"Are you Safe?": Development of an Evidence-Based ID Sex Offender Treatment Programme in New Zealand

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Who are we?

- Forensic ID Secure Services (FIDSS)
  - National ID Secure Services • Pohutukawa
  - **ID Consult / liaison community service: ID Offender Liaison Service (IDOLS)**

IDOLS
(ID Offender Liaison Service)

- Small service
- IDOLS Manager (Jacqui)
- 1 FTE nursing (Janine), 1 FTE Psychology (Joseph), 1 FTE Occupational therapist (Vicki), 0.5 FTE Consultant Psychiatrist (Bede)
- Find us upstairs in the Pohutukawa Unit, Mason Clinic
- We are a tertiary service that aims to assist in preventing upward movement in security for people with ID by facilitating assessment, management and staff support in community services
- Cover the Auckland and the Northland regions (from Bombay Hills to Cape Reinga)

What services do we provide?

- Cognitive and neuropsychological assessment
- Diagnostic clarification
- Medication review
- Specialist assessments (e.g. ASD, Dementia, sensory assessments, etc.)
- Risk assessment and input on risk management
- Functional assessments and behaviour management
- Staff training and education
- Brief specialist therapeutic intervention (e.g. DBT, SOTP, etc.)
- We also engage in activities to upskill the ID sector (e.g. teaching, research, presentation in conferences)

Who do we look after?

- People with an **intellectual disability** who come into contact with the criminal justice system or behave in ways likely to bring them into CJS

- Offences (mainly):
  - Theft/burglary
  - Aggression / violence (physical assault)
  - **Sexual offences**
  - Arson

ID Sex Offenders

- Increasing number of people with ID who come into contact with the CJS due to sexually inappropriate or sexually abusive behaviours
- Offences range from indecent exposure to much more serious offences such as indecent assault (against adults and children) and rape
- There is a paucity of studies conducted locally looking on the prevalence rates of ID sex offenders and on evidence-based sex offender treatment programmes for people with ID
- Presently, we have around 40% of clients in our case load who have a history of sex offences or alleged sex offending.

ID Sex Offenders in NZ

- Presently, there is a huge gap in service provision with regards to sex offender treatment programmes for people with ID.
- There is the Adapted Te Piriti Programme being run at the Auckland prison but this is specific for child sex offenders.
- This is of great concern particularly for care recipients (under the IDCCR Act) who are required to attend sex offender treatment programmes. There are cases where care orders are unnecessarily extended due to lack of access to this programme.

Issues with Services supporting ID Sex offenders

- There is some tendency for staff and caregivers to minimise the risk of sexual offending which may be due to a variety factors (i.e. client's qualities, complacency, clash between cultural practices and risk issues, paternalism, institutionalisation, own values and beliefs, etc.).
- Some staff may underreport or choose not to report incidents due to a variety of reasons (e.g. not wanting to get into trouble, being frightened of them, inconvenience of reporting, etc.)
- There is very limited training and education provided to staff on how they deal with inappropriate sexual behaviours and sexually abusive behaviours of people with ID

Issues with Services supporting ID Sex offenders

- Some services still do not have clear and consistent policies around addressing sexual issues in PWID (e.g. access to pornography, prostitutes, sexual relationships amongst ID clients).
- Treatment provided to ID sex offenders is quite variable with no clear evidence of their effectiveness.
- Lack of expertise and clinical skills in a sub-specialised field

SOTSEC-ID

- Sex Offender Treatment Services Collaborative - Intellectual Disability (SOTSEC-ID)
- ID Sex offender treatment programme developed in the UK
- Run training events & meet every 6 to 8 weeks
- Set up sex offender treatment groups, shared treatment manual to guide therapy (treatment lasts for 1 yr; 2hr sessions, once per week, closed groups)
- Sharing core assessments measures

(Murphy, 2008)

Treatment content

- Group purpose, rule setting
- Human relations & sex education
- The cognitive model (thoughts, feelings, action)
- Sexual offending model (based on Finklehor model)
- General empathy & victim empathy
- Relapse prevention

Far more slow offence disclosure; more on sex education; far more pictorial material & less sophisticated on cognitive side than non-ID programmes; frequent repetitions and review

(Murphy, 2008)

Sex Education

- Provision of sex education is based on the assumption that people with ID have poor sexual knowledge and social skills (Seghorn and Ball, 2000)
- “Counterfeit Deviance” (Lindsay, 2005)
- Difficulties with learning and retaining information could be underlying cause of the lack of sexual knowledge in ID

Inett, 2008

Why provide Sex Education?

- Sex education is also useful in discussing issues around gender roles, consent, legal issues and attitudes may help breakdown cognitive distortion.

Inett, 2008

Cognitive Model

- Marshall et al (1999) describe a range of cognitive distortions with sex offenders which include:
  - Minimizing the offence
  - Denial of a problem
  - Minimizing responsibility
  - Denying/minimizing harm
  - Denying/minimizing planning
  - Denying/minimizing fantasizing

(Sinclair, 2008)

Cognitive Model

- Murphy (1990) claims that cognitive restructuring provides
  - A rationale for the role that cognitions have in maintaining sexual abuse
  - Corrective information and education (e.g. on consent or victim impact)
  - Help in identifying specific cognitive distortions
  - Opportunities to explore and challenge distortions

(Sinclair, 2008)

Cognitive Model

- The model is then applied to:
  - General non-sexual offending examples (e.g. quit smoking, general offending, etc.)
  - General sex offending examples (e.g. examples of scenarios and cases)
  - Followed by actual examples of the participant's previous offences

(Sinclair, 2008)

Sex Offending Model

- Finkelhor (1984) developed a model for men who offend against children which described the four preconditions necessary for abusive behaviour to occur:
  - Motivation to abuse
  - Overcoming internal inhibitors
  - Overcoming external inhibitors
  - Overcoming victim resistance

Sex Offending Model

- Finkelhor's model was adapted and reworked to simplify and consists of the following stages:
  - Thinking not OK sexy thoughts
  - Making it OK
  - Planning to offend
  - Offending

Sex Offending Model

- **Thinking not OK sexy thoughts**
  - Use of visual imagery to replay previous offences or situations and fantasize about future possible offences and risky situations
  - Sexual fantasies are common and acceptable provided they refer to legal sexual activity
  - Link between masturbation, sexual arousal and presence of illegal imagery (e.g. fantasy of rape)

Sex Offending Model

- **Making it OK**
  - Extensive web of cognitive distortions
    - *No one will ever know*
    - *It won't hurt them*
    - *Its how I look after them*
    - *It never hurt me*
    - *They don't seem to mind*

Sex Offending Model

- **Planning to offend**
  - Usually deny and explicit and implicit planning
  - Unsophisticated in comparison to mainstream offenders
  - E.g. taking sweets, extra money, following young girls when out in the community

Sex Offending Model

- **Offending**
  - Ignore any concerns for the well being of the victim
  - SOTSEC-ID focusses on short term sexual and other gains to the exclusion of long term consequences to themselves and others
  - Devastating consequences for the victim as well as focussing on the long term consequences for themselves

Sex Offending Example

- **Thinking not OK sexy thoughts**
  - Me touching their genitals
  - Them touching mine
- **Making it OK to offend**
  - It won't hurt anyone
  - I'll be ok
  - They won't tell

Sex Offending Example

- **Planning to offend**
  - Get close to victim
  - Go to shops/schools/amusement parks
  - Ask up to bedroom
  - Show how to operate computer
- **Offending**
  - Ignore long term consequences
  - Focus on short term thrill
  - Offend

Enhancing Empathy

- Important to regulating pro-social behaviour
- Definitions vary:
  - Shared emotional experience
  - Understanding of affect in other
  - Response to another persons' affect or circumstance

(Murphy, 2008)

Empathy

- Enhancing empathy is part of 94% sex offender programs in USA despite poor evidence
- Clinicians are still highly polarised with the issue on whether empathy work is of some benefit (or may even be detrimental) in sex offending work.
- SOTSED-ID group recommended the need to focus more on victim empathy
  - Given that majority of people with ID have experienced physical, emotional and sexual abuse
  - Methods include reading seeing victim accounts, role playing, writing down victims accounts, role play own victim, writing own victim letters

Enhancing Empathy

- Recognition of emotions in self and others
- When they were victims what happened and how did they feel?
- How would sexual abuse make victims feel (general)?
- Disclose detail of offence
- How did sexual abuse make their particular victim feel? Long term effects?

"Ripple Diagrams"

Murphy, 2008

Relapse Prevention

- The model used with SOTSEC-ID combines adapted Finkelhor (1984) model of sexual offending with the decision matrix originally developed by Marlatt (1985) and prescribed for sex offender treatment by Jenkins-Hall (1989)

Example of a Relapse Prevention Plan

Good: Not Offending	Bad: Offending
Pink Elephant : Picking strawberries at farm. Birds singing.	*Film* : Touching kids all over, genitals, and bottom
Truth : Sex hurts young children: • Frightens and scares them • Mess up their life	*Excuses* : Won't hurt them. They won't tell. This is how I love them.
Planning to Offend : Where someone can see. Not carry sweets and offer children	*Planning to Offend:* No one around except victim. No one can see. Pretend to be a friend.
Not Offend: Stay away from victim. Focus on long term consequences.	*Offend:* Go close to the victim Ignore long term consequences.

Results: first 13 groups (52 men)

- About 40% men who enter treatment are not required to come by law (60% on MHA or CRO)
- Mean age 35 yrs; mean IQ 68 (range 52-83); mean BPVS 10.9yrs
- ASD diagnoses: 23%; personality disorders 28%; mood disorders 23%; mental illness 9%
- Offences: stalking, sexual assault, exposure; rape; victims children and adults, male / female
- Most have long history of similar behaviour (35 with 3 or more such behaviours known)
- 55% were sexually abused themselves in past

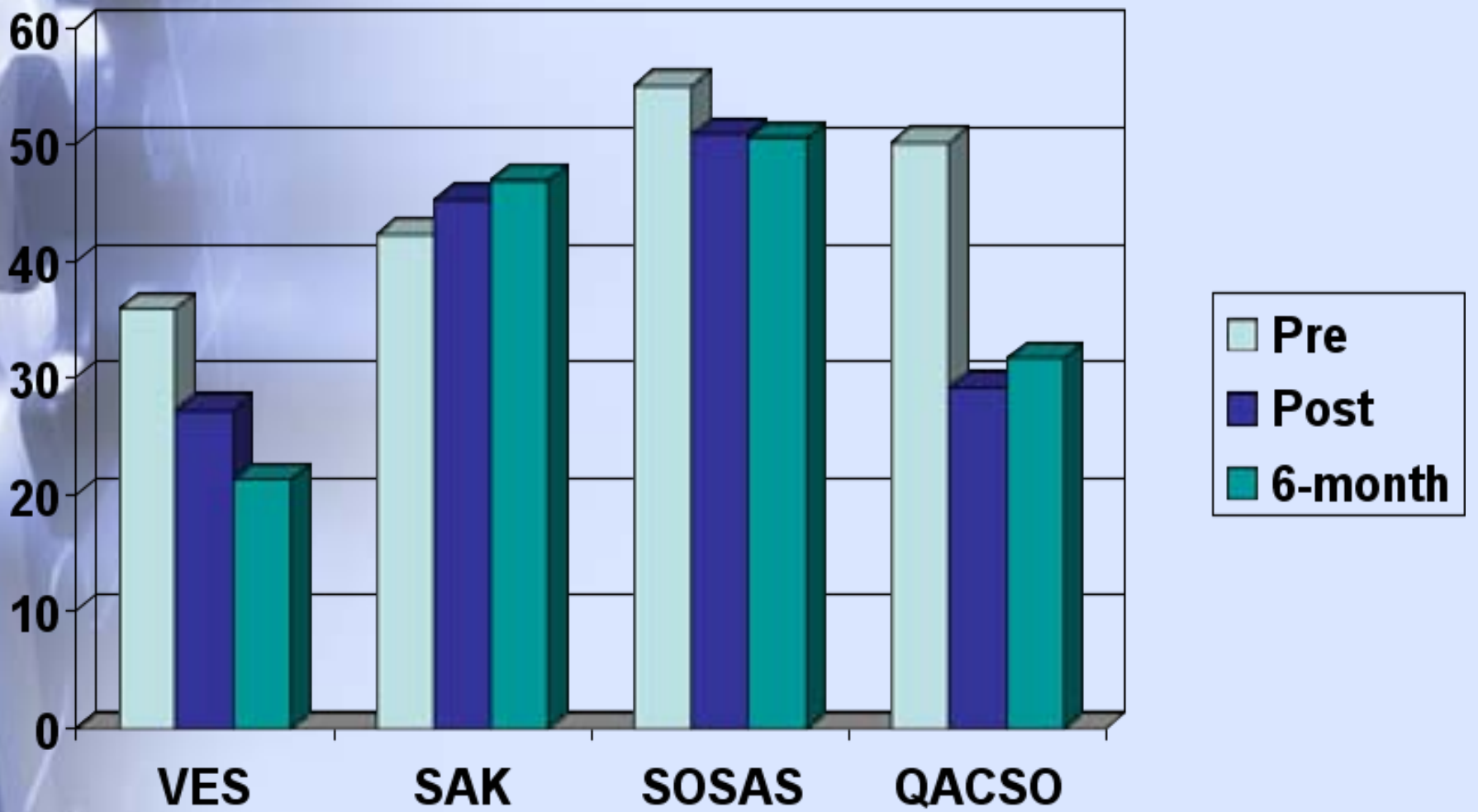
(Murphy, 2008)

Changes in cognitive distortions, sexual knowledge & empathy

- Sexual Attitude and Knowledge Scale (SAKS): significant improvement by end of group, maintained at follow-up
- Questionnaire on Attitudes Consistent with Sex Offending (QACSO) (Lindsay): ditto
- Victim Empathy (Beckett & Fisher): ditto
- Sex Offenders Self- Appraisal Scale (Bray): ditto

(Murphy, 2008)

Cognitive distortions, sexual knowledge & empathy



(Murphy, 2008)

Further sexually abusive behaviour

- During treatment: most men were fine although 6 cases (4 men) showed non-contact ‘offences’
- In 6 month follow-up period: most men fine; but in 7 cases (5 men) DID show non-contact ‘offences’ (5 cases) or sexual touch through clothing (2 cases)
- Prognosis: No relationship to ‘re-offending’: pre- or post-group scores; presence of mental health problems, personality disorder, living in a secure setting, being victim of SA, history of offending.
- Poor prognosis: Concurrent therapy & diagnosis of autism/Aspergers Disorder

(Murphy, 2008)

SAFE-ID Programme

Background

- The SAFE-ID Programme is based on the SOTSEC-ID which is an evidence-based integrated treatment program for ID sex offenders.
- It includes the following components namely;
  - Sex education
  - General empathy and victim empathy
  - Four stage model of sex offending (based on the Finkelhor model),
  - Challenging cognitive distortions (CBT model)
  - Relapse prevention
  - In addition, we have incorporated some DBT concepts to help improve their coping skills.

SAFE ID Programme

Advantages of Running the Programme

- Currently, only known evidence-based, comprehensive sex offender treatment programme specific for ID sex offenders
- The programme is flexible and there are opportunities for us to tailor the programme to suit client needs.
- Important to fill in the huge gap in addressing sex offending with our clients (both inpatient and outpatient) as more than 40% of our IDOLS caseload & 55% of the Pohutukawa unit care recipients have sex related offences and/or inappropriate sexual behaviours

SAFE ID Programme

- The IDOLS team have forged collaborative ties with the SAFE team, which is a community-based service contracted to provide sex offender treatment programmes.

- The SAFE-ID programme is a 7-month programme (2-hour weekly sessions). In addition, each participant receives individual input (either regular debriefing or individual psychotherapy)

- We started running the group in May 2009. We have been using the Whanau room at the Pohutukawa Unit so that ID clients in the inpatient and in the community will be able to attend the programme.

SAFE ID Programme

- We have been running the programme together with SAFE therapists.
- Presence of male and female therapist in every session.
- We require their keyworkers to support them in the group particularly with the first two modules.

SAFE-ID Timetable

- Introduction and Group Rules
- Sex Education and Healthy Relationships (5 weeks)
- Cognitive Model (5 weeks)
- Sex Offending Model (9 weeks)
- General Empathy and Victim Empathy (4 weeks)
- Relapse Prevention and development of their own personal risk management plan (5 weeks)
- In addition, we incorporated DBT coping skills in every session (e.g., mindfulness, distress tolerance, coping skills).
- The group will finish towards the end of December 2009.

SAFE ID Programme

- We have provided staff training and education to RIDCA, RIDSAS, vocational services (FWT) who are supporting clients attending the SOTSEC-ID.
- We are planning to organise one-monthly meeting with the staff to keep them up to speed with the programme and to discuss any ongoing issues.

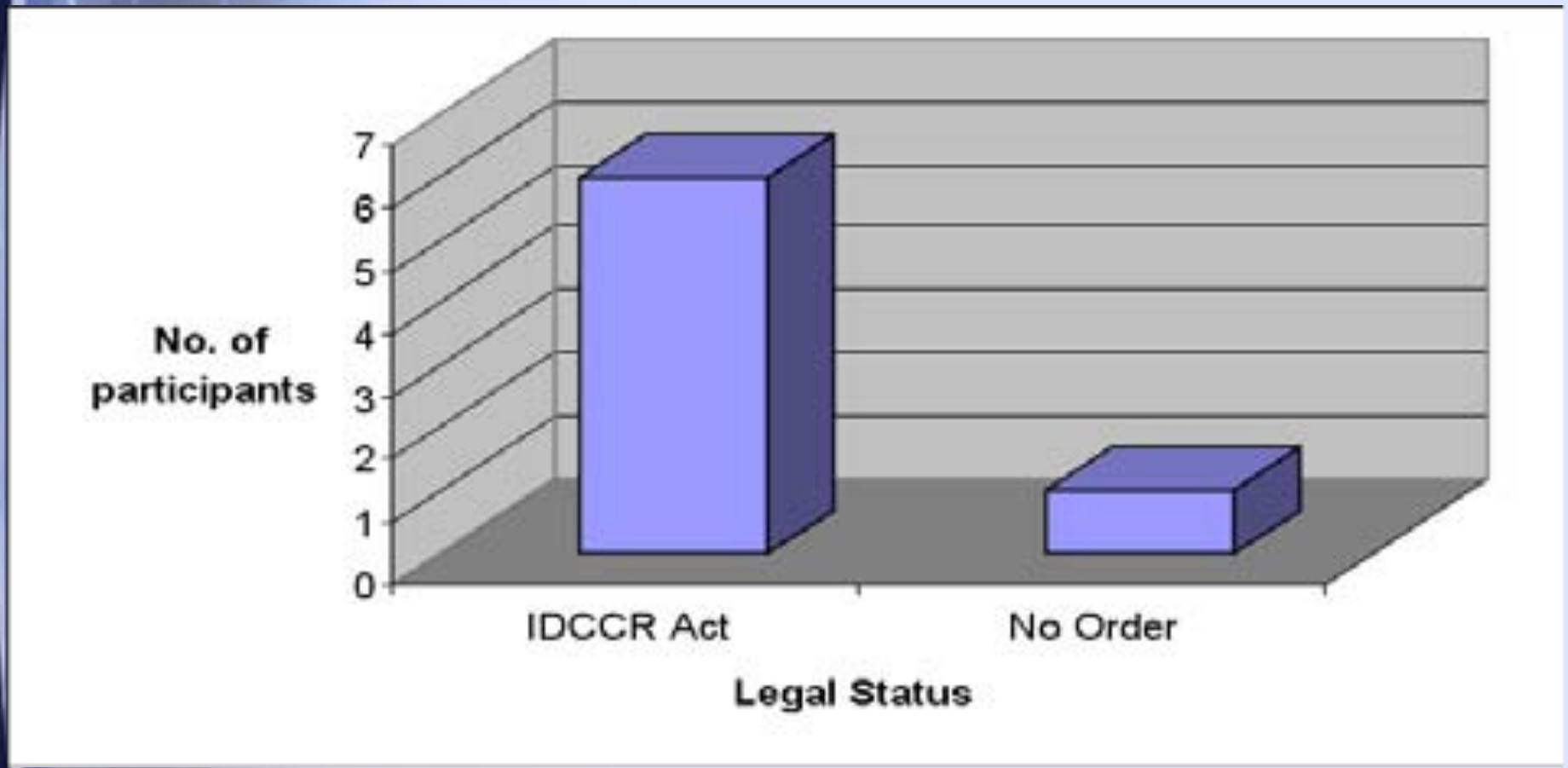
How is the SAFE-ID programme different from SOTSEC-ID?

- More intensive input to services
  - training and education
  - clients attend individual sessions,
  - regular peer supervision,
  - regular meetings with services involved.
- Use of DBT concepts and skills
  - Mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness
  - SOTSEC-ID relies heavily on cognitive restructuring which does not provide them with the behavioural coping skills they need

How is the SAFE-ID programme different from SOTSEC-ID?

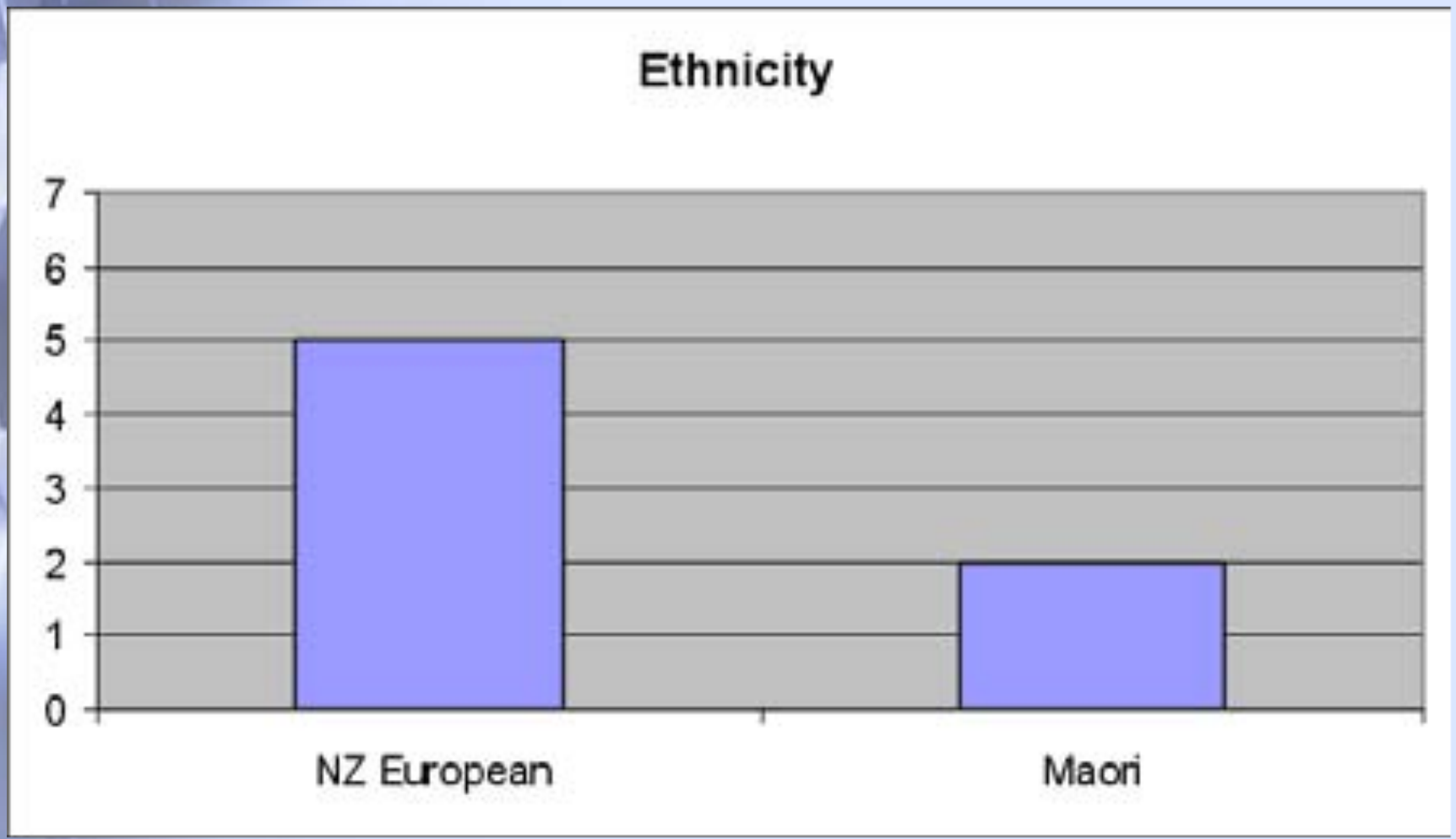
- Slight changes in concepts around sex offending cycle
  - Introduction of the concepts of risky mind, risky thoughts, feelings and actions
  - Risky and wise choices
  - Use of the concept of risky situations rather than planning to offend
- Values based and providing clients with sense of hope
  - “There is more to life than sex offending.”

Preliminary Findings



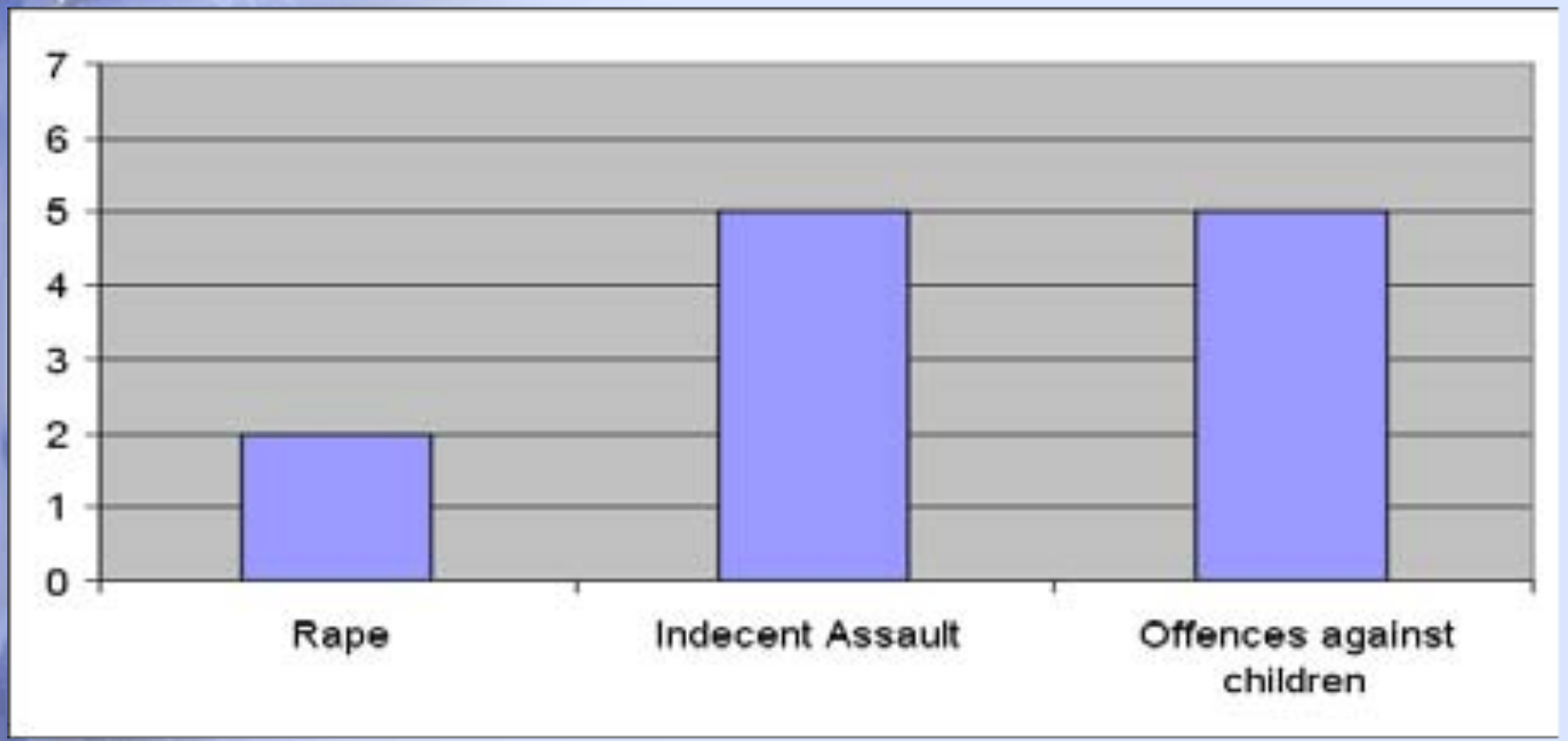
- We started with 7 participants in the group.
- 6 out of the 7 participants are under the IDCCR Act with 2 of the participants under hospital secure orders.

Preliminary Findings



- There are five clients who are of NZ European descent and 2 of Maori descent.

Index Offences



- 2 were charged and convicted for rape
- 5 out of 7 were charged and convicted for indecent assault
- 5 out of 7 have offended (allegedly offended) against children

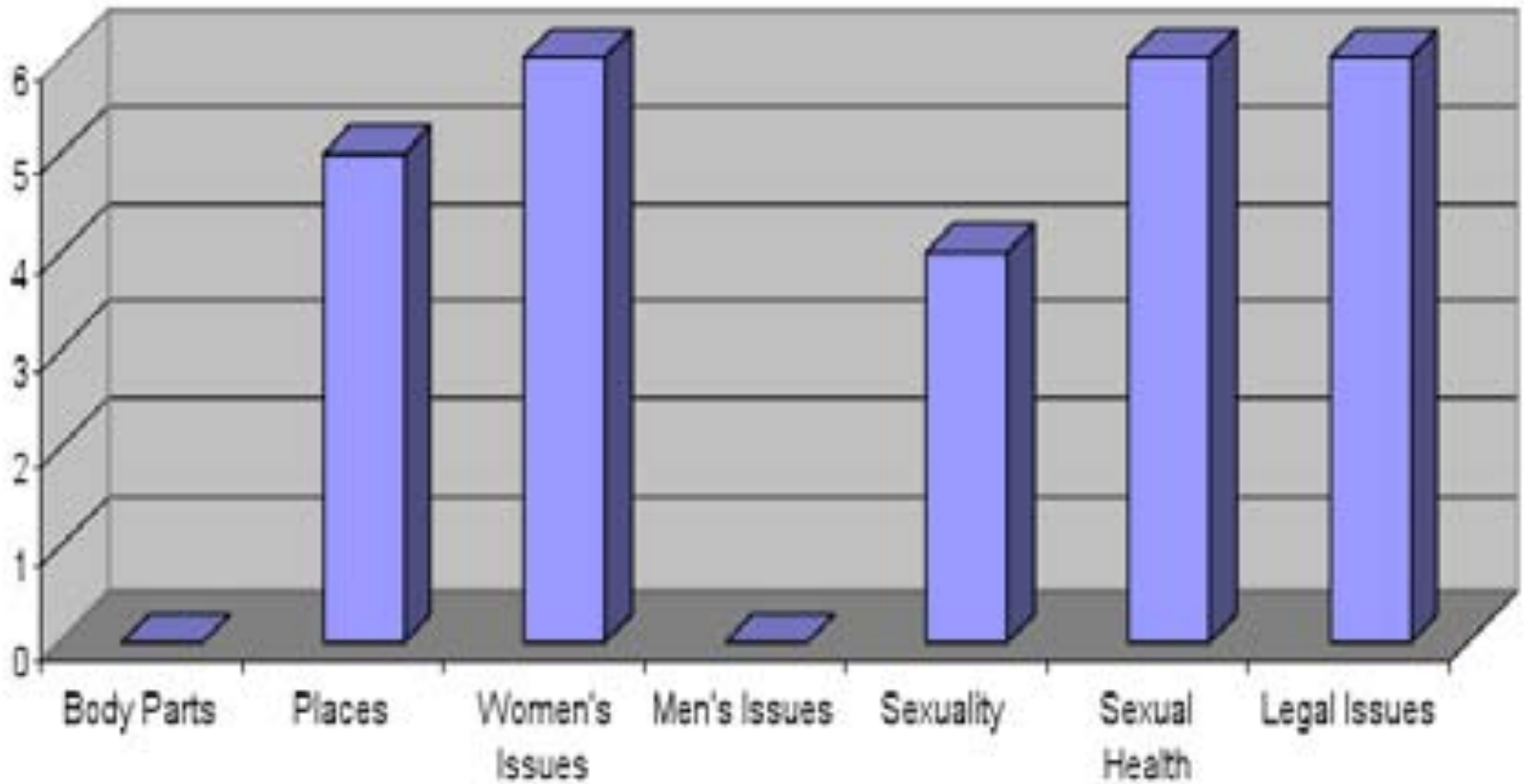
Preliminary Findings

- The participants' mean IQ is in the mild intellectual disability range (Mean= 61; Range 52-70)
- 2 participants have concurrent mental health diagnosis (i.e. schizophrenia)
- 3 out of the 7 participants have formal diagnosis of personality disorder (i.e. ASPD)
- 5 out of 7 have formal diagnosis of sexual disorder (e.g. paraphilia; paedophilia)

Preliminary Findings

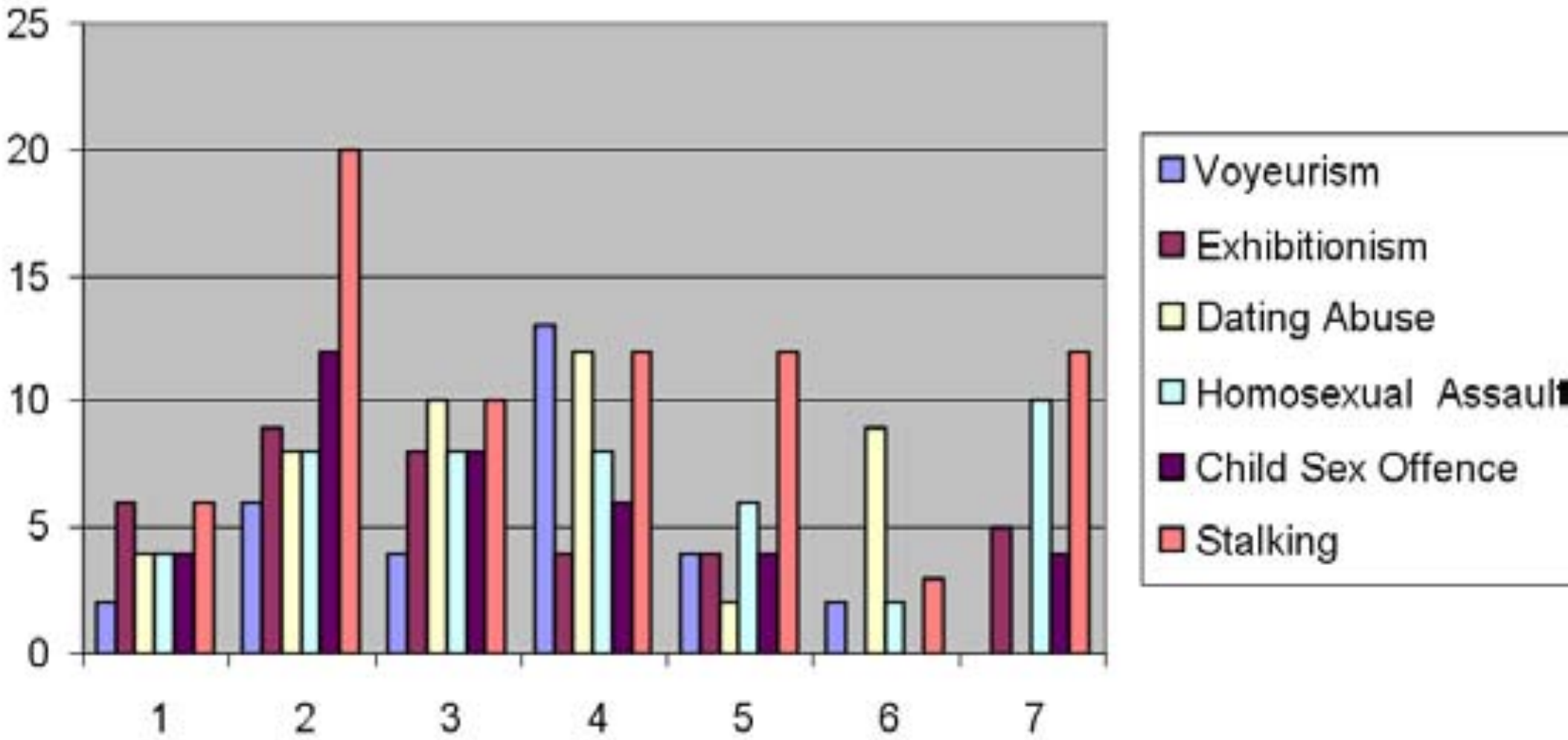
- 5 out of 7 (71%) have history of sexual abuse.
- 6 participants have other non-sex offence charges or convictions (e.g. assault, burglary, property damage, etc.)

Sexual Knowledge



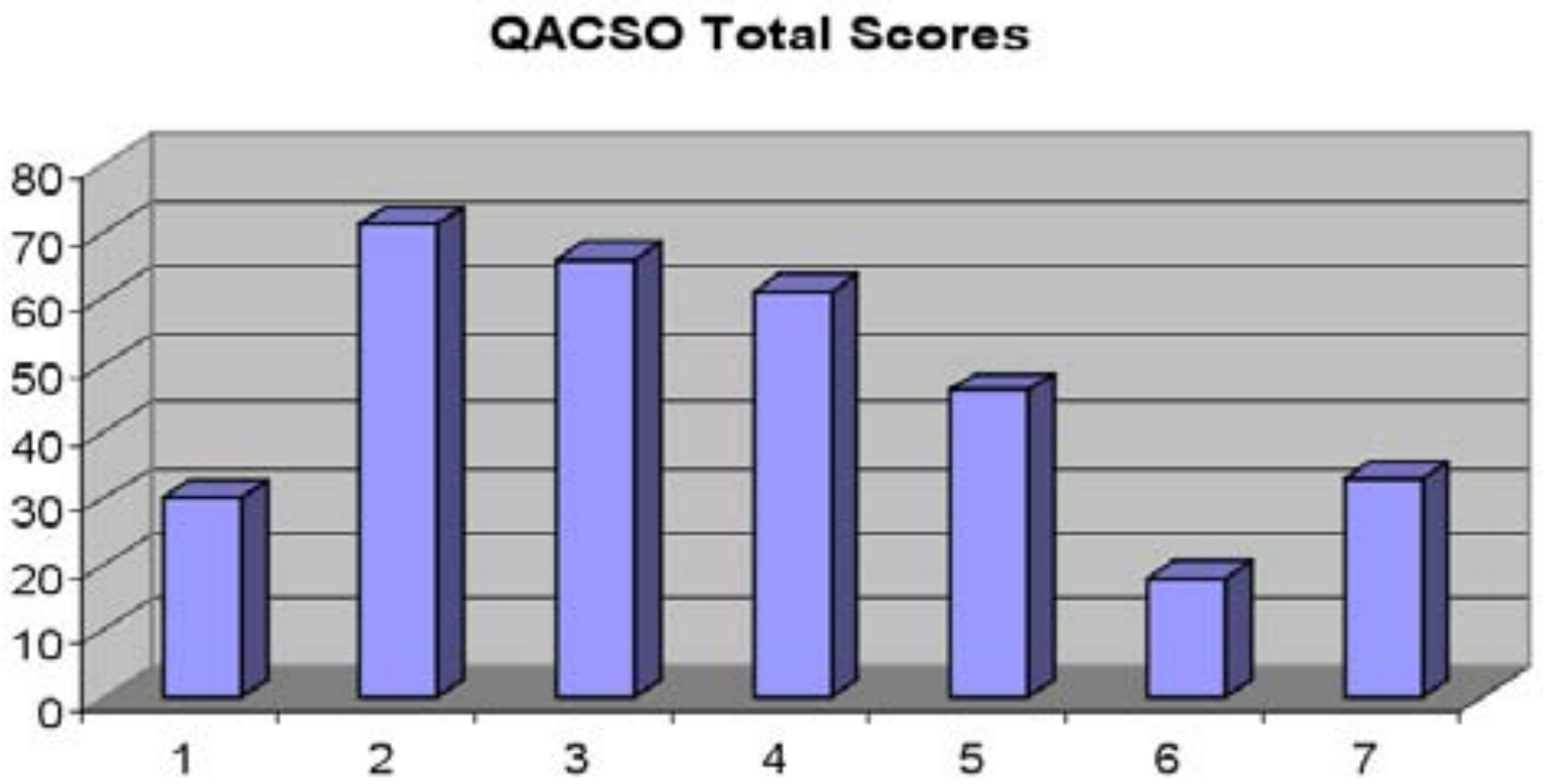
- **Assessment of Sexual Knowledge (ASK)**
  - Good knowledge of body parts and men's issues
  - Significant gaps in understanding of public vs. private places, sexuality, sexual health and STIs, women's issues (pregnancy, menopause, contraception, etc.) and legal issues

Attitudes Consistent with Sex Offences



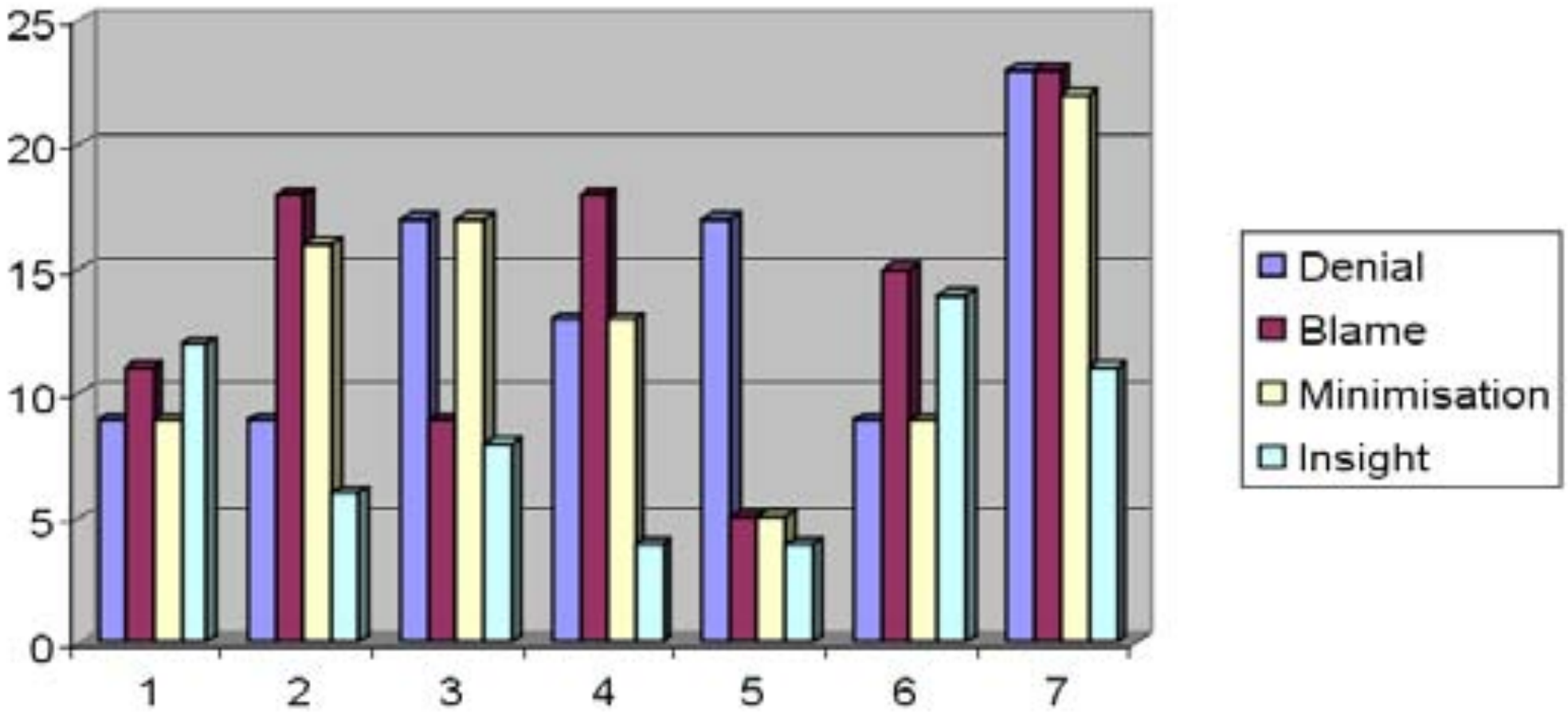
* Majority exhibit attitudes which condone or support sex offending.

QACSO Total Scores



- The QACSO total scores show that it is a heterogeneous group.

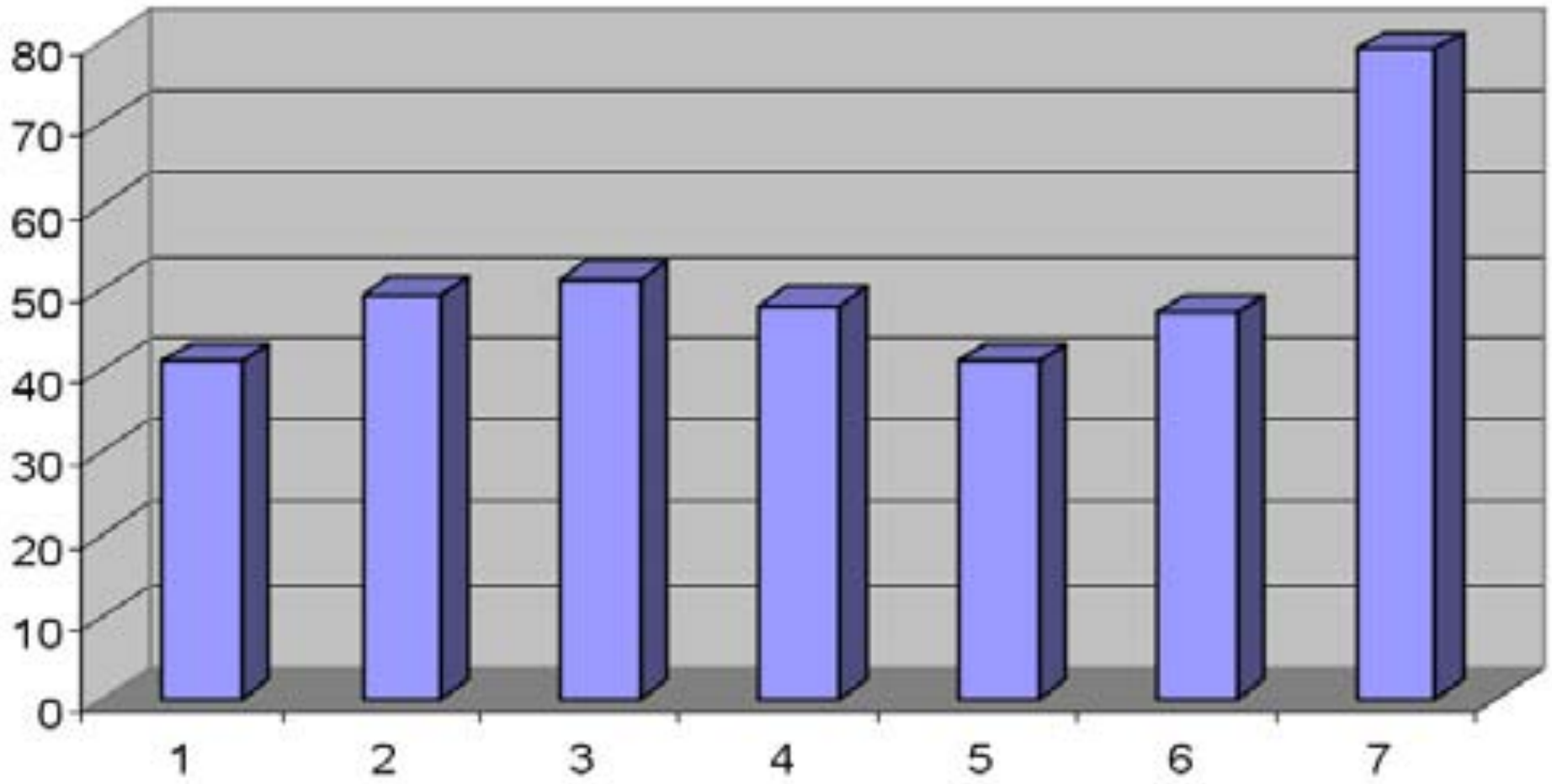
Cognitive Distortions



Sex Offenders Self-Appraisal Scale

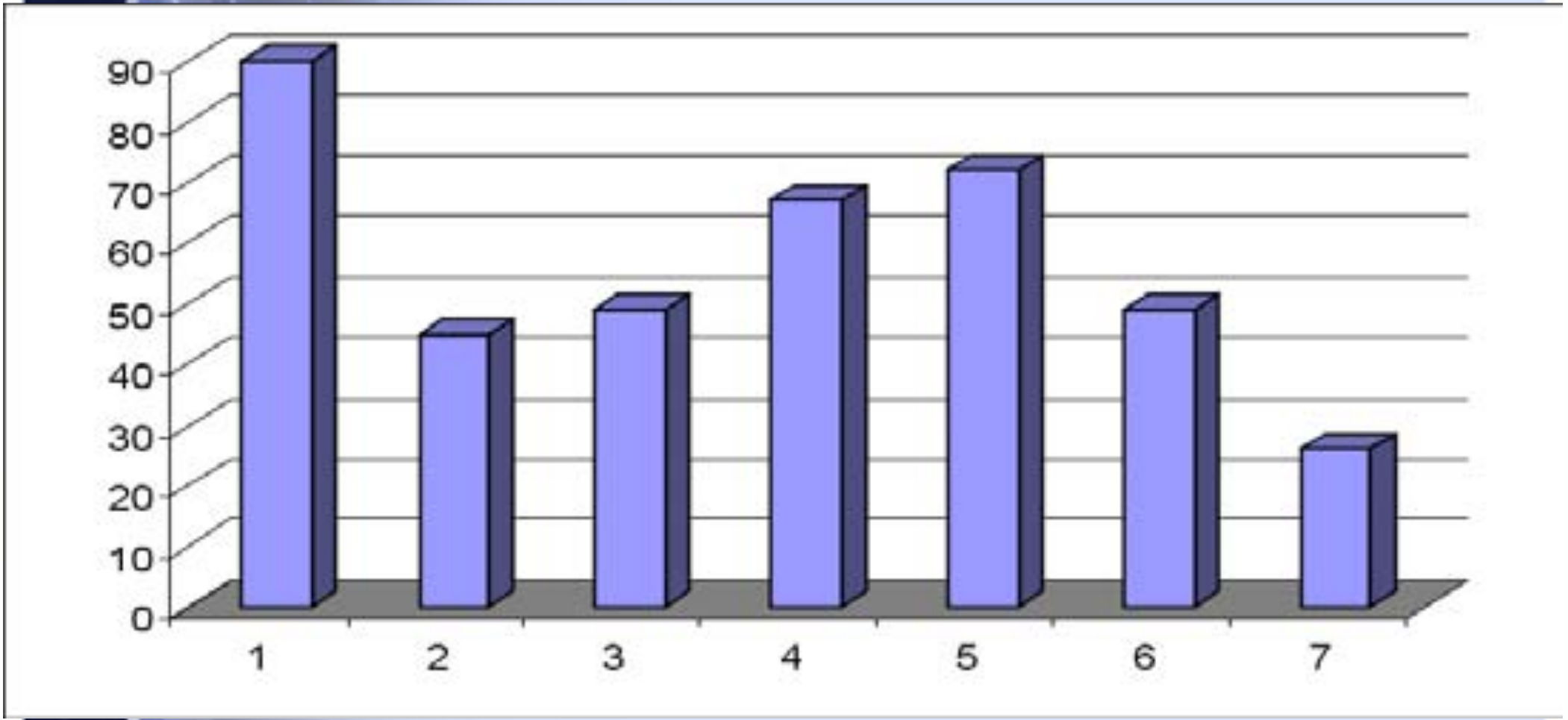
* Cognitive distortions present in all participants
* Mixture of denial, blaming and minimisation

SOSAS Total Scores



* All of the participants scored high on the SOSAS which indicates that clients employ a web of cognitive distortions consistent with sex offending.

Victim Empathy



- **Victim Empathy Scale**
  - Heterogeneous group with individuals having low to medium to medium to high levels of victim empathy

Summary of Findings

- There is significant gaps in sexual knowledge. Of particular concern are the gaps in their knowledge of legal issues, sexual health, sexuality and public and private places.
- There is heterogeneity in the attitudes of the participants towards sex offending. Each participant exhibits a variety of attitudes consistent with sex offending.
- All of the participants employ a web of cognitive distortions to condone or support their sex offences.
- There is a mixture of participants with low to medium to medium to high levels of victim empathy.

Insights and Learning

- The more heterogeneous the group the better as there is less collusion in the group
- Some of them have openly challenged each other's cognitive distortions and anti-social attitudes
- Pleasant surprises from the participants where they stepped up and openly talked about their personal issues and share their insights to the group
- Positive feedback from some of the clients in terms of their learning
- Most of the participants need support with the homework and regular debriefing.

Issues and Challenges

- **It's hard work!**

- Some services have encountered staffing issues (e.g. consistent staff to support the clients)
- Issues with collaborating with therapists with different therapy styles (structured vs. more process oriented)
- Challenges with supporting the clients particularly those who are in the community (e.g. staff support, providing regular debriefing, coordinating with different services, etc.)

Group Rules

- To ensure safety and confidentiality within the group ‘Group Rules’ were outlined from the onset of the group.
- A reminder of the rules occurred at the start of each session and a poster of the rules were placed at the front of group.
- Blue cards were available – these blue cards allowed a client to choose to leave the room with a staff at any time if feeling uncomfortable in the group.

Case Study

- Male
- Mid 20's, European descent
- Diagnosed with: Klinefelters syndrome, Mild Intellectual Disability, historical diagnosis of ADHD
- History of child sexual abuse
- Inappropriate sexual behaviours from early teens
- Extensive history of involvement with special education and mainstream ID services
- History of challenging behaviours, antisocial behaviours and anger management concerns
- Has engaged in 1:1 therapy with Clinical Psychologist for approximately 18 months, addressing anger management and sexual offending.

Progress in the group

- Able to engage in discussions about sex education when previously he could not even cope with talking about sex.
- Challenged by others (facilitators and other group participants) about behaviours presented in group.
- Appropriately challenged other participants on their behaviours in the group.
- Disclosed his ‘life story’ including index offence within the group.

Life Story

- Wrote a narrative about his life, including family, social, leisure and offending history.
- Started to open up about his offending.
- Not yet ready to share information about his own abuse.
- Identified his owns triggers when disclosing his offending including pornographic magazines and the Internet.
- Showed guilt and remorse when disclosing his index offence in the group.
- Able to describe his feelings before and during offending, and associated them with physical aspects (sweaty shaky hands, heart beating faster, etc).

My Life Story

“ I am very sorry for what I did and get angry with myself.”

“ I do realise that what I did was wrong. I feel that the course I am doing is helping me and want to carry on and finish it. Once it is done I can start to plan for the future…”

What NOW?????

- Continue running the programme
- Plan ahead to address potential problems and just deal with others as they come up (e.g. drop outs, incidents, etc.)
- Provide feedback on the evaluation of the programme

Use some of the DBT coping skills to manage our own frustration and distresses (e.g. having a latte and carrot cake) • therapy for the therapists