk assessment is valid (for example, community or hospital).

Risk management is the management and review of assessed risk(s). Allen (1997) offers a brief definition from another author that will serve as a definition of risk management, "The timely identification and subsequent management of risk, in order to protect all parties concerned (cited in Allen, 1997; Roy, 1996). One example of current good practice is the Health and Safety Executive (1994) model for the assessment and management of risk. The framework consists of the following steps: (a) Identify hazards (anything that can cause harm) e.g. a history of violence, sexual offending, epileptic seizures, fire-setting, etc., (b) Who might be harmed and how (potential victims and methods), (c) Evaluation of risks, (i) frequency of hazards (ever present to an occasional occurrence), (ii) potential severity of harm (death to minor injury) and (iii) probability of occurrence (inevitable to likely), (d) Evaluation and adaptation of current risk management precautions (consider minimum legal requirements and acceptable standards of care), and (e) Review of risks and management plan (Taken from Health and Safety Executive, 1994).

Four Factor Risk Management Model for Working with Intellectually Disabled Sex Offenders

There are often competing service ideologies, social forces, measurement developments and task complexities that influence the application of risk assessment and management with sex offenders with an intellectual disability. These are grouped into four factors and described below. A model is outlined that illustrates how these four factors combine together to determine the balance point between risk of further offences on the one hand (false negative predictions) and risk of unnecessary restriction (false positive predictions) on the other.

Factor 1: Prevailing ideology and values in intellectual disability services

In the context of intellectual disability, the term risk has a unique meaning, which first came to prominence in the writing of Robert Perske and others, especially Wolfensberger (Perske, 1972; Wolfensberger, 1972; Wolfensberger, 1982), under the rubric *dignity of risk*. *Dignity of risk* refers to the positive benefits -despite some risks- that flow from the ubiquitous and inevitable risk, which is an integral feature of all our lives (Doren, 2002, p. ix), and from which people with an intellectual disability have been 'protected' by their separation and congregation in institutional services from the Victorian era to recent times (Jacobson & Mulick, 1997). Perske and Wolfensberger argued that in an attempt to reduce the risk of harm, the beneficial aspects of risk have also been removed (what Doren, 2002, p. ix, terms "...its sweet precariousness). This dialectic is still a feature of current decision-making in intellectual disability services. For example, Alaszewski (2002) undertook a survey of 31 intellectual handicap services and found that although there were issues about a lack of explicit balancing between safety and empowerment in risk management, most had risk policies, and about a third of the services had explicitly identified a normalization (Wolfensberger, 1982) or normalization-derived (O'Brien, 1987) value

base. Baldwin and Thirkettle (1998) also discuss the importance of a balance between protection from harm and opportunities for growth and development. This focus on simultaneous protection and empowerment of people with an intellectual disability, is part of a long-standing ideological commitment to decreasing restrictive service practices, increasing opportunities and increasing community involvement and presence for this group (e.g. O' Brien, 1987). Such values are evident in the works of Wolfensberger (1972, Wolfensberger & Glenn, 1975; Wolfensberger & Thomas, 1983) and are still prevalent today. It is not surprising then, that we find a reluctance to address the risks posed by men with an intellectual disability at risk of sexual offending, because the ideological and service orientation is towards decreasing restrictions and increasing opportunities, rather than the reverse as required by most risk management controls. This balance between risks to potential victims verses restrictions on potential offenders lies at the heart of any discussion about risk (Carson, 1996; Doren, 2002) and highlights the moving balance point in this debate. On one hand, there is evidence of difficulty in securing convictions and failure to take sexual offending seriously, especially against other people with an intellectual disability (Brown, et al., 1995; Brown & Thompson, 1997b; Turk & Brown, 1993) and on the other hand, there is the management of risk for such men by admission to secure services away from their home communities and the consequent separation from family, friends and other naturally existing social networks. Lindsay argues that while such a solution may be necessary for some men, it is essentially an anti-therapeutic option that is the "...antithesis of the societal engagement/quality of life component of this treatment model."(Lindsay, 2005, p. 436).

The overall history and tendency within intellectual disability services, therefore, has been to seek to reduce restrictions on all people with an intellectual disability , including those with a forensic history who are potentially at risk of future sexual offending. This pressure tends to shift the prediction errors in the false negative direction, that is, predicting there will not be further offences when further offences are committed.

Factor 2: Rising litigiousness, risk awareness and resultant 'defensive' practice

Community reactions to violent crime, especially sexually violent crime, seems to defy logic. On the one hand, incidents of violent crime in all categories appears to has reduced from 1997 to 2006 (Nicholas, Kershaw, & Walker, 2007), yet community concern about reducing the risk of violent crime seems to be on the increase (Zedner, 2000). In seeking to understand this phenomenon, it is difficult to improve on Lerner and Miller's explanation in 1978:

> Individuals have a need to believe that they live in a world where people generally get what they deserve. The belief that the world is just enables the individual to confront his physical and social environment as though they were stable and orderly. Without such a belief it would be difficult for the individual to commit himself to the pursuit of long-range goals or even to the socially regulated behavior of day-to-day life. Since the belief that the world is just serves such an important adaptive

> function...they can be greatly troubled if they encounter evidence that...the world is not really just or orderly after all.

And further on:

> If others can suffer unjustly, then the individual must admit to the unsettling prospect that he too could suffer unjustly. As a consequence of the perceived interdependence between their own fate and the fate of others in their own environment, individuals confronted with an injustice generally will be motivated to restore justice (Lerner & Miller, 1978, p. 1031).

While Lerner and Miller (1978) linked this 'restoration of justice' to either compensating the victim or the phenomenon of 'blaming the victim' (Ryan, 1971), another way to restore justice is to reduce the risk of future offences by restricting the liberty in one way or another of all those who might perpetrate future violent offences - namely identified offenders. As a result, there has been a rise in public pressure to control violent offenders, including sexually violent offenders, such as Megans's Law in the USA and an equivalent 'Sarah's Law' in the UK, as well as the "Name and Shame" campaign run by a major UK newspaper in 2003, which saw some individuals hounded out of their house by angry mobs (Radley, 2001).

At the same time, there has been a general increase in awareness of and attempts to reduce general risk across a range of sectors including financial (e.g. pensions), computing (BS 7799), public health, and hospitals (Matthews, 1992; Monahan, 1993; Seccombe, 1995; Secker-Walker, 1999). This rise in risk awareness and risk reduction has lead to a rise in litigation for civil claims, pressure on police and the judiciary to detain and reduce the risk of violent offenders, and a general pre-occupation by organizations on risk reduction, whether this be in recovery from natural disasters, computer security or broader health and safety areas (Health and Safety Executive, 2000).

Health and safety risk reduction is covered by the Health and Safety at Work Act (Health and Safety Executive, 1994, 2000). While this primarily refers to physical environmental safety, such as electrical appliances, lighting, preventive maintenance of essential equipment, etc., it has more recently been extended to cover a broader range of activities and individuals encompassed within the physical and organisational environment of a service or organisation. In health organisations, it is sometimes subsumed under the rubric of *clinical risk management* (Secker-Walker, 1999; Snowden, 1997)(Department of Health, 2002; Health Care Commission criteria, NHS Litigation Authority, 2007) and the term owes its origins to the reduction of risk of exposure to insurance claims by insurance companies in the USA in the 1960's (Snowden, 1997) (Mathews, 1992; Snowden, 1997). It refers to risk that accrues from the presence of a clinical (health) programme in a particular location with specific patients, staff members and the public (Snowden, 1997). The extension

to health settings has also been driven by the desire to reduce liability to malpractice and liability claims for both public and private health care organisations (Snowden, 1997). In the UK this process, including the rapid development of Clinical Governance, was hastened in the National Health Service by the loss of Crown immunity in 1991 (Seccombe, 1995). Thus, risk assessment and management of challenging behaviour, including sexual offending and physical assault, that would be assessed as an individual risk by psychologists and others at an individual clinical level, should also be subject to the broader (including health and safety concerns) clinical risk management that seeks to reduce all risks that accrue from the operation of a programme, (seeMonahan, 1993) although these are somewhat distinct undertakings. For example, if a sex offender treatment programme is provided in a community setting where young children are also in attendance, or if a community sex offender treatment programme is located and timed in such a way that participants need to use transport links at the same time as local school children, such risks will not necessarily be addressed by a purely individual risk assessment, which does not also attend to or take account of wider clinical risk management (including health and safety) issues - risks that accrue from the presence of the programme in the particular physical and social environment. It is interesting to see that this perspective is taken in recent Department of Health Publications in relation to Clinical Governance, and also in the standards used by the Clinical Negligence Schemes for Trusts to assess the overall risk level of NHS Trusts in the United Kingdom (NHS Litigation Authority, 2007; Department of Health, 2002; Snowden, 1997). Both Snowden (1997) and Monahan (1993) - well known for a long term career in the risk assessment and management area - point to the need for overall risk management strategies for all health care organisations, which includes a focus on both the traditional health and safety environmental issues and incident reporting and investigation procedures, through a whole range of clinical systems, personnel, financial and information technology systems.

The impact of developments in the area of mental health risk assessment and management, including mentally disordered offenders and offenders with intellectual disability, has unsurprisingly seen an outpouring of clinical and research activity to improve risk assessment and management (Monahan et al, 2001; Doren, 2006; Hanson, 2006;Doren, 2002; Quinsey et al, 2006), but also, arguably, a pressure to increase defensive clinical practice (Bennett et al, 1990; Monahan, 1993; Harrison, 1997; Carson,1996;). Risk assessment and management has assumed more importance due to the risk of legal liability for individual practitioners or services that do not keep up with good practice in this area (Allen, 1997; Carson, 1996). The requirement for organisations is to be able to demonstrate that individual practitioners and services have acted reasonably, with reasonableness being interpreted according to the Bolam Principle. The Bolam Principle owes its origin to the 1957 benchmark decision in Bolam v Friern Hospital, quoted in Harrison (1997, p. 37), " A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men (sic) skilled in that particular art". Carson (1996) stipulates that individual practitioners or services must conform to practices that would be deemed acceptable by a typical contemporary practitioner (arguably treating a typical patient) in the field (Allen, 1997), which Allen argues would require familiarity with current good practice requirements in risk assessment, and Harrison (1997) argues would require implementation of professional and statutory guidelines around relevant clinical practices and procedures, such as the

Care Programme Approach (Kingdon,1994), and risk assessment, management and review guidance (e.g. DOH, 2007).

These trends across the diverse areas of public opinion on risk in general and violent crime in particular, changes in the scope and expectations of health and safety practice, increasing litigation for damages brought about by poorly controlled risk, and the resultant pressure on individual practitioners all combine to press for the imposition of greater restrictions on people with an intellectual disability at risk of sexual offending. The effect of this pressure is to shift the prediction errors in the false positive direction, incorrectly predicting re-offending when it does not necessarily occur.

Factor 3: Improvements in measuring and managing risk

As was the case for sex offender *treatment* programmes, approaches to *risk* assessment and management in intellectual disability (Green, Gray & Willner, 2003; Lindsay & Beail, 2004; Boer, Tough & Haaven, 2004; Quinsey, 2004) are largely derived from mainstream risk assessment and management approaches in the broad area of risk assessment and management (Allen, 1997; Edens and Otto, 2001; Gardner, Lidz, Mulvey & Shaw, 1996; Kraemer, et al., 1997; Monahan et al., 2001; Silver, Smith & Banks, 2000; Snowden, 1997) as well as the narrower area of sexual offender risk assessment and management (Doren, 2002; 2006; Fisher, 1993; Grubin, 1997; Hanson, 2006).

While it might be argued that risk assessment and management had its nadir in the period following Monahan's influential monograph (Monahan, 1981), which argued that clinical prediction of future violent events was lower than chance, there has been a steady recovery and development since then. Indeed, Mossman, (2000) has shown after a re-analysis of the original data that the conclusions were overly harsh and that most of the long term predictions were actually better than, or at least equal to, chance. He used Receiver operating characteristic curves[3] to look at the short, medium and long term studies in the Monahan paper. Of the four long-term studies, one was equal to chance, one was better than chance but not significantly so, and two were significantly better than chance. Furthermore, prediction in the long-term studies was as accurate as short-term and medium prediction studies. Nonetheless, a problem with clinical predictions was demonstrated, and the superiority of actuarial predictions repeatedly demonstrated.

The last 30-40 years have seen the unfolding of a paradigm shift from dangerousness prediction to risk assessment, and later to also include risk management (Douglas, Ogloff, Nicholls, & Grant, 1999; Monahan, 1981; Monahan & Steadman, 1994; Taylor, 2001). Monahan and Steadman (1994) argue for the term 'risk of violence' instead of 'dangerousness' as part of this move towards risk assessment. Part of the reason for the paradigm shift has been that the reliability of risk predictions,

[3] The receiver operating characteristic (referred to as ROC) describe the accuracy of a procedure for classification. Curves are generated through plotting sensitivity (ability of an instrument to correctly predict an event occurring) against 1- specificity (ability to correctly predict no event occurring) at different cutting points throughout its range. See Buchanan & Leese, 2006; Bewisk, Cheek, & Ball, 2004; and McMillan et al, 2004 for examples of applications and fuller descriptions.

especially of violence in offender and psychiatric populations, has dramatically increased over recent years (Douglas, Cox, & Webster, 1999; Hanson, 2006; Hanson & Thornton, 2000)

(Douglas, Cox, et al., 1999; Hanson & Thornton, 2000; Johnston, 2002; Maden, 1996; Taylor, 2001), and new risk assessment instruments are providing consistently better than chance predictions. Instruments, such as the Violence Risk Assessment Guide (VRAG, Harris, Rice, & Quinsey, 1993), SORAG, RASSOR, Static-99, HCR-20 (Webster, Douglas, Eaves, & Hart, 1997), Psychopathy Check List- Revised (PCL-R, Hare, 1991) among a number of other such instruments (Douglas, Ogloff, et al., 1999), have provided increasingly accurate estimates of the probability of violent recidivism amongst offenders and more recently among psychiatric inpatients (see for example Johnston, 2002). The overall features of the two paradigms are contrasted in an article by Maden (1996), which has been adapted and appears below in Table 1.

Table 1. Comparison of dangerousness prediction and risk assessment paradigms (Adapted from Maden, 1996)

Dangerousness Prediction Paradigm	Risk Assessment Paradigm
Categorical: all or none. Dangerous or not	Able to be analysed and objectively measured. What, who, how, when, etc.
Distinguishes between dangerous patients and others	More emphasis on continuity of risk and on different levels
Property of the individual	Responsive to the individual and environmental factors in combination
Unchangeable	Changes with time and situations
Implies one big decision: discharge or not	Implies a series of smaller decisions over time; i.e., risk management

This paradigm shift and the developments in risk assessment and management in mainstream forensic and psychiatric assessment has led to an increasing specification and description of different types of risk and their assessment, as well as the emergence of key factors such as psychopathy, treatment compliance, substance abuse, anger, and violent fantasies that significantly increase the risk of violence (Monahan et al, 2001). For example, in addition to the instruments identified above, there are a number of specific risk assessment instruments that have been developed, such as the Spousal Assault Risk Assessment Guide (SARA- Kropp et al, 1995, Sexual Violence Risk-20 (SVR-20), Early Assessment Risk List for Boys (EARL), all cited in Douglas et al (Douglas, Ogloff, et al., 1999). Improvements in such instruments continue apace. For example, Hanson and Thornton (2000) have developed an improved risk assessment instrument for sexual offending in identified offenders by combining two previous instruments, the Rapid Risk Assessment for Sex Offence Recidivism (RRASOR), widely used in the USA and Canada, and the Structured Anchored Clinical Judgement (SACJ), widely used in the UK for the same purpose. Doren (2002) reported the existence of 27 instruments designed to measure risk of future sexual offending, and highly impressive prediction results have been

reported by Monahan et al. (2001) for risk of violence by psychiatric patients using a decision tree approach and a statistical technique called 'bootstrapping', in which repeated sampling of the same set of scores is used to examine the stability of the scores and to avoid 'overfitting'- the problem of having the data fit the variables so closely, the solution is unlikely to generalise (Monahan et al, 2001; Tabachnick & Fiddell, 2007). The construct of psychopathy, as assessed by the Psychopathy Check List, Revised (Hare, 1991) has demonstrated consistently high correlations between psychopathy scores and violence (Hare, 1996; Hemphill, 1998), and is itself a component of many other risk assessment protocols (e.g. the VRAG, HCR-20, SORAG).

Statistics for describing and analyzing risk assessment scores have also developed, as the above application involving bootstrapping from Monahan et al. (2001) and the previous description of Receiver Operating Characteristic illustrates. Whenever a specific prediction is made about an adverse event occurring in the future, such as recidivism, there are four possible outcomes:
(a) Predict the event when it did occur (true positive)
(b) Predict the event when it did not occur (false positive)
(c) Predict no event when it did occur (false negative) or
(d) Predict no event when it did not occur (true negative).
These outcomes are shown in Table 2 below. The crucial point about this table, like the hypothesis testing table of which it is reminiscent, is that it is difficult to minimize both types of errors (false positives and false negatives) at the same time. Similar to Type I and Type II errors in hypothesis testing, minimizing one type of error only serves to increase the other, so a cut off score (analogous to the probability level set for hypothesis testing) must be selected that optimizes the error rate for the particular group and risk being considered.

Table 2. Possible Risk Assessment Outcomes

Prediction/Reality	Event does happen	Event does not happen
Predict event does happen	True Positive	False Positive
Predict event does not happen	False negative	True Negative

The ability of risk assessment instruments to correctly predict an event occurring is known as Sensitivity: Sensitivity = true positives/true positives + false negatives. The ability to correctly predict no event occurring is known as specificity: Specificity = true negatives/true negatives + false positives. Positive predictive value and negative predictive value capture the underlying rate of the predicted event in the population (it is easier to predict events when the rate of events in the population is higher). The measure of effectiveness of a risk assessment is captured by plotting sensitivity against specificity for various cut-off scores (a cut-off score being the point above which and below which, a different description is applied, e.g. high and low risk) and deriving a statistic: Area under the curve or AUC. The AUC is the probability that the scores on the assessment instrument of two randomly selected

people, one of whom commits a violent act and one of whom doesn't, will accurately reflect the true state of affairs. AUC's can range from 0 through to 1 where: (a) 0= perfect negative prediction, (b) 0.5= chance prediction, (c) 1.0= perfect positive prediction.

AUC's of 0.7 and above are considered large effects, i.e., significantly better than chance. See earlier description for Receiver operating characteristic. Douglas et al (Douglas, Ogloff, et al., 1999) looked at the effectiveness of risk assessment tools in this area, in comparison to other areas of prediction, and found that the results compare favorably to other procedures in psychology (psychotherapy, offender treatment) and medicine (by-pass and transplant surgery).

As described above, forensic and forensic psychiatric risk assessments have developed from purely impressionistic 'clinical judgement' to actuarial methods, and more recently to approaches (such as the HCR-20) that combine both. Actuarial (or statistical or mechanical) approaches use variables in a static, formal and algorithmic way to undertake an assessment, while clinical approaches have previously been characterised as using variables in an impressionistic and subjective manner, without formal procedure (e.g. Douglas et al, 1999). Both approaches can use the same variables, and both approaches utilize clinical judgement. For example, the PCL-R relies extensively on clinical judgement for each of its 20 factors, although this is included as a factor in many actuarial measures (e.g. the HCR-20, VRAG and the SORAG). Douglas et al. (Douglas, Ogloff, et al., 1999) argue that the correct approach to use is, "empirically validated, structured clinical assessment... (which they contrast with)...unstructured 'in the head impressionistic global clinical judgement..." (p. 156). However, it should be noted that the actuarial verses clinical debate has progressed considerably in recent years, and some agreement has been achieved, largely through Hanson and Thornton's (2000) distinction between static and dynamic factors. A recent statement of this position, in which long-term risk levels are set by static assessments and medium and short-term risks are set by dynamic (previously called clinical) assessments is outlined by Doren (2006).

Douglas et al. (1999) argue for a broad approach to risk assessment and management, which involves: (a) identification of appropriate formal measures for the client group and setting; (b) use of Formal measures (such as the HCR-20); (c) recognition of critical items for a particular individual, including: historical and static factors, and dynamic and clinical factors; (d) recognition of factors that will be responsive to the risk assessment and management process such as readiness to change and cooperation with the risk management plan; (e) using instrument(s) such as "assessment protocols" (p. 165) rather than only actuarial predictors; and finally (f) risk management and re-evaluation as well as risk assessment.

Doren (2002) in contrast, along with Quinsey, Harris, Rice and Cormier (2006), strongly advocates for actuarial assessments as the only empirically defensible approach, although Doran (2002) does allow for clinical adjustment for the individual and setting after completion of the actuarial instrument in the prescribed manner (p.143), and does encourage the use of multiple complementary instruments.

In addition to features listed that combine both actuarial and clinical approaches, a further distillation of the general guidance available in the literature on

risk assessment and management would suggest that risk assessment and management should: (a) Be a continuous and iterative process; (b) Be multi-disciplinary; (c) Be integrated with other clinical review processes, such as CPA and internal reviews (Gilleard, 1995; Kingdon, 1994; Vick, 2002); (d) Incorporate interventions such as therapy, individual support guidelines and day activity programmes; (e) Be reviewed systematically and at crisis points; and (f) Be explicit, rigorous and testable (Duggan, 1997). The effect of these steady and consistent improvements in tools and techniques used to estimate risk in the area of intellectually handicapped offenders, is to improve the accuracy of predictions so that the number of false positives and false negatives is minimized, thus leading to lower recidivism and requiring less restrictions on previous offenders unlikely to re-offend.

Factor 4: Complexities of the risk assessment and management process

While on one hand improvements in assessment methodology will tend to lead to lower false positive and negative predictions, there are some inherent difficulties in the risk assessment and management process itself that will mean that given our current limited state of knowledge of the variables which are responsible for future sexual offending in general (Dorren, 2002) and sexual offending by people with an intellectual disability in particular (Boer, Tough & Haaven, 2004), this complexity will keep the false prediction rate at an uncomfortable level for the foreseeable future.

Variables that might usefully be considered when attempting to estimate risk of future sexual offending have been divided into two main groups, static factors and dynamic factors (Hanson and Harris, 2000; Lindsay & Beail, 2004). Other categories have been proposed, for example Lindsay and Beail (2004) discuss Steadman's four categories of historical, dispositional and personal, contextual and clinical, but the static and dynamic grouping has achieved currency and appears more useful. Dynamic factors have in turn, been categorised into dynamic stable and dynamic acute groupings. Table 3 below shows these groupings, along with the purpose served by assessing the value of each set of variables.

Table 3. Risk variables, purpose of assessment and risk reduction strategies

Risk variable category	Purpose of assessment	Example of measure	Example of measure	Type of risk reduction (control) interventions
Static variables	Predict long term risk of event	VRAG SORAG RRASOR Static-99	HCR-20 &	Long term (even life-time) control strategies, eg prison, long term supervision, prohibition from work with children
Dynamic stable variables	Predict medium term risk of event	PCL-R- Deviant sexual arousal-PPG; Motivation Cognitive distortions	SVR-20	Proximal risk factor scale & Problem identification checklist Completion of relevant treatment eg Medication, psychological treatment
Dynamic acute variables	Predict imminent risk event	DRAMS (Lindsay et al 2004). START (Webster, Martin, Brink, Nicholls, & Desmarais, 2009)		Provision of resources (eg staffing), removal of potential victims

Static factors are largely unchangeable or historic variables, including events such as age at and type of first offence, present age, gender, number of prior convictions and family background factors associated with reoffending such as having an abusive childhood. These factors are thought to be unresponsive to intervention, and could be viewed as setting upper and lower probability limits to risk assessments that are relatively unchangeable. This might be the case because such historical factors are largely reflective of the occurrence or impact of developmental factors, which are likely to have an impact on overall functioning through mechanisms such as resilience (Marshall et al, 1999) or self efficacy (Bandurah, 1977). The term actuarial is also sometimes used in association with this group of factors, and refers to the allocation of probabilities to different scores or profiles on static risk assessment tools on the basis of known outcomes from previous studies.

The term derives from the practice in the insurance industry of assigning actuarial values to events such as death, illness etc on the basis of known tables that link factors such as age, sex, etc to these outcomes. The actuarial process, therefore, can only be applied when there is sufficient previous data for the population from which the individual is drawn that links relevant variables (usually static ones) to known rates of occurrence of the risk event. There are problems in the sex offending area generally, due to the incompleteness of the empirical picture, the debate about which factors are most salient, and the fact that most sexual offences are not detected. The main purpose in assessing static risk is to assess long term probabilities for the reoccurrence of the risk event, and therefore to set long term risk management strategies, such as control measures, for example restriction of liberty, supervision, monitoring, tagging, etc. This is shown in

Time

Figure 1.

Probability limits set and estimated by static risk factors, in which for any given individual for a particular risk event, static factors set long term upper and lower limits between which the probability of the risk varies, but the probability does not exceed these upper and lower limits unless there is a change in the static factors. By definition, there should not normally be any change.

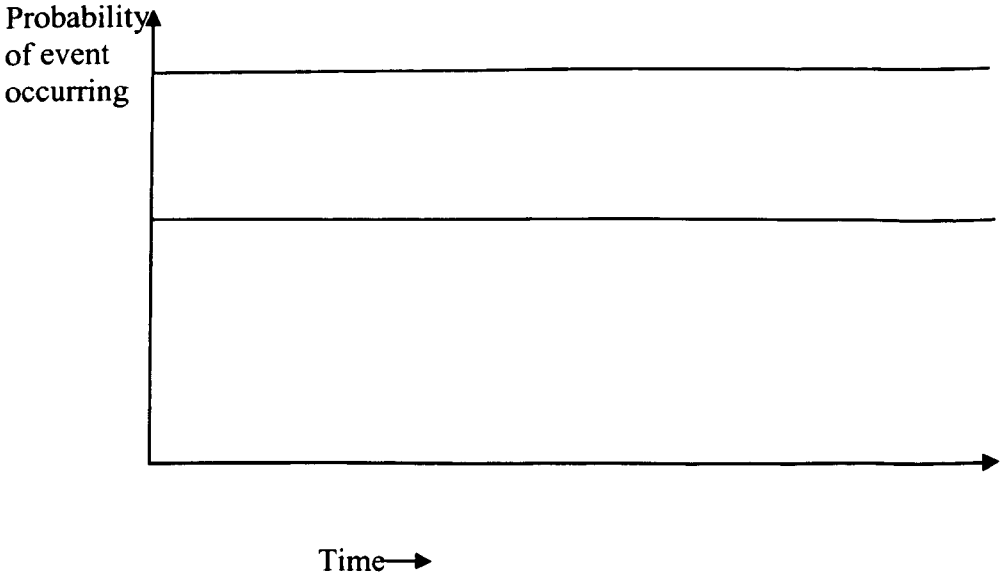


Figure 1.

Probability limits set and estimated by static risk factors

Dynamic factors are variables that are at least potentially changeable, and occur closer in time to the risk event than static factors. For this reason, they are sometimes referred to as proximal factors. Dynamic factors are divided into dynamic stable and dynamic acute by Hanson & Harris (2000) and discussed in reference to intellectual disability by Lindsay and Beail (2004). Dynamic stable factors refer to variables that are stable over several months or even years, such as intimacy deficits, sexual self-regulation, mental illness, mood regulation skills and employment status. These factors have been referred to as criminogenic needs in the context of recidivism risk, or causal psychological risk factors more generally (Hanson, 2006), and are the logical focus of most psychological treatment programmes, for example sexual offender treatment programmes and anger treatment programmes . Dynamic stable factors are subject to such treatment programmes on the basis of a putative connection between changes in these factors and changes in the probability of the risk event (Dorren, 2002; Hanson, 2006). These factors correspond to the description of criminogenic factors and to the "what works" treatment literature (Andrews & Bontna, 2002). The purpose in assessing dynamic stable factors is therefore to determine appropriate treatment goals for an individual that are likely to affect (even if within the limits set by the actuarial assessment) risk estimates. This is shown in Figure 2 below, where a theoretical probability function based on assessment of dynamic stable factors is drawn between the limits set by the static assessment referred to above. It can be noted that the slope of the function is shallow, indicating that change in risk due to dynamic stable factors occurs slowly.

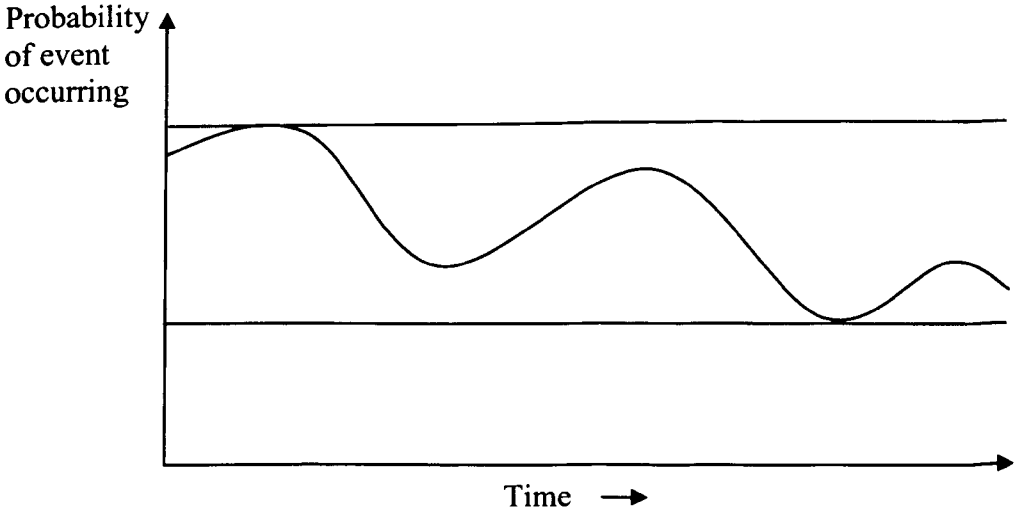


Figure 2 .

Probability function set and estimated by static and dynamic stable risk factors

Dynamic acute factors, on the other hand, refer to short-term states such as intoxication, mood changes, mental state, subjective distress, and sexual arousal, which Beech and Ward (2004) refer to as triggering events or contextual risk factors. Such dynamic acute factors can serve as immediate warnings of a risk event (Hanson, 2006). Which dynamic acute factors predict reoffending in general, and sexual reoffending in particular has not been closely examined previously, although some research has started to focus on the area of sexual offending (Hanson & Harris, 2000) and intellectual disability for both physical violence (Lindsay et al, 2004- the DRAMS article) and sexual violence (Boer, Tough and Haaven, 2004). The main purpose of identifying and measuring dynamic acute risk factors is to assist in the prediction of an imminent risk event and therefore to help in managing such events rather than preventing their occurrence. This is shown in Figure 3 below, where a theoretical probability function based on assessment of static, dynamic stable and dynamic acute factors is shown. It will be noted that the function now has times when the slope of the line is steep, showing rapid changes over short periods of time, corresponding to changes in dynamic acute factors.

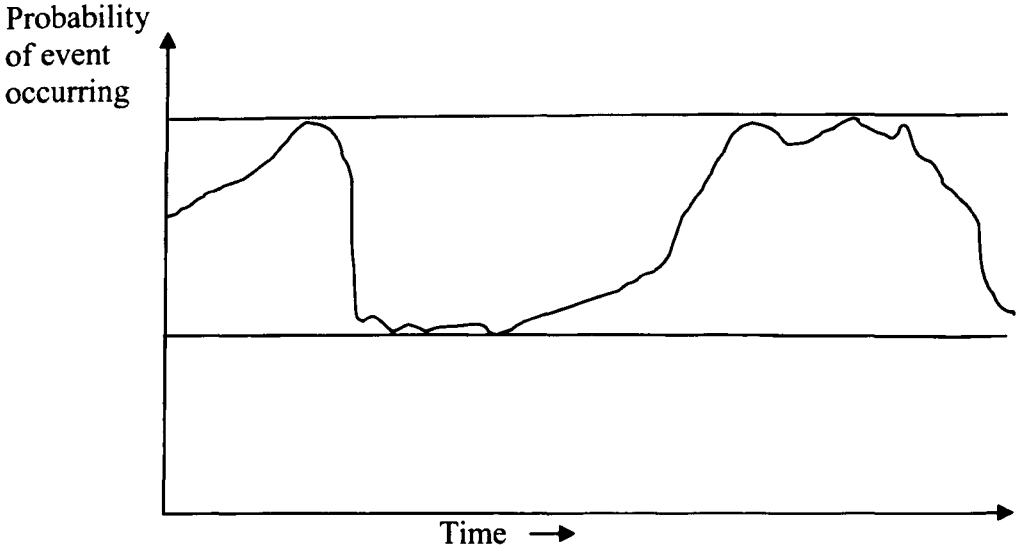


Figure 3 .

Probability function set and estimated by static, dynamic stable and dynamic acute risk factors

The above figures all show only the risk assessment phase of the process, albeit for static, dynamic stable and dynamic acute factors, but without any actual risk

management, minimisation, or risk control strategies having been implemented. Figure 4 below shows the probability function incorporating all three types of factors, with the addition of risk management, and shows a gradual reduction in risk and flattening of sudden risk fluctuations after risk management strategies have been applied.

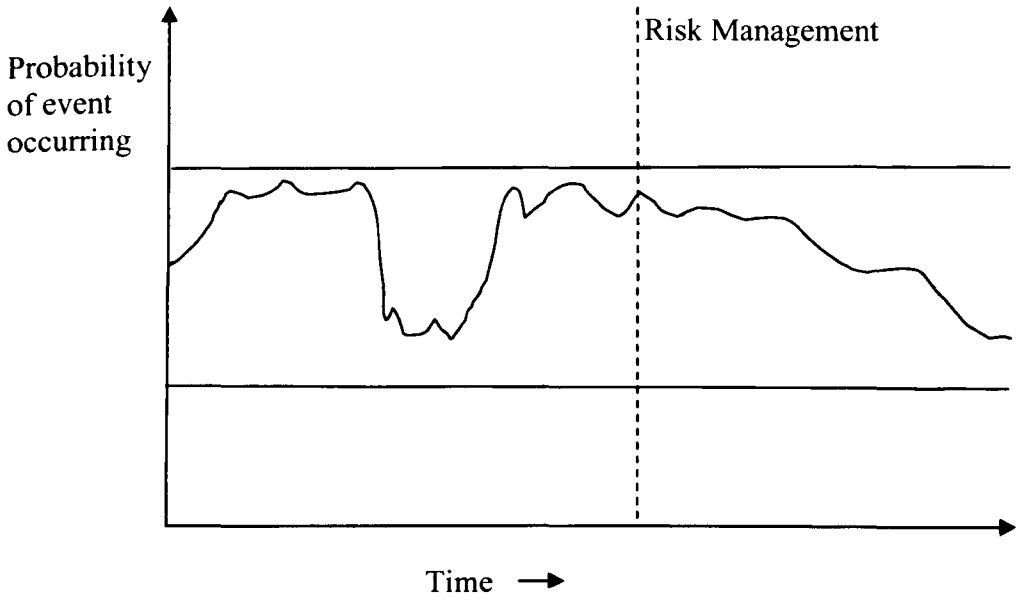


Figure 4.

Probability function set and assessed by static, dynamic stable and dynamic acute risk and risk management factors

The above analysis depicts the probability of a risk event occurring in the future for one risk area, for example sexual offending, for one individual. When we consider that there is an iterative relationship between risk assessment and risk management resulting in repeated risk assessment and risk management cycles, that many of the individuals with intellectual disability at risk of sexual offending will have additional risk areas such as physical violence, fire-setting, and/or epilepsy, and that there are likely to be complex interactions between risk areas that we can only imagine at this point in time (e.g. an increased risk of a seizure in one individual may increase the risk of sexual offending, while reducing it in another), the task of risk assessment, risk management and risk re-assessment is complex, protracted and not to be underestimated. The net effect of this complexity is to increase the rate of both false positive and false negative errors in the prediction process. A further complication to the above model is exemplified in the Quinsey, Book and Skilling study (2004). In this study, Quinsey et al used all or some of the subscales of the Problem Identification Checklist and the Proximal Risk Factor Scale as static risk predictors in part one of their study, by having them rated from file or staff interview, and then asking staff to rate clients on the scales each month as dynamic risk predictors in part two. So while the above distinction between static and dynamic variables holds up to some extent, the boundaries may be slightly porous, and presumably even more so between dynamic stable and acute factors. Mossman (2000), who introduced the Receiver Operating Characteristics (ROC) analysis to the statistical tools used to compare different prediction instruments, reminds us that

improving prediction for low rate behaviours like violence is extremely difficult. He further points out that while getting the risk assessment approach as good as possible is desirable, and achieving an optimal 'cutting point' between false and positive errors is important to this task, and that static predictors are slightly better than clinical predictors in prediction, clinical tools are essential for helping clarify where we should intervene clinically, and this will do more to reduce the risk in the long term, anyway.

This review has proposed there are four main groups of factors that arguably influence risk assessment and management in intellectual disability, namely the prevailing ideology and values in intellectual disability services; rising litigiousness, risk awareness and resultant 'defensive' practice; improvements in measuring and managing risk; and complexities of the risk assessment and management process. The way in which these four factors interact with each other to effect risk assessment and management in intellectual disability in terms of the proportions of true and false positive and negative predictions is shown in Figure 5 below.

It will be recalled that the aim of risk assessment is to minimise the number of false positive predictions (predicting someone will engage in the risk event when they subsequently don't) and false negative predictions (predicting someone won't engage in the risk event when they subsequently do), while simultaneously maximising the number of true positive and true negative predictions. As outlined in the relevant section above, Factor One, the prevailing ideology and values in intellectual disability services, tends to increase both false and true negative predictions because of the reluctance to apply restrictive controls. Working against this tendency, however, is Factor Two, the rising litigiousness, concern over clinical risk management, and resultant pressure for defensive clinical practice, which tends to increase the rate of true and false positive predictions because of the reluctance to run the risk of any repeated risk events - especially when the event in question is sexual offending. At the same time Factor Three, improvements in assessment methodology, and Factor Four, complexity of the risk assessment and management process, also operate against each other, but this time to increase or decrease the accuracy of the measurement process itself, and therefore to affect the proportion of false positive and false negative predictions.

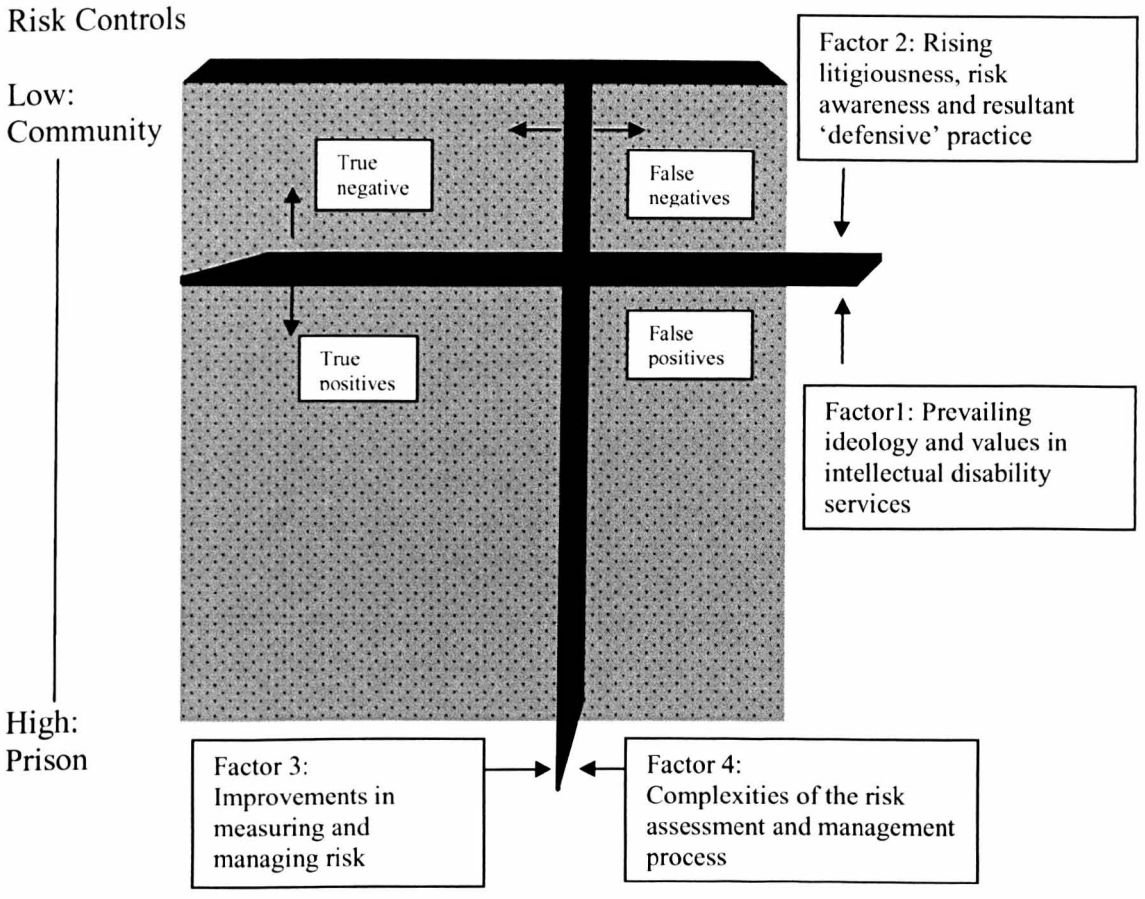


Figure 5.

Diagram showing the relationship of the four factors to the proportion of true and false positives and negatives

Applications to Intellectual Disability

The year 2002 seems to mark a turning point in the literature on risk assessment and management in intellectual disability. There were limited applied research or protocols published up to this point and a general consensus that there was nothing suitable published and limited guidance available for practice (Johnston, 2002). From 2003 onwards, especially with the publication in December 2004 of the special issue on risk assessment and management in the Journal of Applied Research in Intellectual Disability, the links to wider risk assessment and management were established (e.g. Lindsay & Beail, 2004), and a start made on intellectual disability

specific measures where these seem required (Lindsay et al, 2004). The literature will now be reviewed within these two periods.

Risk Assessment and Management in Intellectual Disability prior to 2002

Despite the extensive publications on risk assessment in the mainstream forensic area, and also, though to a lesser extent, in the area of psychiatric inpatient violence, there had been very limited publications specific to risk assessment in intellectual disability up to 2002 (Halstead, 1997; Johnston, 2002; Murphy, 1997a; Taylor, 2001; Turner, 1998). Susan Johnston, in an extensive search of the literature (2002) revealed only ten articles that specifically referred to risk assessment of people with an intellectual disability at risk of offending, and some of these references were within an article addressing a wider group. Only five of the references listed by Johnston include this dual reference to risk assessment and intellectual disability in their title. Although Johnston warns about transferring risk predictive variables from wider populations to people with an intellectual disability, subsequent research, including some by Johnston herself, resulted in a different conclusion. This will be examined shortly.

Until 2002, there was no widely accepted approach to risk assessment and management within intellectual disability, as the lack of relevant literature and absence of any published protocols demonstrates (Johnston, 2002). There was, as a consequence, a wide variety of 'In-house' protocols, many of which had originally been developed within Mental Health Services (Johnston, 2002). Unfortunately, none of these had been published, and generally practitioners were left to their own devices to determine what was best practice for risk assessment and management for a challenging population. Unsurprisingly, there had been no major reviews or controlled studies of different approaches (Johnston, 2002). Taylor & Halstead (2001)pointed to the rapid increase in forensic intellectual disability services in more recent years, the rapid developments in mainstream risk assessment and management approaches, and point to NHS guidance requiring that risk assessment be part of the Care Programme Approach (CPA) for all clients discharged under the provision of the Mental Health Act (1983). They reiterated Johnston's (2002) concerns regarding the lack of published protocols for people with intellectual disability, and the inappropriateness of mainstream tools for this population, and then argued for and demonstrated an example of a more systematic approach to risk assessment and management for a client at risk of sexual offending against children. They developed a list of clinically relevant factors for the individual using an aetiological model for the offending (Finkelhor, 1984), and then mapped each of these factors against two dimensions: stability of the factor and impact of the factor on probability of offending. These were then separated into static and dynamic factors, and a risk management plan developed around the dynamic factors.

Murphy (1997b) took a functional approach to risk assessment, and identified the relevant factors which should be considered, namely: victim characteristics, place/location of offence, level of supervision, perpetrator characteristics, previous offence details, psychological characteristics, level of cognitive distortions related to offences, situational characteristics such as the number of other clients and level of intellectual disability, level of supervision and availability of 'secret' places. A review by Steve Turner (2000) also found no norms for all existing mainstream

measures such as the PCL-R, VRAG and the SORAG, and therefore no good justification for their use with people with an intellectual disability at that time. However, Turner also found, as had others, that no specific measures existed or seemed to be being developed for people with an intellectual disability. Interestingly, Johnston (2002) argues that many studies on ID offenders include individuals with IQs up to 85. Rice (2003) has also referred to the inclusion of people with an intellectual disability in existing VRAG norms. This point was later supported by Quinsey, Book, and Skilling (2004), who said that "...the VRAG was as accurate with offenders who had intellectual disabilities as with offenders who did not..."(p. 244). So even in 2002, early indications were that while some specific measures may turn out to be necessary, existing mainstream risk measures could well be suitable – possibly with some procedural adjustments - and should be considered prior to the development of more population specific measures. Green, Gray and Willner (2002) examined the relationship between ratings of risk by care managers and the level of supervision they recommended for each case. They found a poor relationship between these two variables, and also a poor relationship between subjective risk ratings and actuarial results. However, the methodology and analysis raised three questions. The first of these is the two-way analysis of variance reported that uses the dependant measure of risk rating by the care managers to examine the relationship between type of offence and presence or absence of management.

The first main effect showed that care managers perceived a greater risk of re-offending without management than with management, and is unsurprisingly a simple confirmation of their risk perception ratings , while the second main effect shows that care managers perceive that supervision of clients (the managed condition) is likely to lead to a greater reduction in risk of sexual offending. This is also unsurprising, in that the group is predominantly a group at risk of sexual offending, with this being the only common feature amongst all 46 clients. Supervision arrangements would therefore be naturally biased towards supervision for sexual offending as a primary concern, and expecting greater reductions in the risk of future sexual offending as opposed to physical or other types of offending is also unremarkable. This interpretation of the main effect for type of offence also explains the apparent interaction effect.

The second question has to do with the comparison of the effect of levels of supervision across managed (current arrangements) or unmanaged care. Given that the two lowest levels of supervision are 0 = no supervision and 1 = informal supervision (e.g. by family) with no action taken by services to prevent access to victims, there is no distinction between the managed and unmanaged scenario at these lower levels. Unsurprisingly, the risk ratings showed that the care managers surveyed also saw no difference between these two levels. The difference found at levels 2 and 3 are again unsurprising in that they simply show that for clients for whom there is believed to be a risk and moderate or high levels of supervision are currently being provided, that care managers believe the risk will be increased should these management arrangements be removed.

This does not detract from the major finding of the paper, which highlights the naivety and lack of sophistication of the initial risk perception process by care managers. Given the way in which the supervision variable has been constructed, however, comparison to a managed / unmanaged scenario is spurious, because of the

similarity of the managed and unmanaged scenarios at levels 0 and 1 of supervision levels. The key feature in these levels is probably an attempt to prevent access to victims in levels 2 and 3. The third question relates to the conclusions about the level of management actually provided being unrelated to characteristics of clients offending known to correlate with increased risk and formal risk assessment (SACG-Min) scores. It is possible there is a further confounding variable, in that acceptability by the client and significant others of the supervision measures provided may have mitigated the relationship between risk perception and risk management. In other words, level of supervision was a function of perceived risk (however poorly judged) and perceived feasibility of implementation of supervision. Level of supervision provided needs to take account of both of these two factors, rather than just perceived risk.

Other approaches were described by Respond (1997) and Robertson, (1994), and there was a brief reference to risk management in Kearns & O'Connor (1988), as well as the only book exclusively focusing on risk assessment in intellectual disability by Sellars (2002), but there is little in these publications in addition to the material already covered.

Risk Assessment and Management in Intellectual Disability Post 2002

McBrien, Hodgetts and Gregory (2003) undertook a survey of people with intellectual disability who had contact with the Criminal Justice System in various forms, across a local authority area. This was an excellent study, with surprisingly high levels of risky behaviour and levels of contact. Of a known population with an intellectual disability who had contact with services of 1,326, the authors reported that while only 9.7% had contact with the Criminal Justice System and 2.9% had a criminal conviction, 26% behaved in ways that could be construed as offences. Comparable figures for the general population are presumably lower, but are not provided.

Lambrick (2003) points out the importance of diagnostic clarification, arguing for a cut-off point for intellectual disability of an IQ of 75. He also points out the lack of differentiation of norms for people with an intellectual disability in a number of mainstream measures, although this population is often included in research samples used for establishing norms. Rice (2003) argues that there has been a long history of VRAG use with special needs groups, including people with intellectual disability. She has argued that there was 128 with an IQ of less than 85 in the original sample for the VRAG, though this obviously points to a lack of agreement in practice about what does constitute an appropriate cut-off point for intellectual disability. A largely unhelpful review by Shoumitro and Roberts (2005) of the evidence base for management of imminent violence amongst people with an intellectual disability examined the use of restraint and seclusion, the impact of staff training and acute medication treatment, and policy and planning. Stein, 2005 reported on a year-long implementation of a modification of the Sainsbury Risk Assessment Tool for mental health and learning disability services especially at first point of contact.

In a study that points to the need for a range of specific risk assessment tools across a range of risk areas, Vallenga, Grypdonck, Tan, Lendemeijer, and Boon

(2006) present a multiple embedded case study of the risk management of epilepsy in 15 clients with intellectual disability.

The relevance of the Care Programme Approach to risk assessment was examined by Bhaumik, Nadkarni, Biswas, and Watson (2005), who audited all records for CPA standards over a 6-month period and found major deficiencies in risk assessment and management. Vick, Birke, and McKenzie (2002) also looked at the integration of risk assessment procedures with the CPA process at Redford Lodge.

Morrissey, Hogue, Mooney, Lindsay, Steptoe, Taylor, and Johnston (2005) presented some data supportive of the application of the PCL-R with ID population, though argued more research was needed.

The publication in December 2004 of the special issue of the Journal of Applied Research in Intellectual Disability created a forum in which a number of commentators could present their views and research on the application of general risk assessment and management approaches within intellectual disability, and intellectual disability specific tools and approaches could begin to be explored. In the editorial, Harris and Tough (2004) argue that the state of risk assessment methodology for mainstream offenders is such that they should be used as a matter of course by all clinicians, and argue that this is probably true also for clinicians to LD clients, although they acknowledge that "nobody has developed a reliable static actuarial measure specifically for ... people with intellectual disability." (p. 237). They make a similar but less detailed suggestion of using the RRASOR as a static tool and the STABLE-2000 to assess stable dynamic risk, and point out that Hanson and Harris (2001) have data on 52 sex offenders with intellectual disability, using the STABLE- 2000.

STABLE Dynamic Risk:
Significant Social Influences
Intimacy deficits
Lovers/intimate partners
Emotional identification with children
Hostility towards women
General social rejection/loneliness
Lack of concern for others
Sexual self-regulation
Sexual preoccupation/sex drive
Sex as coping
Deviant sexual attitudes
Attitudes supportive of sexual assault
Entitlement attitudes
Attitudes supporting sexual assaults-adults
Attitudes supporting sexual assaults-child molester attitudes
Cooperation with supervision
General self-regulation
Impulsive acts
Poor cognitive problem solving
Negative emotionality/hostility.

Quinsey, Book, and Skilling (2004) describe two studies in which they utilize an institutional closure to look at the utility of static (VRAG) and dynamic tools in predicting future anti-social behaviours after discharge into the local community. Fifty-eight men who were resettled into the local community were followed up for 16 months. For the first study, prior to discharge, the VRAG and two other measures were completed in full or in part (Problem Identification Checklist and the Proximal Risk Factor Scale). These were then correlated with over 500 incidents which occurred in the community. Only 27 involved actual violence. Subscales of Mood problems , Inappropriate and Antisocial Behaviours , Dynamic antisociality , and Denies all problems all correlated well with the occurrence of any incident, and the VRAG correlated best with presence of any violent incident. The VRAG's predictive accuracy in terms of the area under the ROC curve, was .69. The second study used the same group and the existing VRAG scores to undertake a field trial of dynamic risk indicators. Results showed good reliability amongst the dynamic measures, significant differences on the scales between those who were involved in incidents and those who were not, and preliminary results suggestive of a rise in these dynamic scores in the month before an incident.

McMillan, Hastings, and Coldwell (2004) present an interesting study, in which they compared the prediction rates of actuarial and clinical prediction approaches within a hospital setting for people with an intellectual disability. A catch-up longitudinal design was used, in which existing hospital recording systems for risk assessment and violent incidents were used as the predictor variables. These were multi-disciplinary team risk ratings on a 9-point scale and an actuarial predictor consisting of the number of previous violent incidents in the past 6 months, with 10 as a maximum value in predicting future violent incidents over a six month period. Area under the Curve (AUC) analyses showed that both clinical and actuarial assessment systems were significantly better than chance at 0.74 for the clinical predictor, and 0.77 for the actuarial predictor. While there were some minor queries over methodology, the study had a reasonable n of 124, and demonstrated an elegant and simple approach to predicting future violence for institutional settings where well-established violence and risk assessment recording systems are in place.

In an early but very promising piece of research, Lindsay, Murphy, Smith et al (2004) and Murphy (2005) developed and tested a risk assessment tool which for people with an intellectual disability would have immediate relevance in service settings to assess dynamic risk. The Dynamic Risk Assessment and Management System (DRAMS) sampled variables from the four domains of dynamic risk identified by Thornton (2002), as well as others taken from Hanson and Harris (2000), and Quinsey and colleagues.(Quinsey, et al., 2006). The scoring system is not clear, but seems to be a 6-point scale, with 2 categories for each of no, moderate or extreme problem, and a corresponding traffic light system of green (no problems), amber (moderate problems) and red (severe problems) respectively. The latter feature intended to make it more amenable to understanding and use by clients on a collaborative basis. The factors selected and scoring choices provided included:

> Mood - Inappropriate anger, anxiety, mania and sadness.
> Antisocial behaviour - Verbal or non-verbal threats, violence to self, others or property, sexually inappropriate behaviour, winding others up.

Thoughts - Aberrant sexual thoughts, suspicious thoughts and criminal thoughts.
Psychotic symptoms.
Self-regulation - impulsiveness and sexual impulsiveness.
Therapeutic alliance - complaining about staff, blaming others, refusing to engage in therapy and refusing medication.
Substance abuse - alcohol and drug/solvent abuse.
Compliance with routine - looking after room, looking after self and daily routine.
Recent renewal of emotional relationships.

Scores on the DRAMS were collected each day at Carstairs Hospital prospectively, and then a comparison of three DRAMS scores was made after a three month period. Although there were originally 25 participants, only 5 had a full data set in reference to 18 incidents. The three DRAMS scores compared were scores on the day of the incident, the day prior to the incident (to control for retrospective bias), and a random control day. Results were encouraging, with moderate or high reliabilities for 6 of the DRAMS factors (including the total score as one factor), and significant differences between the three DRAMS measures on the three days for four of the factors. As this study is the first published empirical study of a risk assessment tool specifically designed for intellectual disability, the results are reproduced in the Table 4 below. The table represents a combination of information from tables 1 and 2 in the article, as well as additional material from the text. While the study is based on a very small n (5) it shows early promise with regard to both a general application dynamic risk assessment tool, and a specific tool for intellectual disability settings. The table shows that the factors of Mood, Antisocial behaviour, Aberrant thoughts, Psychotic symptoms, Self-regulation, Compliance with routine and Total all had moderate or high reliability, while Mood, Antisocial behaviour, Aberrant thoughts and Total were all predictive of the 28 violent incidents recorded on the incident management system.

Appendix15: Themes and Sub-themes from the IPA Analysis of the first three Qualitative Interviews

Table 4 . DRAMS Factors, reliabilities and comparison of means (F test) across day of incident, day prior to incident and a control day

Drams Factor	Reliability: Spearman *r* High/mod/low	CD[1]	DPTI[2]	DOI[3]	F[4] p
Mood	.51** High	1.72	4.54	3.8	72.69 p <.01
Antisocial behaviour	.34** Moderate	5.18	10.42	7.84	47.79 p <.01
Aberrant Thoughts:	.328* Moderate	.12	.66	.52	22.86 p <.01
Psychotic symptoms	.76** High	Scores were too low to use.			
Self-regulation:	.715** High	1.3	2.48	2.34	7.23 p<.055
Therapeutic alliance	-.002 Low	.68	.64	.48	1.14 p <.35
Substance abuse:	Insufficient data				
Compliance with routine:	.612** High	2.76	6.06	4.64	7.33 p <.054
Recent renewal	Insufficient data				
Opportunity	Insufficient data				
Total	.447** High	11.76	24.80	19.62	64.22 p <.01

* p< .05; ** p< .01 1. CD = control day; 2. DPTI = Day prior to an incident; 3. DOI = day of incident; 4. F = comparison of three means.

Boer, Tough, and Haaven (2004) consider the specific problem of risk assessment and management for people with an intellectual disability at risk of sexual offending. They argue for a convergent approach in which both static and clinical methods are used to present an "...overall risk picture of the client..."(p. 276), because there is no single suitable instrument at present, especially for LD sex offenders. They outline methodology that includes the administration of the RRASOR to establish risk levels on the basis of static factors and comparison to the nearest comparative group, the administration of the PCL-R for those for whom it is indicated, and selection of relevant items from a list of factors that attempt to sample relevant dynamic stable and acute variables across relevant domains. These are listed below:

Stable Dynamic: Staff and environment:
Attitude towards ID sex offenders
Communication among supervisory staff
Client specific knowledge by supervisory staff
Consistency of supervision-boundaries
Environmental consistency

APPENDIX 16: QUALITATIVE INTERVIEW GUIDE

Acute Dynamic: Staff and Environment
New supervisory staff
Monitoring of offender by staff-changes in routine of resident, phone use, etc
Victim access
Environmental changes

Stable Dynamic: Offenders
Attitude towards and compliance with supervision and treatment
Knowledge of faulty thoughts, crime cycle, risk factors and relapse prevention plan
Sexual Knowledge and self-management of sexuality
Mental health problems, self knowledge, monitoring ability, and self management (including medication compliance and past diagnoses for personality disorder or major mental illness)
Time management skills
Substance abuse
Victim selection and acquisition / grooming behaviour
General coping ability and self-efficacy
Relationship and 'relating to others' skills
Use of violence or threats of violence towards self or others
Impulsiveness (including general lifestyle impulsiveness and impulsive violence)
Offender-specific stable dynamic factors.

Acute Dynamic: Offenders
Changes in social support or significant relationship
Changes to substance abuse pattern
Changes in sexual preoccupation
Changes in emotional state and or changes in ability to manage emotional changes
Changes in victim access or preoccupation with victim selection and acquisition or grooming of victim
Changes in attitude or behaviour toward supervision or treatment.
Changes in ability to use coping strategies (RPP) or recognize risky situations, or failure to use well-established problem-solving strategies.
Changes to routine
Offender-specific acute dynamic factors.

Smith and Wilner (2004) compared care managers and direct care staff responses to vignettes of inappropriate sexual behaviour by men with intellectual disability, systematically varying dimensions of response topography (intimate contact vs non-contact) and victim type (child or adult with an intellectual disability). The results showed that both groups rated intimate contact offences and offences against children more seriously, but found lower levels of concern by care managers than care staff.

Lindsay, Elliot, and Astell (2004) took a set of both static and dynamic variable from the wider risk assessment and sexual offending prediction literature and used them as predictors of offending in a retrospective and correlational study of 52 men, 18 of

whom were believed to have offended, and the variables were retrospectively rated (with some safeguards) and used as predictors in a multiple regression analysis. The analysis showed that the best predictors were very similar to those identified for general sex offenders, namely anti-social attitude, and poor motivation/response to treatment.

Boer, McVilly and Lambrick (2007) have recently made a case for the development of specific methodology for risk assessment and management in intellectual disability, which takes into account contextual factors such as physical environment, staffing, and level of service provision. They specifically point to inadequacies of general instruments such as the HCR-20 and the SVR-20, amongst others in the context of intellectual, and identify three major weaknesses of a simple extension to this group. The first is due to the need to redefine some key terms within these instruments such as relationship problems, employment and supervision violations. The second is the impact of different treatment received by people with an intellectual disability in the criminal justice system, which invalidates some rating items in the above assessments. For example, any items relying on prior convictions or court-ordered sanctions. The third weakness has to do with the greater reliance people with an intellectual disability typically have on a service system to support them in a variety of specific and often individual ways that impact upon both an assessment of the level of risk, and which also needs to be part of any risk management solution. They describe a risk assessment and management system that seeks to remedy some of these weaknesses, called Assessment of Risk and Manageability for Individuals with Developmental, Intellectual, or Learning limitations who Offend (ARMIDILLO).

We have seen in this narrow area, that over the last five years a series of rapid developments has occurred, in which the absence of suitable guidance for risk assessment and management in intellectual disability was initially identified (e.g. Johnston, 2002), the scope of the problem explored (Green et al., 2002; McBrien et al, 2003), and then applications of general tools to intellectual disability tested (Morrissey et al, 2005; Rice, 2003). Weaknesses of this extension have been identified (Boer et al, 2007), and specific intellectual disability tools have also begun to be developed (Lindsay et al, 2004; Boer et al, 2007). A recent edited book by Craig, Lindsay and Brown (Craig, et al., 2010) brings together recent developments and recommendations for assessment of recidivism risk (Lindsay & Taylor, 2010), and for adapting the procedures for using risk tools such as the HCR-20 (Boer, et al., 2010a), the SVR-20 (Boer, et al., 2010b)and the PCL-R (Morrissey, 2010) for an intellectually disabled population where risk of sexual offending is a concern.

Implementing risk assessment and management in intellectual disability services

At the time in which consideration was initially given to the area of risk assessment and management for the first potential participants for this project in 1997, available guidance for conducting risk assessment and management for intellectually disabled men at risk of sexual offending was virtually absent, as demonstrated in the

review above. As a result of the absence of formal published protocols, a protocol was developed in conjunction with a colleague called the Risk Assessment and Management Protocol (RAMP). This was developed on the basis of what could be gleaned from a range of extant unpublished tools and the literature at that time, such as Kemshall (1999, 1996), Murphy (1997) and RESPOND (1997). Several revisions were made and a guidance document developed. The RAMP was included as an appendix in the SOTSEC-ID Treatment Manual (Sinclair, et al., 2002).

A model for conceptualising the various facets of risk assessment and management has been developed in order to describe the relationship between risk and clinical procedures in an applied clinical context. This model is set out below in *Figure 6*. The key feature of the model is that it shows the separation and relationship between risk reduction (risk assessment and management) processes, and amelioration/treatment (clinical assessment and treatment) processes which, while sometimes overlapping, serve a different and potentially conflicting purpose - risk reduction to reduce future risk incidents usually for the wider communities' benefit, and amelioration/treatment to reduce stress or suffering or restore functioning for the individual. The model also shows the relationship, including iterative feedback, which exists between assessment and management in risk reduction, and assessment and treatment. The model shows the constant feedback required to allow ongoing adjustment of the risk reduction or risk management plan, essential to keep it effective (Craig, Browne and Stringer, 2004), and also shows a risk formulation stage, comparable to the clinical formulation stage that is an essential feature of psychological treatment. The role of risk assessment tools in suggesting strategies for risk management is a key requirement for risk reduction to occur (Monahan et al, 2001; Lindsay et al, 2004; Boer et al, 2007), and in the same way that there is a constant iterative relationship between clinical assessment, formulation and treatment, this is also the case between risk assessment, risk formulation and risk management. Assessments, formulation and intervention on one side of the process (e.g. risk reduction) will inform the other - also on an ongoing basis. Part of the debate about different tools (e.g. VRAG verses HCR-20) and approaches (e.g. static verses clinical) has, I believe, been a confusion over which aspects of the process each tool is addressing, and it is not surprising to see a developing realisation that we need a range of assessment, management and process tools to assist risk reduction efforts in the same way that a range of tools have had to be developed for amelioration/ treatment. Contextual factors that have not been detailed in the model include the assumption that multi-disciplinary discussion and agreement will form a key feature of the risk management process, as it already does for treatment, and that the risk reduction activity occurs within a culture of clear clinical risk management policies, clinical guidance and appropriate training.

While it will be quite some years before we can confidently select an appropriate and psychometrically robust tool from a range of possible alternatives to assist with assessment, formulation or reduction of risk when working with men with an intellectual disability at risk of sexual offending, we have moved forward on a number of important steps towards that goal. The final two tables in this chapter depict a clinical risk assessment and management system that might be implemented in a forensic or

challenging behaviour intellectual disability setting, based on the literature, guidance and research reviewed in this chapter.

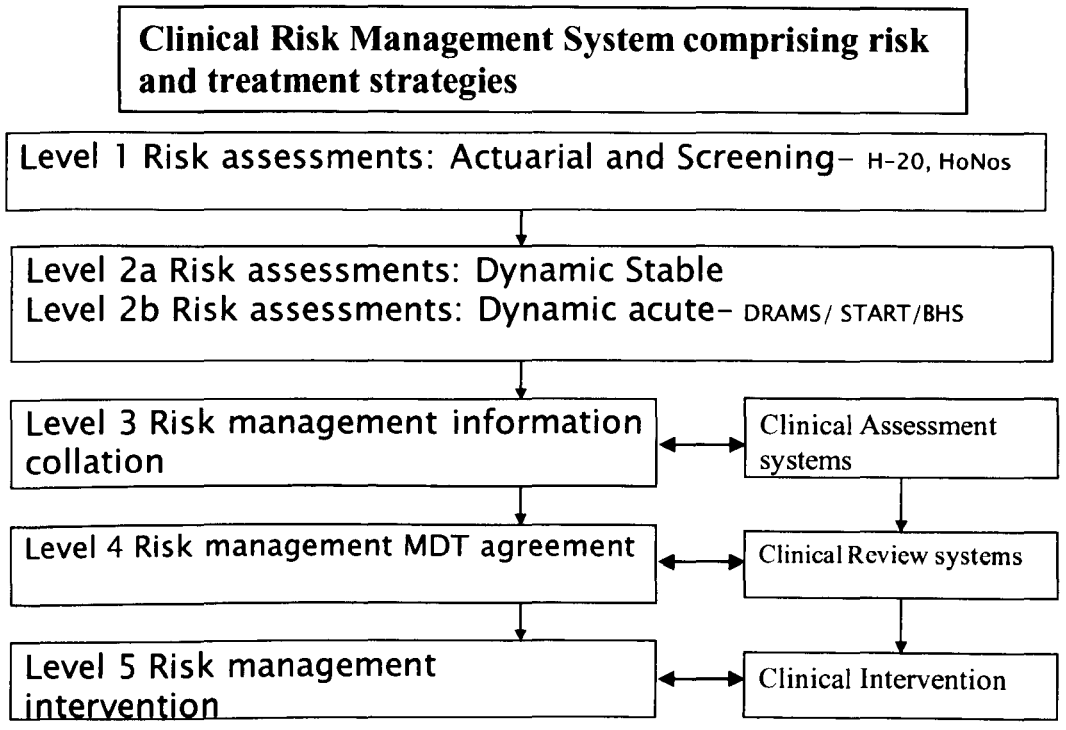


Figure 6 .

Conceptual model showing different stages of risk assessment and management and integration between risk assessment and management and treatment

Table 5 . Example risk assessment and management framework for forensic intellectual disability service

Activity		Tools/Techniques	When	Purpose
Risk Screening		HoNOS-Secure, Version 2b. NB not a risk assessment tool. Part one of the RAMP	Prior to admission and at change points, eg start of community leave.	Alerts service and clinicians to areas of risk concern for client (HoNOS and RAMP). Set outcome levels at point of admission (HoNOS). Prioritise areas of concern and provide a brief overview of risk areas (RAMP). Prompts collation of relevant risk history, ameliorative attempts and current risk guidance.
Risk Assessment	Static	VRAG for general violence, SORAG for sexual offending. Both include PCL-R or PCL-SV (P-Scan as a screening tool to indicate when full PCL-R needed). Static-99	During first 2 months and at subsequent change points or 3- yearly.	Sets long term risk probability parameters and therefore guidance for long term level of community integration, escort and observation levels.
	Dynamic	Initially HCR-20 or similar (eg SVR-20), and then ARMIDILLO and/or DRAMS after appraisal and training. START	Dynamic stable HCR-20, SVR-20 and ARMIDILLO: Most frequent of annually or when significant change in programme. Dynamic Acute-DRAMS: Weekly or monthly depending on area of risk and frequency of change of dynamic acute indicators.	Provides list of treatment goals from dynamic stable factors (eg anger management skills, cognitive distortions), and warning of imminent risk events from dynamic acute factors (eg mental state, family crises, new admission). Dynamic acute linked to ongoing mental state and mood assessments on a daily or pre-trip basis by Clinical Nursing staff.
Risk Management		RAMAS; Sainsbury system or RAMP.	On admission. When risk information changes. At reviews.	To summarise risk information in a convenient format for discussion and agreement at MDT reviews, communication to others, and to accumulate risk relevant information.