VOLUME I

STAFF'S EXPERIENCE OF FACTORS SUPPORTING SEX OFFENDERS WITH A LEARNING DISABILITY IN COMMUNITY SETTINGS

By

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT TO THE UNIVERSITY OF BIMRINGHAM FOR THE DEGREE OF DOCTOR OF FORENSIC CLINICAL PSYCHOLOGY

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The University of Birmingham

May 2020

Overview

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Forensic Clinical Psychology (ForenClinPsyD) at the University of Birmingham. The thesis consists of two volumes.

Volume 1 is comprised of three chapters. The first chapter presents a meta-analysis exploring people's attitudes towards the reintegration of sex offenders into the community. The second chapter presents the empirical paper of a qualitative study exploring staff's perception of the factors that are supporting sex offenders with a learning disability to reintegrate into community settings. The final chapter contains a public domain paper which outlines the research undertaken in the empirical paper suitable for a public audience.

Volume II contains five Forensic Clinical Practice Reports (FCPRs) which evidence clinical work conducted across various services: Adult Mental Health, Learning Disability, Child and Adolescent Mental Health and Prison. The first report presents a cognitive-behavioural and psychodynamic formulation to understand the presenting difficulties of a young female detained under section. The second report presents a service audit comparing the national guidelines on the Prevention of Suicide within a forensic hospital. The third report is a single-case experimental design investigating the change in assertiveness and sexual knowledge of a male patient in a secure hospital. The final FCPR was a case study of a male prisoner presented as an oral presentation for which an abstract is presented.

To my family, thank you for all your love, support and helping me throughout this journey.

To my husband, thank you for always encouraging me to keep going and your love and patience from across the globe.

To Allah, for keeping me grounded and ever closer to my faith.

Acknowledgements

Firstly, I would like to thank my Academic Supervisors, Dr Owen Forster, Dr Christopher Jones, Professor John Rose, Monica Lloyd and my External Research Supervisor Dr Anne-Marie Mensink, for their on-going support, time and guidance throughout the duration of my research. Your time and expertise have been much appreciated.

Secondly, I would like to thank my family. You have been my mental, physical and emotional support throughout the whole process of my doctorate. Thank you for always giving me the encouragement I have needed as well as reminding me to keep my faith in Allah to help me through this. I could not have achieved this without you. I love you all for everything and blessed to have you in my life.

And finally, I would like to thank my husband, Adeel Irfan. You never allowed the distance between us to affect the amount of unconditional love and support you gave me during my doctorate. You have been my rock throughout all of this, and I am so blessed to have you in my life. I love you so much.

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I

META-ANALYSIS

A meta-analysis of attitudes towards the reintegration of sex offenders into the community

Abstract

Aim: Research has suggested that people's attitudes towards sex offenders are generally negative and often based on inaccurate information relayed through the media and stereotypes (Willis, Levenson & Ward, 2010). Yet, the public's opinion plays an important role in the development of public policies around the management of sex offenders in the community (Shackley, Weiner, Day & Willis, 2014). This meta-analysis aims to understand the general populations attitude towards sex offenders in the community and whether there are any significant differences in attitudes among certain sub-groups.

Method: A systematic review of the quantitative literature was completed, specifically those using the Community Attitudes Towards Sex Offenders (CATSO) scale. PsycInfo, SCOPUS and Web of Science databases were used. A total of 11 papers were found to be suitable for the meta- analysis, with a total of 6,730 participants.

Results: The meta-analysis revealed that people's attitudes towards sex offenders in the community were in the middle (M= 56) based on the Total Score scale of the CATSO. Significant differences were found in sub-group analysis of continent and sample groups. However, definitive conclusions could not be drawn due to the large amounts of heterogeneity, resulting from limited papers available in the literature.

Conclusion: Gaps within the literature were identified, therefore highlighting the need for further research. Future research exploring professional's attitudes of sex offenders in the community is required and future studies utilising the CATSO scale need to ensure they are reporting all the data to avoid discrepancies.

Introduction

Background

The term "sex offender" has been found to invoke feelings of 'anger, disgust and fear' among the general public (Olver & Barlow, 2010). It also raises a host of other negative stereotypical beliefs among community members such as most sex offenders are strangers (Craun & Theriot, 2009), they are dangerous and unpredictable (Willis, Levenson & Ward, 2010) and they are mostly a group of unmarried and sexually frustrated men (Sanghara & Wilson, 2006).

Corabian and Hogan (2015) reported that sex offenders have a tendency to create fear and other strong emotional reactions among the public in comparison to other offences. Research has found that this tends to be the case despite evidence suggesting low rates of recidivism among sexual offenders (Harris & Hanson, 2004) however, sex offenders are more likely to recidivate with nonsexual offences (Hanson & Morton-Bourgon, 2004). Furthermore, Lösel and Schmucker (2005) found that treatment of sex offenders can in fact decrease rates of sexual offending and Friendship, Mann and Beech (2003) evidenced some findings which supported the use of the sex offender treatment programme (SOTP).

However, a recent study conducted in the UK by a research team from the Ministry of Justice (MoJ) found negative results (i.e. an increase in their risk) among sex offenders after completing the core SOTP within the prison service (Mews, Di Bella & Purver, 2017) which possibly suggests an unclear relationship between treatment and change in offending behaviours. They found that the sexual reoffending was greater among treated

sex offenders (10%) in comparison to the control group (8%). As a result, this led to replacing the core and extended programmes within the prison service to new Offending Behaviour Programmes (OBP) known as Kaizen (High Intensity OBP) and Horizon (Medium Intensity OBP) in order to address the highlighted issues identified from Mews et al. (2017) study. Critics of this study argue that whether the results of a single study, which already holds some degree of methodological controversy within its design should result in such drastic changes both politically and practically (Lösel et al., 2020).

Overall, results such as the one found by Mews et al. (2017), which gained a lot of public attention, further exacerbates the general negativity towards sex offenders and possibly leads to the perception that they are untreatable and should not be released within the community. Research highlights that attitudes towards sex offenders are generally negative and the public's perception of those who commit sexual offences are found to be imprecise (Levenson, Brannon, Fortney, & Baker, 2007; Willis et al., 2010).

Key Terms

Attitudes

Eagly and Chaiken (1993, p.1) defined attitudes as a *"psychological tendency that is expressed by evaluating a particular entity with some degree of favour or unfavour"*. Further, Breckler (1984) identified that attitudes are comprised of three components; cognition, relating to the types of beliefs an individual holds, affect, relating to the emotional response of an individual from a particular topic and finally behaviour, how an individual acts in response to the topic. The term is often interchangeably used with

'perceptions', however, this is understood more as a person's stereotypical view and therefore, more prone to knowledge-based attributions (Jussim, 2012).

Sex offender

Craig, Browne and Beech (2008) define sex offenders as individuals who commit either "non-contact sex offences", which involves little or no contact with the victim (for example exhibitionism and internet offenders) or "contact sex offences", which can involve sexually assaulting a child or adult victim (for example rapists or paedophiles).

What is the extent of sexual offending?

The Ministry of Justice (2019) reported that since March 2019 there were 13,359 prisoners convicted for sexual offences and this represented 18% of the prison population. The Ministry of Justice Statistics Bulletin (2018) reported 58,637 Registered Sexual Offenders (RSO) in the United Kingdom and the Office for National Statistics (2017) reported a total of 11, 311 incidents of sexual offences committed by males by the end of 2017.

In the United States, the Child Rescue Network (2019) reported over 750,000 RSO in the United States, with almost 400,000 cases involving crimes against children. In Australia, the number of individuals convicted of sexual assault and related offences was 8,123 between 2016-2017, showing an increase of 3% from the previous year (Australian Bureau of Statistics, 2019). Hong Kong reported 522 persons arrested for sexual offences in 2018 (Census and Statistics Department, 2019). In 2017, there were 43,217 names on

the National Sex Offender Registry in Canada (Friscolanti, 2017). These figures across the world highlight that sexual offending continues to be an area that requires further investigation both for research and public safety.

As a result of higher numbers of male sex offenders, the majority of the literature refers to male sex offenders in comparison to female sex offenders (Denov, 2001; Gakhal & Brown, 2011; HM Inspectorate of Probation & HM Inspectorate of Prisons, 2019). Reasons for this prevalence are a result of a number of societal and political factors, some of which will be explored here. Firstly, the public tend to hold certain gender stereotypes about women such that they are generally considered sexually submissive, nurturers, innocent, passive and often perceived as mothers and providers of care (Tozdan, Briken & Dekker, 2019) in comparison to male sex offenders. This reflects findings found by Vandiver and Walker (2002) in which they reported that the public viewed men to be more dangerous and more likely to commit sex offences in comparison to women. Other factors such as the media (i.e. sensationalising predominately male sex offenders) and less harsh court sentencing for female sex offenders (Denov 2001; Mellor & Deering 2010; Shields & Cochran, 2020) play an important role in further leading the public to perceive female sex offenders as less threatening and harmful (Denov, 2003; Denov & Cortoni, 2006; Mellor & Deering, 2010). Landor and Eisenchlas (2012) reported that media reports strongly criticise male sexual offenders in comparison to female sexual offenders who are presented more sympathetically.

Though this is not far from the truth, as the literature demonstrates that there is a higher proportion of sexual offences committed by males in comparison to female sex offenders (Smith et al., 2017), it is important to highlight that females do commit sexual offences

and are more likely to commit such offences against children (Williams & Bierie, 2015) with the most prominent distinction being that female sex offenders are more likely to commit sexual offences with a co-offender (Vandiver, 2006). Therefore, the typologies of sexual offending between male and female sex offenders is a distinguishing factor which further highlights their differences. Finally, female sexual offending cases tend to be underreported and as a result render it difficult to study this offending population group (Tozdan et al., 2019).

Legal context

Sex offender register

The majority of public safety policies are welcomed by lawmakers and the public, despite there being little empirical evidence to demonstrate their effectiveness in reducing sexual violence and recidivism (Levenson, Brannon, Fortney & Baker, 2007).

In recent years several countries (such as the United Kingdom, North America and Australia as a few to name) have implemented such policies with the aims to protect the public from threats of sexual victimisation (Vess, Day, Powell & Graffam, 2013). The most common measure introduced to serve this purpose is the sex offender register, which aims to prevent sexual offending recidivism through methods such as supervision and monitoring of RSO (Sample & Kadleck, 2008).

Currently, only the US and Hong Kong allow public access to information on the register through community notification laws. Countries such as the UK, Australia, Canada, France, Ireland and Japan currently do not allow access to the public to this information (Vess et al., 2013).

Notification laws

The US and Hong Kong have established further legislative measures to provide a sense of security for the public in the form of community notification and residence restriction laws. Community notification laws have been created to alert the public of sex offenders living within their area of residence (Mercado, Alvarez & Levenson, 2008). Residence restriction laws aim to increase protection for the public by placing limitations on where sex offenders can live (Mercado et al., 2008). The justification for implementing such laws is to prevent sexual recidivism (Socia, Dum & Rydberg, 2019).

However, despite seemingly being effective and reflecting strong emotions held by the public (McCartney & Parent, 2018), the utility of these laws remains to be a controversial area. The efficacy of the register has raised concerns regarding its actual ability to reduce sexual recidivism and rather whether it potentially increases the risk of sexual offending (Mercado et al., 2008). Based on the few studies that have researched this area, the majority have found no significant reduction in recidivism as a result of community notification (Levenson, D'Amora & Hern, 2007) yet, despite the evidence, the public is still highly in favour of implementing such policies (Shackley, Weiner, Day & Willis, 2014).

Notification laws carry detrimental effects for offenders and cause them to suffer unnecessarily (McCartney & Parent, 2018). Public notification laws can result in humiliating, degrading and brutalising offenders in front of the public (Pratt, 2000). Further, O'Malley (2010) argues that at times by putting community safety at the forefront can in fact harm offenders such as causing them difficulties that go beyond their

sentences. These include isolation and exposure to vigilantism, which can impact both the offender and their families. It can also promote harassment, cause the loss of jobs and future job opportunities, subject them to physical assaults (Tewksbury & Lees, 2006) and in turn reduce their chances of successful reintegration into the community (Levenson, 2008).

The public's attitudes and its importance?

Implementation of the public's attitude into policies

The public play a key role in the legislative process and the development of public policies regarding the management of sex offenders in the community (Shackley et al., 2014). Generally, members of the public accept that sex offenders will return to the community eventually, however they still endorsed marginalisation of this offending group through the use of public notification rather than alternative methods such as treatment, reintegration and supervision by criminal justice professionals (Olver & Barlow, 2010).

Stigma

The majority of policies that have been implemented within legislation, are a result of shared fears, assumptions and myths about sex offenders held by policymakers (Jeglic & Calkins, 2016; Sample & Bray, 2003; Sample & Kadleck, 2008). However, creating sex offender legislation as a result of public outcry has been shown to cause unintended consequences such as increasing offender instability and recidivism by exacerbating criminal offender risk factors (Levenson & Cotter, 2005; Tewksbury, 2005). Stigma has been found to have negative personal and economic effects for all criminal offenders

(Bonta & Andrews, 2007) however research has found that sex offenders experience this stigma at a more intense degree than other offenders (Tewksbury, 2005).

Conley, Hill, Church, Stoeckel and Allen (2011) reported the importance of exploring the attitudes held against sex offenders. As a result of incorrect information, policies and legislative decisions can influence and misinform the public's need and in turn, potentially cause a host of negative consequences for sex offenders and increase sexual recidivism. Levenson, Brannon, Fortney and Baker (2007) highlighted that generally, the public overestimated rates of recidivism of sex offenders by approximately three times the actual reported rate.

Media

Brown, Deakin and Spencer (2008) reported that the government experiences large amounts of pressure regarding the management of sex offenders and this is due to the interaction between the media and public opinion. As a result, governments across the world have implemented monitoring strategies into legislation to control sex offenders and therefore, provide the public a sense of security (Brown et al., 2008). Sex offenders experience the most media attention and more often are demonstrated in a scandalous, probing and universally condemning manner (Fedoroff & Morgan, 1997). In recent times, more victims of sex crimes have become vocal and have gained the attention of politicians, who as a result have become convinced that management of sex crimes is a priority and require corrective legislative countermeasures (Fedoroff & Morgan, 1997).

Zilney & Zilney (2009) reported that highly sensationalised media reports of serious crimes and profiles of high-risk offenders tend to influence the public's attitudes towards sanctions for sex offenders. Despite a reduction in convicted rates of sexual violence over the years in Canada (Brennan & Taylor-Butts, 2008), United States (Federal Bureau of Investigation, 2017) and in the United Kingdom with a 1% decrease in the sentenced sexual offender population between April 2018 to March 2019 (Ministry of Justice, 2019), the media has increased its attention towards rare and exceptional incidents of sexual assault. As a result, this has created a 'moral panic' which in turn has escalated the perceived danger of the public from sexual offenders (Zilney & Zilney, 2009) and legislative measures have been implemented to manage the public's anxieties.

Aim for the review

This systematic review aims to understand the general population's attitude toward sex offenders in the community. The second aim is to explore whether there are identifiable subgroups who differ in their attitudes towards sex offenders. These subgroups include a 'Sample' group (i.e. comparing attitudes towards sex offenders between the Public and Professional), 'Continent' group (i.e. comparing attitudes towards sex offenders between Asia, Europe and USA & Canada) and Year (i.e. determining whether attitudes towards sex offenders change across the years.

The importance of understanding people's attitudes has been highlighted within the literature and the reason for this is due to the significant role they play in impacting successful rehabilitation and treatment as well as in legislation and policies in the management of sex offenders both in regards to sanctions and within the community

(Conley et al., 2011; Corabian & Hogan, 2012; Sample & Kadleck, 2008). Sex offenders ultimately will be reintegrated and accepted back into society and to allow them to lead a fulfilling life (Rogers, Hirst & Davies, 2011) it is important to understand how to achieve this.

Methodology

Identifying Primary Studies

Search of electronic databases

The Preferred Reporting Items for Systematic and Meta-Analyses (PRISMA) model (Moher, Liberati, Tetzlaff & Altman, 2009) was used to select the final papers used for the purpose of this review. The databases were accessed between June to July 2019 and included PsycInfo, SCOPUS and Web of Science. In order to maximise the search results, Boolean logical operators were used. The logical operator "AND" was utilised in order to combine two or more of the descriptor terns. The different searches that were completed can be seen in Table 1.1.

Table 1.1

Search terms used in electronic database searches

Descriptor Terms and Key Words				
SEX OFFENDERS		**ATTITUDES**		**COMMUNITY**
Sex Offenders		Attitudes		Community
	AND	Public opinion	*AND*	Reintegration

It should be noted that a limited set of key words were used specifically within this meta-analysis. The reason for this was that whilst accessing the databases it was observed that there was a presence of a large number of papers which were not relevant to the inclusion criteria outlined in Table 1.2 for the purpose of this meta-analysis. However, it can be argued, that as a result of using such limited key words, there is a possibility that certain

papers using key words such as ‘sexual offending’, ‘sexual offender/s’ and ‘sex offender’ could have been missed during the search process. To ensure that this was not the case, the selected databases were re-run with such key words, and it was apparent that no difference was made to the final papers selected for the purpose of this meta-analysis at the time of writing.

Inclusion and exclusion criteria

Table 1.2 demonstrates a checklist of the criteria used to include or exclude records.

Table 1.2

Inclusion and Exclusion criteria for Search Strategy

Inclusion criteria	**Justification**
Include papers that use a validated or reliable quantitative measure**.**	This is to ensure that the attitudes that are being measured are based on reliable and valid tools of assessment.
Include papers that assess attitudes of the public towards sex offenders.	This is to ensure that the aim of the meta-analysis is addressed.
Include papers that assess attitudes of professional samples.	This is so both groups can be compared in the meta-analysis in order to identify if there are any differences between the sampling group.
Exclusion criteria	**Justification**

Exclude papers that refer to female sex offenders	As evidenced by the literature, male and female sex offenders are considered as two heterogenous offending groups, with greater emphasis in the literature on male sex offenders. Therefore, in order to avoid heterogeneity, papers referring to female sex offenders were not included for the purpose of this meta-analysis.
Exclude papers that use only qualitative methods	Due to the nature of a meta-analysis, papers using quantitative methods would only be appropriate to use.

Exclude papers that pre-date 1990	This is to ensure that the analysis captures different demographics, responses and attitudes within people over the years, however not so outdated as to skew the results.
Exclude papers where the participant sample are offending populations	This is due to the nature of the question being explored in the meta-analysis which is focusing on people's attitudes.

Results of the systematic search

The initial searches drew up a total of 1,005 records. From this a total of 95 records were removed due to duplication and in turn left a total of 910 records to be screened. These

910 records were screened according to the relevance of their title and abstracts for this review, from which 833 were removed due to their irrelevance (i.e. not fitting to the inclusion and exclusion criteria highlighted in Table 1.2). 77 records were identified as eligible for full review. Following full review of these records, 57 records were found to be ineligible for the review and were removed (reasons can be seen in Figure 1.1.). From the remaining 20 papers, 14 papers were identified as utilising the Community Attitudes Towards Sex Offenders (CATSO) scale and were found suitable for the purpose of this review and met the inclusion criteria outlined in Table 1.2.

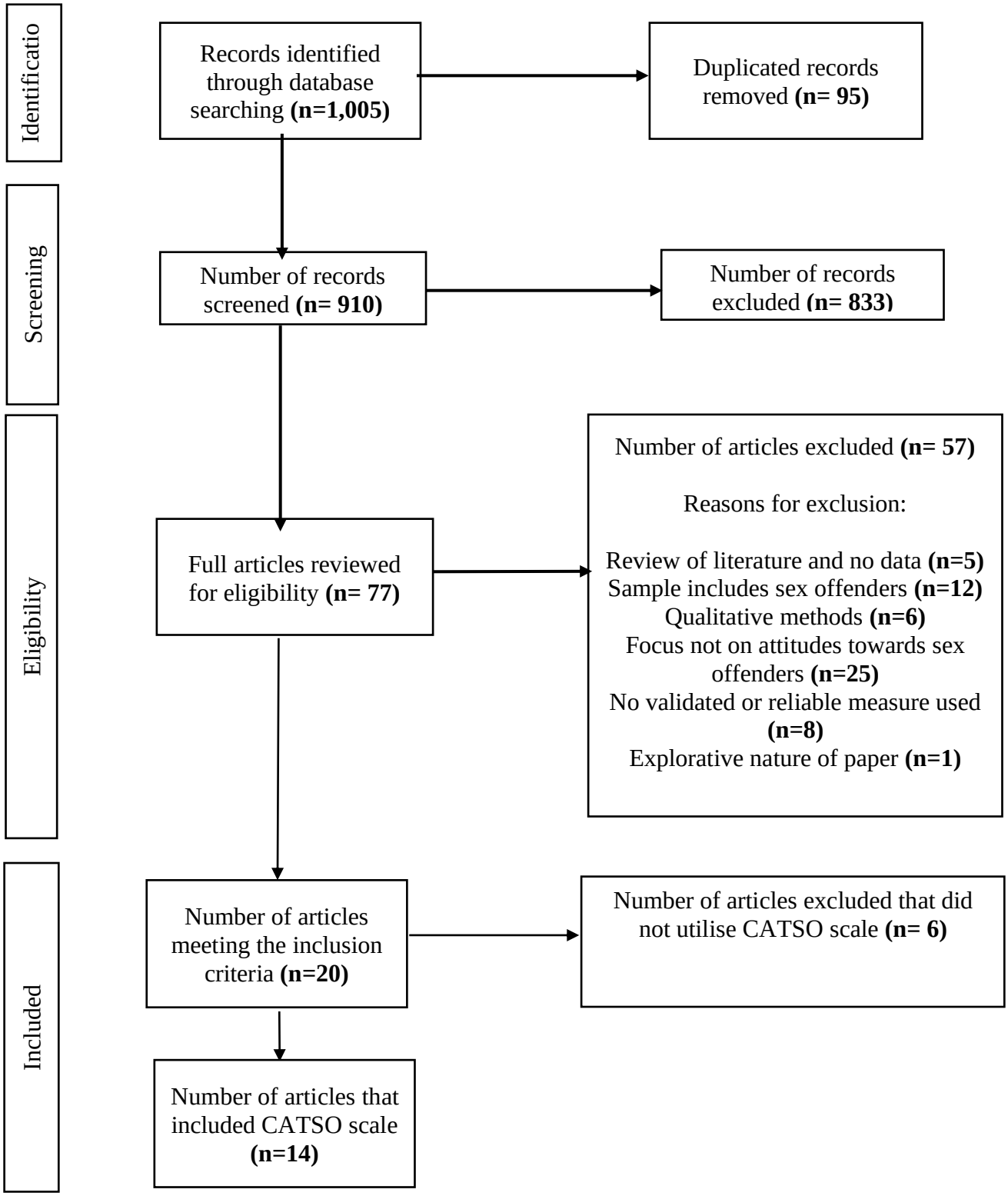


Figure 1.1. PRISMA flow chart (Moher, Liberati, Tetzlaff, Altman & PRISMA Group, 2009).

Note. n = number of papers.

Data Extraction and Quality Ratings

From the 20 papers that were finalised, 14 papers made reference and used the Community Attitudes Toward Sex Offenders (CATSO) scale (Church, Wakeman, Miller, Clements, & Sun, 2008) within their studies. The justification for focusing on the CATSO scale is that it is the most commonly used when assessing community attitudes towards sex offenders within the literature and its application ranges across different countries such as the United Kingdom, Europe, New Zealand, United States, Canada, Australia and Hong Kong. Furthermore, the scale reports adequate levels of internal reliability (Cronbach's alpha) with coefficients consistently reported as .74 (Harper & Hogue, 2015). Due to the wide range of the use of CATSO across different studies, meta-analytic methods can be used to provide a robust answer to the research question.

The studies were reviewed by the author and data was extracted in order to rate the methodological quality of them. The following data was extracted from the papers: author, year of publication, country of study, the sample group (public or professional), sample size, CATSO scales (CATSO Total score, Social Isolation, Sexual Deviancy, Severity and Dangerousness and Capacity to Change), means and standard deviations of each of the CATSO scales. Some of the papers had not presented the means and standard deviations of the CATSO scales clearly, therefore combined subgroups were used to calculate the required data.

During data extraction, it was found that a further three papers had to be removed as they did not report any statistical data relevant for the purpose of this meta-analysis, such as a lack of reporting means and standard deviations of any the CATSO scales. The papers

that were removed were Lowe and Willis (2019), Mustaine, Tewksbury, Connor and Payne (2015) and Tewksbury, Mustaine and Payne (2012). It was also found that the public sample data presented within Kerr, Tully and Völlm (2018) had already been reported within the paper by Höing, Petrina, Hare Duke, Völlm and Vogelvang (2016), however there were reporting inconsistencies across both papers. Therefore, Kerr et al. (2018) public sample data was removed from the meta-analysis. As a result, a final of 11 papers were used for the purpose of this meta-analysis. Appendix A demonstrates a summary of the data that was extracted.

Study population and study design

The total number of participants was 6,730, from which 4,224 were females and 2,506 were males. The ages of participants ranged between 18-82 years. The studies ranged from different countries; United Kingdom (n= 2), United States (n= 3), Hong Kong (n=1), Australia (n=1), New Zealand (n=2), USA and Canada (n=1) and Europe (n=1). The participants ranged from different populations and professions including the general population, university students and volunteers from Circles (UK).

Quality of studies

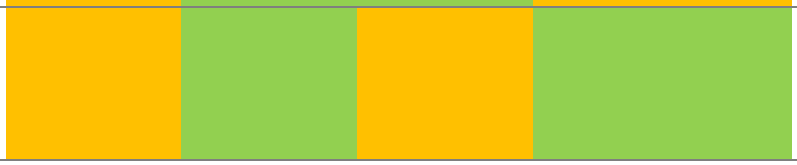
The risk of bias was assessed within each of the studies using s set of quality criteria (see Appendix B). The quality criteria assessed four potential sources of bias which included; selection bias, detection bias, reporting bias and generalisability. The criteria were adapted from frameworks already in place including Downs and Black (1998) and The Cochrane Collaboration Risk of Bias Tool (Higgins et al., 2011). Each source of bias was given a quality rating of low, *unclear* or *high risk of bias* in accordance with the quality

criteria (see Table 1.3). The ratings produced a quality rating between 0% to 100%, whereby 0% indicates a high risk of bias and 100% indicates low risk of bias within studies. Each of the risk areas were allocated two points for low risk, one point for unclear risk and zero points for high risk. The total points were calculated for each study and divided by the total number of points available in order to produce a final percentage of risk quality.

Table 1.3

Summary of Applied Quality Criteria with Studies ordered Chronologically

Study	Selection Bias	Detection Bias	Reporting Bias	Generalisability	Quality Index [a]
Rogers et al. (2011)					75%
Willis et al. (2013)					75%
Malinen et al. (2014)					38%
Shackley et al. (2014)					75%
Chui et al. (2015)					75%
Höing et al. (2016)					88%

Jung et al. (2017)		63%
Rosselli & Jeglic (2017)		63%
DeLuca et al. (2018)		75%
Kerr et al. (2018)		75%
Spoo et al. (2018)		75%

Note. Green indicates low risk of bias (i.e. if there are no indications of any unclear or high risk ratings according to the criteria in Appendix B), orange indicates unclear risk of bias (i.e. if there is a single indication of unclear risk but no indication of high risk according to the criteria in Appendix B) and red indicates high risk of bias (i.e. if there is at least a single indication of high risk according to the criteria in Appendix B).

[a] Quality Index = Final overall quality rating with 0% indicating high risk and 100% indicating low risk.

Selection Bias

A total of five papers were rated as unclear risk for selection bias. Jung, Allison and Martin (2017), Kerr et al. (2018), Malinen, Willis and Johnston (2014), Rosseli and Jeglic (2017) and Spoo et al. (2018) all used target sampling within their selection methods and

used a student sample. Jung et al. (2017), however, did also include members of the community within their sample. Malinen et al. (2014) was also reported unclear risk due to not describing the characteristics of their sample clearly and only reported the gender and age of the participants used.

Detection Bias

Papers were rated unclear risk for not defining the four subscales included within the CATSO scale. The papers which were rated unclear risk for detection bias for this missing information included Chui, Cheng & Yoke-chan (2015), DeLuca et al. (2018), , Malinen et al. (2014), Rosseli and Jeglic (2017) and Willis, Malinen and Johnston (2013). Papers were also rated unclear risk for not reporting the Cronbach Alpha of the CATSO scale and these included Chui et al. (2015), Jung et al. (2017) and Rogers et al. (2011) . Finally, papers were also rated unclear risk for not reporting the use of a 6-point Likert scale to rate each item within the CATSO scale and Jung et al. (2017) did not report this within their paper.

Reporting Bias

All of the papers, apart from Kerr et al. (2018), were rated unclear risk or high risk of reporting bias. A total of nine papers reported only some of the descriptive and/or summary statistics and as a result were rated unclear risk of reporting bias. Rogers et al. (2011) only reported means and standard deviations (SD) for three subscales of the CATSO scale and did not report the subscale means and SD's for one subscale and the total CATSO scale. Willis et al. (2013) only reported the means and SD of the total CATSO scale and not for the four subscales, which had to be manually calculated using the data provided. Malinen et al. (2014) and Rosseli and Jeglic (2017) only reported the

means and SD of the total CATSO scale and not for the four subscales. Chui et al. (2015) only reported means and SD of two subscales of the CATSO scale. Höing et al. (2016) and Jung et al. (2017) did not report the means and SD of the total CATSO scale, however, did for the four subscales. DeLuca et al. (2018) only reported the means and SD for each variable within the CATSO scale, therefore the means and SD for the total CATSO scale had to be manually calculated. Shackley et al. (2014) was rated high risk of reporting bias as there was no evidence of means and SD within their paper for any of the CATSO subscales or total CATSO scale, therefore these had to be manually calculated.

Papers were also rated unclear risk if they reported only some of the data in figures or tables. A total of eight papers were rated unclear risk of reporting bias under these criteria. Chui et al. (2015), DeLuca (2018), Malinen et al. (2014), Rogers et al. (2011), Rosseli and Jeglic (2017), Spoo (2018) and Willis et al. (2013) only reported CATSO outcomes in a table but did not report a table for participant's demographics. Shackley et al. (2014) reported a table for participant's demographics, however, did not report a table demonstrating the CATSO outcomes.

Generalisability

All papers, with the exception of Malinen et al. (2014) (high risk as sample size was less than 30) and Kerr et al. (2018) (unclear risk as sample size was between 30 and 100), were rated low risk of generalisability due to consisting a sample size greater than 100.

Data Analysis Strategy

The following steps were taken to handle data that may violate analysis assumptions.

Normalisation and variance stabilisation

In order to calculate between studies variation (tau) for fitting the random-effects model, DerSimonian and Laird method is the most common approach used. This method assumes that the random effect is normally distributed in the population and therefore the effect sizes reported in the primary studies should also approximate a normal distribution. A QQ-chart can be used in order to test the assumption of normality by plotting the primary study effects. Where non-normality is noted within the QQ-chart, then between studies variation can be calculated using the restricted maximum likelihood estimator and this is known to be robust to violations of the normality assumption.

The Omnibus test

To calculate the Omnibus test, the fixed-effects or the random effects model can be used. The assumption under the fixed-effects model is that the true effect size is the same for all studies and that sampling error appears to be the reason for the varying effect sizes between studies. As a result, the fixed-effects model assigns weights to the different studies and information in the smaller studies can be ignored due to having better information about the same effect size in larger studies. On the other hand, under the random-effects model, it assumes that the data has been gathered from a cohort of studies that have been operated on independently by different researchers and therefore, unlikely to assume equivalent functionality as the participants or even the interventions utilised within these studies can impact the results. As a result, a common effect size cannot be assumed and, in such cases, a random-effects model is more easily justified to use. Based on these two assumptions, the random-effects model was considered most appropriate and was used for the purpose of this meta-analysis.

Handling problematic variance

Where an effect presents with variation from the meta-analysis synthesis and it cannot be attributed to true variation, it is considered heterogeneous. There are a number of reasons that can cause this such as methodological variation in the studies, measurement error or uncontrolled individual difference factors within the literature. The most common way to measure heterogeneity is Higgins I^2. The greater the value of I^2, this demonstrates variation in effect that is not attributed to true variation in the distribution of the effect. Due to there being a large amount of variation within the methodologies of the studies used to calculate the meta-analytic synthesis, heterogeneity that caused problems was defined as a value of Higgins I^2 greater than 75%. If problems within heterogeneity were evident, a leave-one-out analysis was carried out in order to identify those studies that were causing the greatest amount of influential effect on the meta-analytical synthesis. These studies were reviewed in light of possibly being excluded due to holding a risk of bias. Further to this, subgroup analyses and meta-regression was used as a means to investigate the cause of problems within heterogeneity and will be reported.

Identifying influential studies

In order to identify if a particular study/studies were producing a high influence on the meta-analytic effect, a procedure known as “one-left-out” was carried out. This method highlighted which of the study/studies caused a high amount of influence within the qualitative synthesis by individually removing each study in turn. Where a study was removed, and it resulted in an effect that fell outside of the 95% confidence interval (CI) for the entire meta-analysis, then the study was considered to carry a high influence and was removed from the omnibus test.

The Quality Effects Model

Within the random effects model, the effect precision is determined by the function of the sample size from where it has been derived. The random effects model is extended within the quality effects model (Doi & Thalib, 2008) through the inclusion of the methodological rating quality alongside the sample size in the estimation of precision. For the purpose of this review, the quality effects model was calculated using the total score from the risk of bias ratings. The quality effects model was used to interpret the meta-analytic synthesis that would have been obtained had all the studies been of the same methodological quality, based on the best study within the review. As a result, the quality effects model offers a measure of attrition attributable to methodological variation.

Identifying Publication Bias and Small Study Effects

In cases where there were a sufficient number of primary studies, visual and statistical inspection using a funnel plot was utilised in order to identify publication bias and small study effects. A funnel plot is a scatterplot of the effects against a measure of study precision. The main function of this plot is in order to use it as visual aid to detect systematic heterogeneity.

Where publication bias was not present, studies that have high precision were plotted near the average (i.e. the meta-analytic synthesis), and studies with low precision were plotted evenly on either side of the average. This in effect created a funnel-shaped distribution, whereby the distance from the average is inversely proportionate to the precision of the study. A ‘well-behaved’ presentation of the data is displayed as a symmetric inverted funnel shape, which demonstrates the unlikelihood of publication bias. However,

deviation from this shape would indicate publication bias, specifically if there is an absence of studies in those areas which are associated with small sample sizes and non-significant effects.

Planned Contrasts

In circumstances where a specific a priori hypothesis had been made, sub-group analysis was carried out for categorical moderators and meta-regression were carried out for continuous moderators. Specific sub-groups that were analysed were for Continent (Asia, Europe and USA & Canada) and between sample groups (Public and Professional) and a meta-regression was carried out for the date of publication of the studies (Year). Summary effects and associated heterogeneity measures were calculated from each sub-group in instances where categorical moderators are considered. Significant differences between the sub-groups were evaluated by comparison of their 95% confidence intervals. Meta-regression is where the effects of the primary studies are predicted according to the values of one or more explanatory variables. However, there is more influence of larger studies on the relationship than smaller studies, as studies are weighted by the precision of their effect estimate.

Results

Total Score scale of the CATSO

The papers included for the meta-analysis of Total Score scale of the CATSO were DeLuca et al. (2018), Kerr et al. (2018), Malinen et al. (2014), Rosselli et al. (2017), Shackley et al. (2014), Spoo et al. (2018) and Willis et al. (2013). The DerSimonian and Laird method was used in order to calculate between studies variation for fitting the random-effects model. A QQ-chart demonstrated that the data across the seven papers were normally distributed (see Figure 1.2). To calculate the Omnibus Test, the random-effects model was used and produced a mean difference of 56.60 and a confidence interval between 54.54 and 58.66.

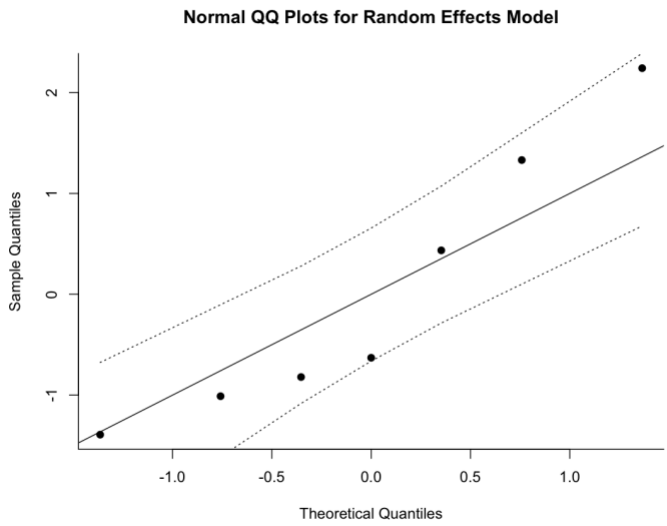


Figure 1.2. A QQ-chart demonstrating normally distributed variation across the papers

Note. QQ = Quantile-Quantile. The dots represent the quantiles (i.e. data from each study) and have been plotted against one another in order to assess if they are normally distributed. Normally distributed data would sit in a straight line (i.e. the middle line).

However, the results demonstrated a substantial amount of heterogeneity (Higgin's I^2 = 96.9%), therefore demonstrating high amounts of variance that cannot be attributed to the effect. Figure 1.3 demonstrates a forest plot evidencing the variation between the studies.

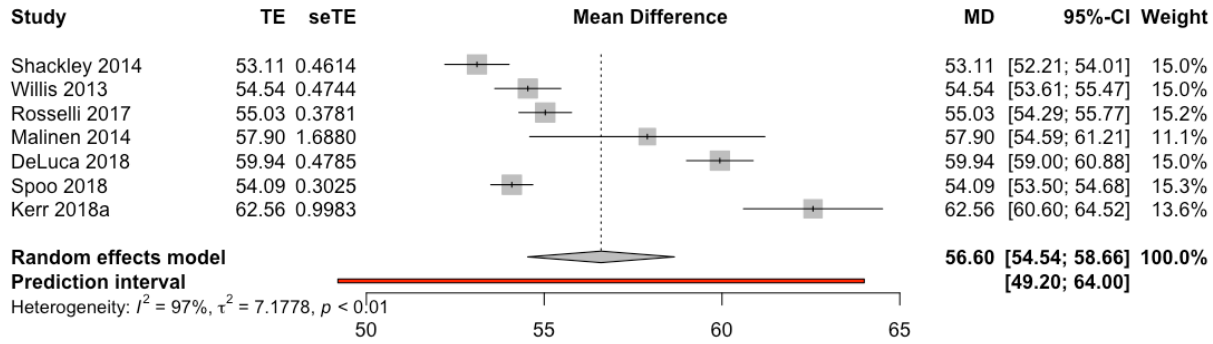


Figure 1.3. Forest plot of variation between the studies for Total Score scale of CATSO

Note. TE= The Effect, seTE = Standard Error of The Effect, MD = Mean Difference, CI= Confidence Interval at 95% and Weight = influence of study on the overall meta-analysis. The diamond in the centre represents the pooled mean difference across all the studies. The vertical dotted line represents the line of no effect (i.e. no difference between the studies). Each square represents the effect estimates of each study and the line across each square represents the 95% confidence interval of each study.

Due to the evidence of large amounts of heterogeneity, a leave-one-out analysis was carried out in order to identify any influential studies. Figure 1.4 demonstrates a Baujat scatter plot to explore the heterogeneity within the meta-analysis.

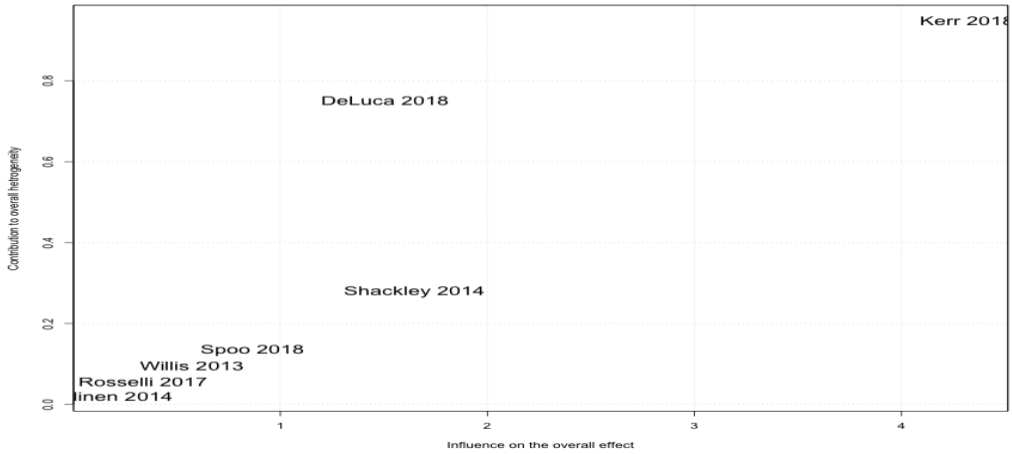


Figure 1.4. A Baujat scatter plot demonstrating the heterogeneity within the meta-analysis.

Note. The x-axis represents the amount of heterogeneity contributed towards the overall effect. The y-axis represents the influence of each study on the overall effect. Studies on the top right of the plot have greater influence on the results and have a bigger contribution to heterogeneity.

The scatter plot demonstrated that the paper by Kerr et al. (2018) evidenced the most influence on the overall effect as well as contributing the most heterogeneity. However, the results demonstrated no significant difference by removing Kerr et al. (2018) from the analysis with a 0.6% change in Higgin's I^2 (96.3%). The quality effects model was used in order to weight the papers on their quality. However, the results demonstrated no significant difference from the original mean difference with an estimate score of 56.69. Therefore, the result is robust to variation in overall quality index. A funnel plot was used in order to identify publication bias and small study effects. The results demonstrated that due to large amounts of heterogeneity and small number of studies, formal analysis of publication bias was not possible (see Figure 1.5).

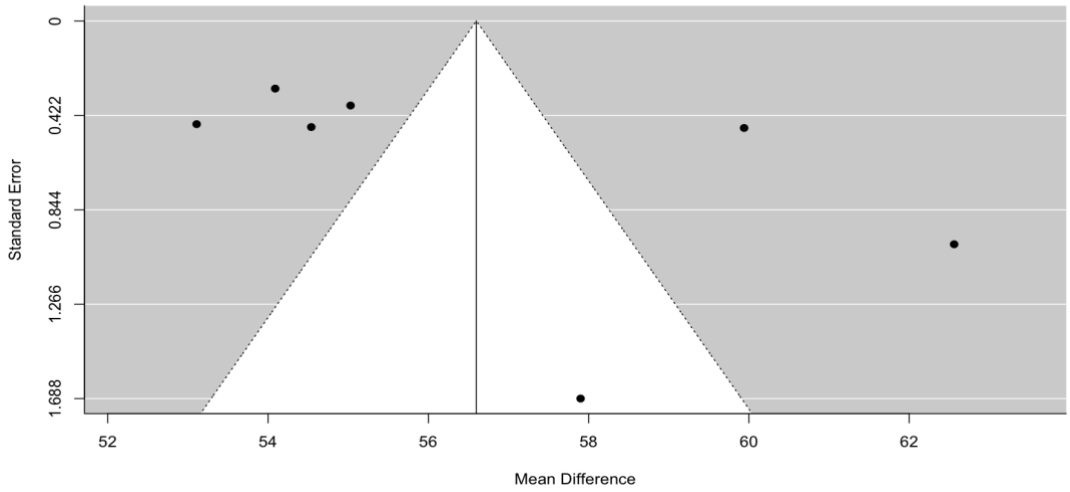


Figure 1.5. Funnel plot to identify publication bias and small study effects across the studies

Note. The dots represent each study. Dots placed outside of the funnel (i.e. the white pyramid) in the grey region demonstrate bias and therefore lead to an asymmetrical appearance of the funnel plot. More pronounced asymmetry represents greater amount of bias.

Planned contrasts were carried out using sub-group analysis to determine whether differences could be established between different groups based on their quality indicators and these are reported in Table 1.4.

Table 1.4

Sub-group analysis based on quality indicators across studies using Total Score scale

		Number of studies	Random Effects Model		Hetergeneity			Between groups comparison
			Cohens D	**95% CI**	**Higgins I^2**	**Tau^2**	**Cochrane's Q**	
Selection bias	Low Risk	4	55.86	51.80; 59.92	98.3%	12.65	115.91	*Q=0.28* *df=1* *p=0.59*
	High Risk	3	57.18	54.55; 59.80	95.7%	6.32	69.29	
Detection bias	Low Risk	3	56.41	52.92; 59.91	97.4%	9.13	75.59	*Q= 0.02* *df=1* *p= 0.88*
	High Risk	4	56.78	53.96; 59.59	96.4%	7.54	83.81	
Reporting bias	Low Risk	1	62.56	60.60; 64.52	Not reported	Not reported	0	*Q= 24.33* *df= 1* *p= 0.0001**
	High Risk	6	55.64	53.71; 57.57	96.3%	5.34	136.21	
Generalisability	Low Risk	5	55.33	53.27; 57.40	97.0%	5.36	133.35	*Q= 4.00* *df= 1* *p= 0.05**
	High Risk	2	60.43	55.88; 64.98	82.3%	8.93	5.65	

Note. Cohens D = effect size for comparison between the means, CI= Confidence Interval at 95%, Higgins I^2 = the percentage of variability in estimates of effect size that is attributable to between-study variation (heterogeneity), Tau^2 = variance of true effect sizes, Cochrane's Q = measuring the differences between the different studies, Q = subgroup differences and df = degrees of freedom.

*Indicates *p* value scores that are statistically significant

The results demonstrated that between groups comparison in selection bias and detection bias were not significant. Between groups comparison within reporting bias was found to be significant, therefore suggesting low risk reported a higher effect size. However, there was only one study of low risk within reporting bias against six studies of high risk, therefore the results should be interpreted with caution. Between groups comparison within generalisability was found to be significant, therefore suggesting a larger sample size produces a lower effect size. However, the effect size found within this analysis (55.33) was not substantially different to that of the original effect size of 56.60, therefore demonstrating a very small difference. Further planned contrasts were conducted between other sub-groups which included continent and sample group. Figure 1.6 demonstrates the sub-group analysis for continent and Figure 1.7 demonstrates the sub-group analysis for sample group.

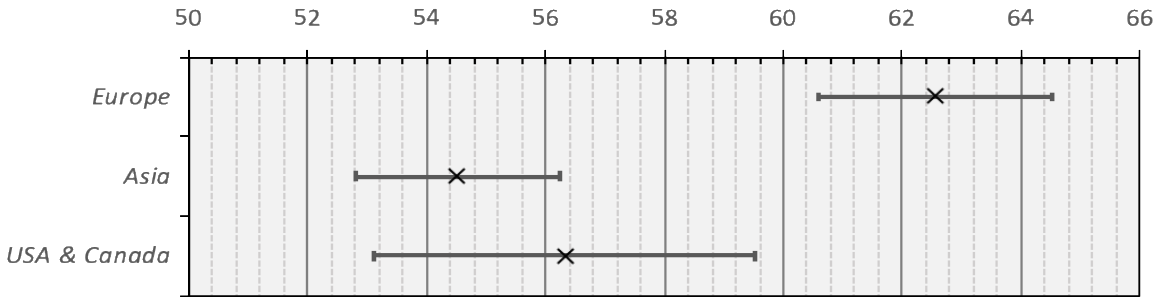


Figure 1.6. Sub-group analysis for continent between studies in Europe, Asia and USA & Canada for Total Score scale

Note. Comparison of the confidence intervals between the three continents. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results for sub-group analysis for continent found a significant difference between groups comparison (Q= 37.48, df= 2, p= 0.001*)*. The results found that Europe (MD= 62.56, CI= 60.60; 64.52*)* scored significantly higher in comparison to Asia (MD= 54.52, CI= 52.80; 56.24, tau^2= 1.64, I^2= 80.7%, Q= 10.34) and USA & Canada (MD= 56.34 , CI= 53.16; 59.51, tau^2= 7.73, I^2= 98.2%, Q= 109.36). However, the results should be interpreted with caution as there is only one study in Europe compared to three studies in both Asia and USA & Canada.

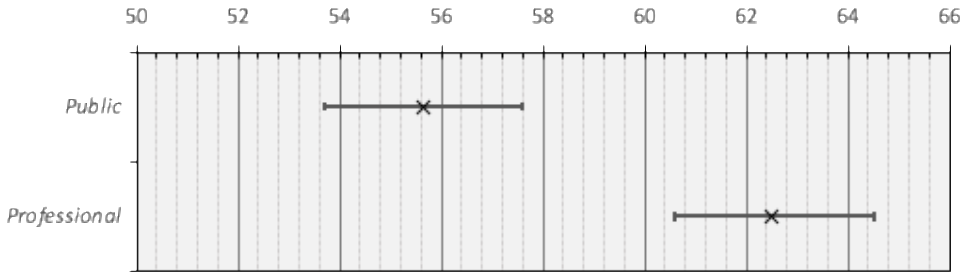


Figure 1.7. Sub-group analysis for sample group between the public and professionals for Total Score scale

Note. Comparison of the confidence intervals between the sample groups. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results for subgroup analysis for sample group found a significant difference between groups comparison (Q= 24.33, df= 1, p= 0.001*)*. The results found that Professionals (MD= 62.56, CI= 60.60; 64.52*)* scored significantly higher in comparison to the Public (MD= 55.64, CI= 53.71; 57.71, tau^2= 5.34, I^2= 96.3%, Q= 136.21). However, the results should be interpreted with caution as there was only one study utilising a Professional sample against six studies using a Public sample. A meta-regression was carried out to determine whether the year the study was published established a difference in how

participants scored on the total score of the CATSO scale. The results demonstrated no significant difference (mods= 0.77, p= 0.15).

Severity and Dangerousness, Capacity to Change, Sexual Deviancy and Social Isolation Scales

The papers that were included for the meta-analysis for each of the scales have been summarised in Table 1.5 below.

Table 1.5

Papers used within each of the CATSO scales for the Meta-analysis

CATSO Scale	Papers Included
Severity and Dangerousness	Höing et al. (2016) Jung et al. (2017) Kerr et al. (2018) Spoo et al. (2018) Willis et al. (2013)
Capacity to Change	Höing et al. (2016) Jung et al. (2017) Kerr et al. (2018) Rogers et al. (2011) Spoo et al. (2018) Willis et al. (2013)
Sexual Deviancy	Chui et al. (2015)

	Höing et al. (2016)
	Jung et al. (2017)
	Kerr et al. (2018)
	Rogers et al. (2011)
	Spoo et al. (2018)
	Willis et al. (2013)
Social Isolation	Chui et al. (2015)
	Höing et al. (2016)
	Jung et al. (2017)
	Kerr et al. (2018)
	Rogers et al. (2011)
	Spoo et al. (2018)
	Willis et al. (2013)

The data for Severity and Dangerousness was not normally distributed under the DerSimonian-Laird method, therefore, the restricted maximum-likelihood estimator (RMLE) was used, which is more robust than the DerSimonian-Laird method. The QQ-chart demonstrates that the data across the five studies were normally distributed for Severity and Dangerousness (see Figure 1.8) using the RMLE method. Capacity to Change, Sexual Deviancy and Social Isolation were all normally distributed as displayed in their QQ-charts (see Figure 1.9, 1.10 and 1.11 respectively) under the DerSerimonian method.

The Omnibus Test was calculated using the random-effects model and produced a mean difference of 3.41 and a confidence interval between 2.25 and 4.57 across studies for

Severity and Dangerousness, a mean difference of 3.14 and a confidence interval between 2.53 and 3.74 across studies for Capacity to Change, a mean difference of 3.25 and a confidence interval between 2.83 and 3.68 across studies for Sexual Deviancy and a mean difference of 3.19 and a confidence interval between 2.78 and 3.59 across studies for Social Isolation.

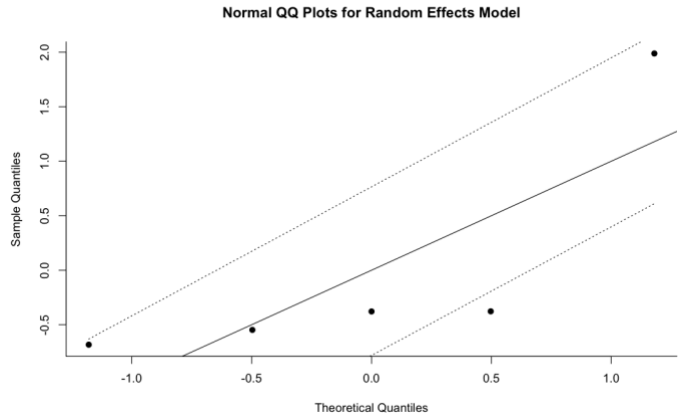


Figure 1.8. A QQ-chart demonstrating normally distributed variation across the studies for Severity and Dangerousness

Note. QQ = Quantile-Quantile. The dots represent the quantiles (i.e. data from each study) and have been plotted against one another in order to assess if they are normally distributed. Normally distributed data would sit in a straight line (i.e. the middle line).

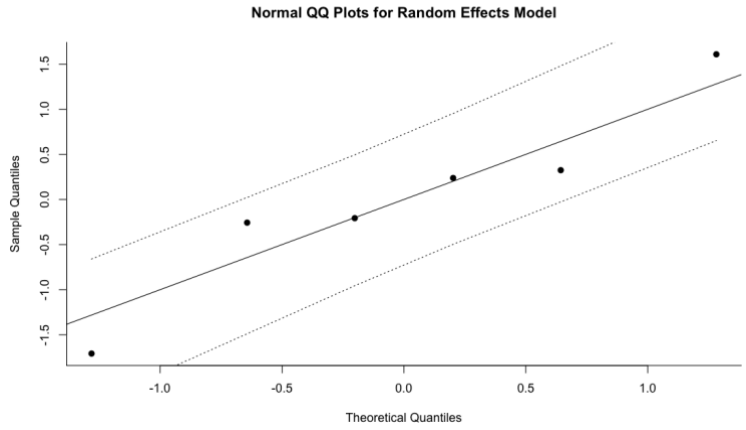


Figure 1.9. A QQ-chart demonstrating normally distributed variation across the studies for Capacity to Change

Note. QQ = Quantile-Quantile. The dots represent the quantiles (i.e. data from each study) and have been plotted against one another in order to assess if they are normally distributed. Normally distributed data would sit in a straight line (i.e. the middle line).

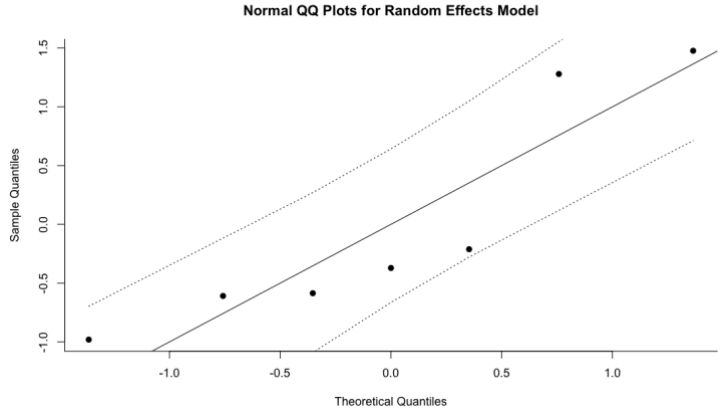


Figure 1.10. A QQ-chart demonstrating normally distributed variation across the studies for Sexual Deviancy

Note. QQ = Quantile-Quantile. The dots represent the quantiles (i.e. data from each study) and have been plotted against one another in order to assess if they are normally distributed. Normally distributed data would sit in a straight line (i.e. the middle line).

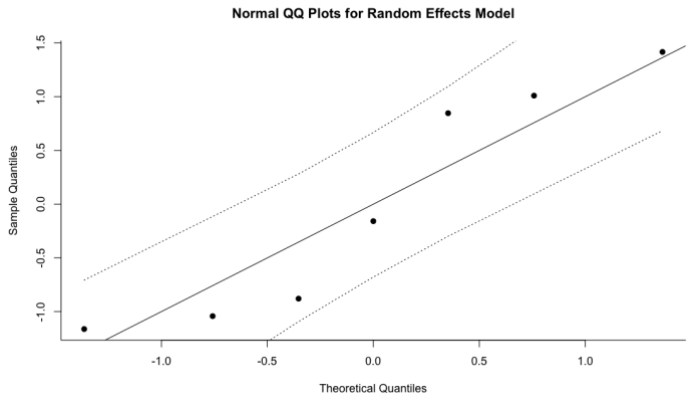


Figure 1.11. A QQ-chart demonstrating normally distributed variation across the studies for Social Isolation

Note. QQ = Quantile-Quantile. The dots represent the quantiles (i.e. data from each study) and have been plotted against one another in order to assess if they are normally distributed. Normally distributed data would sit in a straight line (i.e. the middle line).

However, the results demonstrated a substantial amount of heterogeneity across studies for Severity and Dangerousness (Higgin's I^2 = 99.8%), Capacity to Change (Higgin's I^2 = 99.7%), Sexual Deviancy (Higgin's I^2 = 99.6%) and Social Isolation (Higgin's I^2 = 99.5%). Therefore, demonstrating high amounts of variance across all the scales that cannot be attributed to the effect. Figure 1.12- 1.15 demonstrate forest plots evidencing the variation between the studies across the scales.

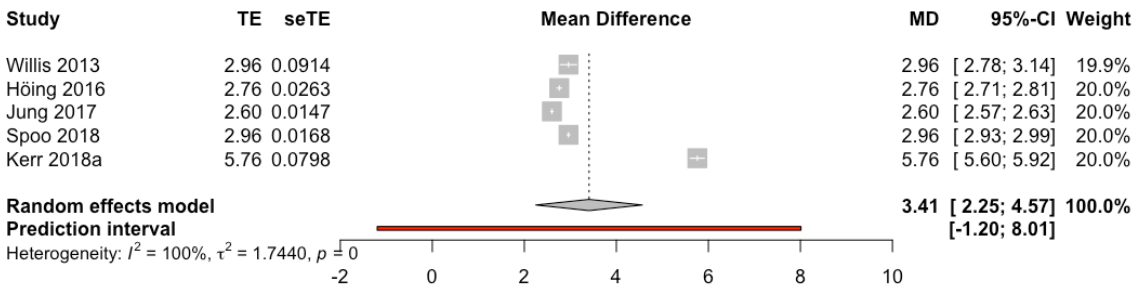


Figure 1.12. Forest plot of variation between the studies for Severity and Dangerousness scale

Note. TE= The Effect, seTE = Standard Error of The Effect, MD = Mean Difference, CI= Confidence Interval at 95% and Weight = influence of study on the overall meta-analysis. The diamond in the centre represents the pooled mean difference across all the studies. The vertical dotted line represents the line of no effect (i.e. no difference between the studies). Each square represents the effect estimates of each study and the line across each square represents the 95% confidence interval of each study.

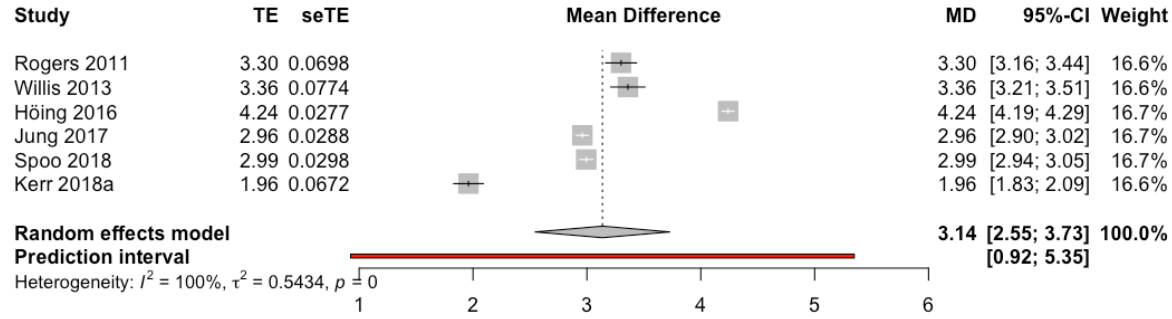


Figure 1.13. Forest plot of variation between the studies for Capacity to Change scale

Note. TE= The Effect, seTE = Standard Error of The Effect, MD = Mean Difference, CI= Confidence Interval at 95% and Weight = influence of study on the overall meta-analysis. The diamond in the centre represents the pooled mean difference across all the studies.

The vertical dotted line represents the line of no effect (i.e. no difference between the studies). Each square represents the effect estimates of each study and the line across each square represents the 95% confidence interval of each study.

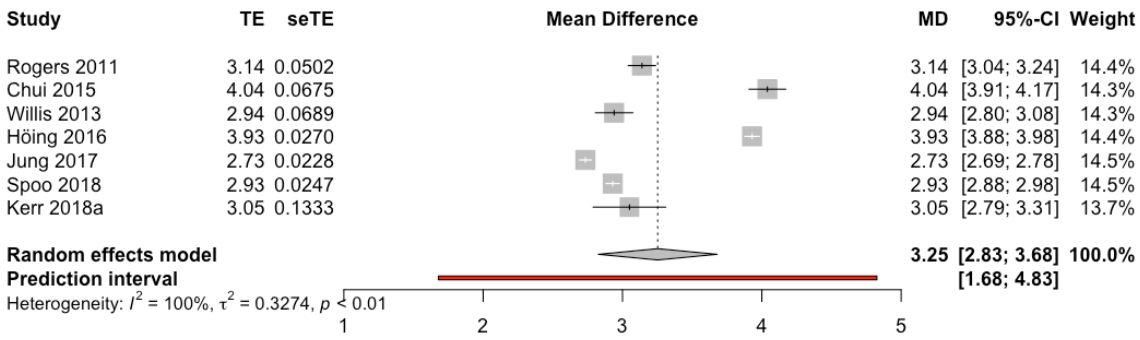


Figure 1.14. Forest plot of variation between the studies for Sexual Deviancy scale

Note. TE= The Effect, seTE = Standard Error of The Effect, MD = Mean Difference, CI= Confidence Interval at 95% and Weight = influence of study on the overall meta-analysis. The diamond in the centre represents the pooled mean difference across all the studies. The vertical dotted line represents the line of no effect (i.e. no difference between the studies). Each square represents the effect estimates of each study and the line across each square represents the 95% confidence interval of each study.

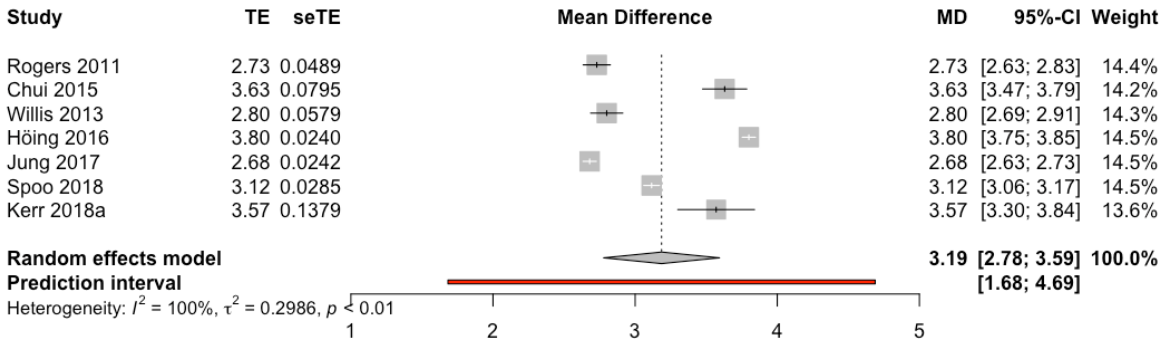


Figure 1.15. Forest plot of variation between the studies for Social Isolation scale

Note. TE= The Effect, seTE = Standard Error of The Effect, MD = Mean Difference, CI= Confidence Interval at 95% and Weight = influence of study on the overall meta-analysis. The diamond in the centre represents the pooled mean difference across all the studies. The vertical dotted line represents the line of no effect (i.e. no difference between the studies). Each square represents the effect estimates of each study and the line across each square represents the 95% confidence interval of each study.

Due to the evidence of large amounts of heterogeneity, a leave-one-out analysis was carried out in order to identify any influential studies. Figure 1.16-1.19 demonstrate Baujat scatter plots to explore the heterogeneity within the meta-analysis for Severity and Dangerousness, Capacity to Change, Sexual Deviancy and Social Isolation scales. The scatter plot demonstrated that the paper by Kerr et al. (2018) evidenced the most influence on the overall effect for both Severity and Dangerousness, Capacity to Change scale and Sexual Deviancy. However, removing Kerr et al. (2018) from the analysis created no significant reduction in the heterogeneity for both scales. Höing et al. (2016) evidenced the most influence for Social Isolation, however removing the study from the analysis created no significant change in the heterogeneity.

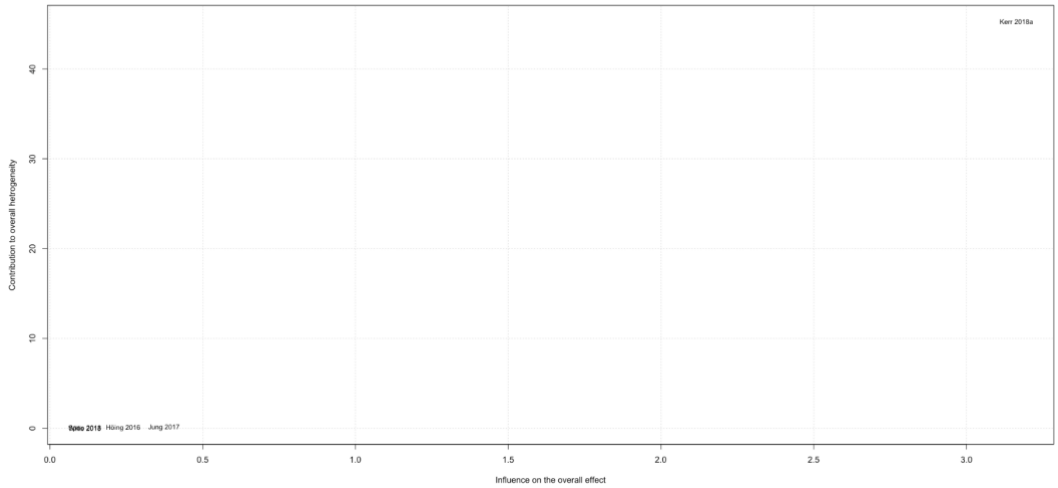


Figure 1.16. A Baujat Scatter plot demonstrating the heterogeneity within the meta-analysis for Severity and Dangerousness

Note. The x-axis represents the amount of heterogeneity contributed towards the overall effect. The y-axis represents the influence of each study on the overall effect. Studies on the top right of the plot have greater influence on the results and have a bigger contribution to heterogeneity.

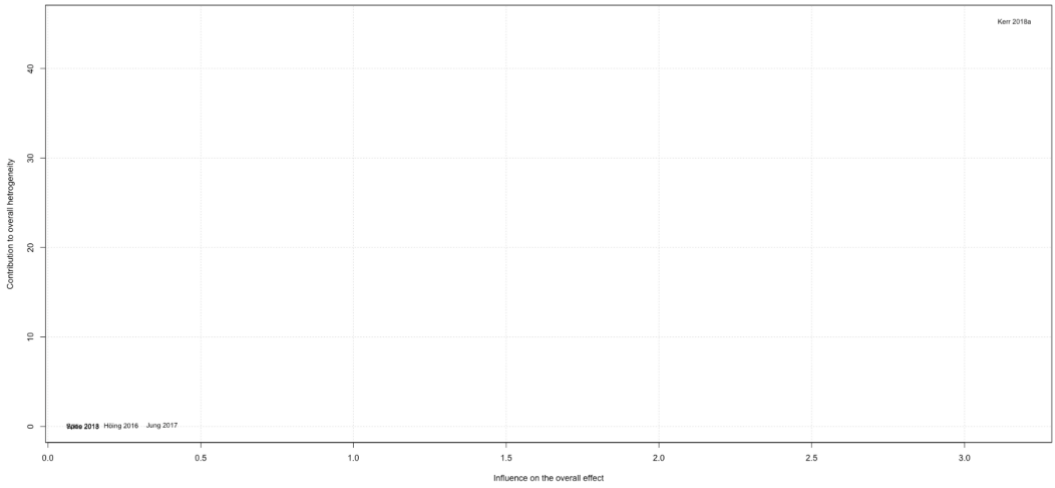


Figure 1.17. A Baujat Scatter plot demonstrating the heterogeneity within the meta-analysis for Capacity to Change

Note. The x-axis represents the amount of heterogeneity contributed towards the overall effect. The y-axis represents the influence of each study on the overall effect. Studies on the top right of the plot have greater influence on the results and have a bigger contribution to heterogeneity.

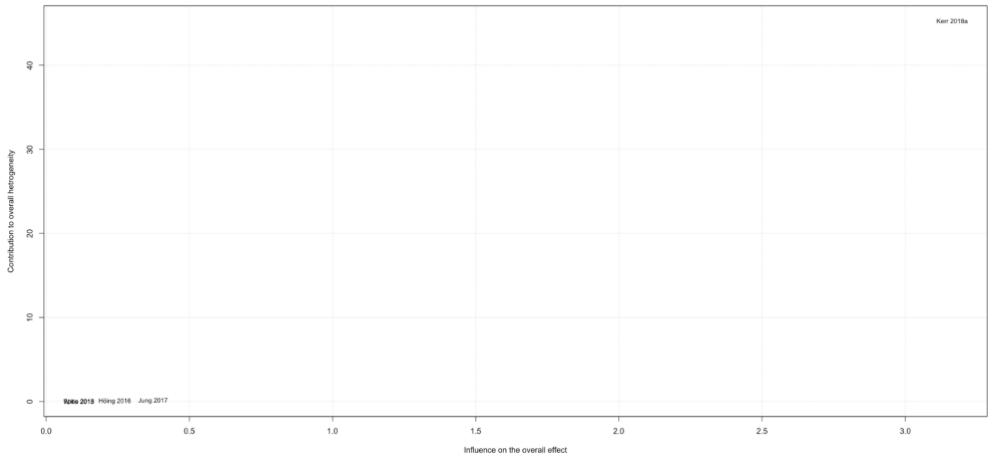


Figure 1.18. A Baujat Scatter plot demonstrating the heterogeneity within the meta-analysis for Sexual Deviancy

Note. The x-axis represents the amount of heterogeneity contributed towards the overall effect. The y-axis represents the influence of each study on the overall effect. Studies on the top right of the plot have greater influence on the results and have a bigger contribution to heterogeneity.

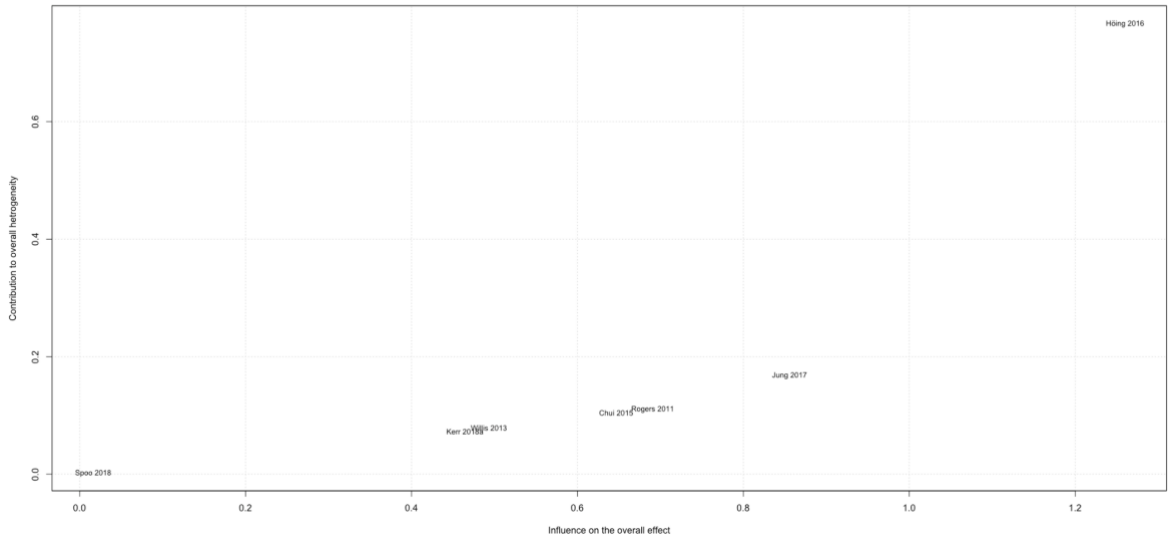


Figure 1.19. A Baujat Scatter plot demonstrating the heterogeneity within the meta-analysis for Social Isolation

Note. The x-axis represents the amount of heterogeneity contributed towards the overall effect. The y-axis represents the influence of each study on the overall effect. Studies on the top right of the plot have greater influence on the results and have a bigger contribution to heterogeneity.

The quality effects model was conducted across all four scales and the results demonstrated no significant difference from the original mean difference with an estimate score of 3.46 (Severity and Dangerousness), 3.16 (Capacity to Change), 3.30 (Sexual Deviancy) and 3.24 (Social Isolation). Therefore, evidencing that the result is robust to variation in overall quality index. A funnel plot was used, and the results demonstrated that formal analysis of publication bias was not possible across studies in all four scales (see Figure 1.20-1.23).

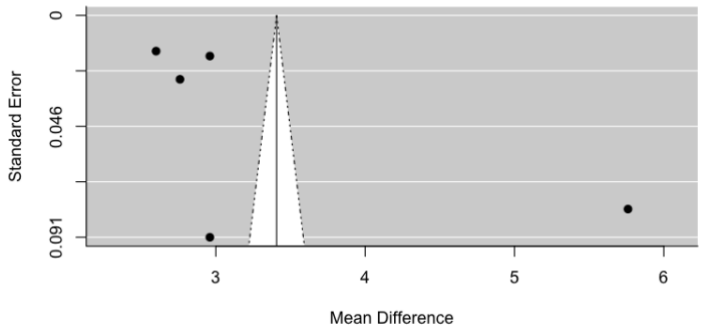


Figure 1.20. Funnel plot to identify publication bias and small study effects across the studies for Severity and Dangerousness

Note. The dots represent each study. Dots placed outside of the funnel (i.e. the white pyramid) in the grey region demonstrate bias and therefore lead to an asymmetrical appearance of the funnel plot. More pronounced asymmetry represents greater amount of bias.

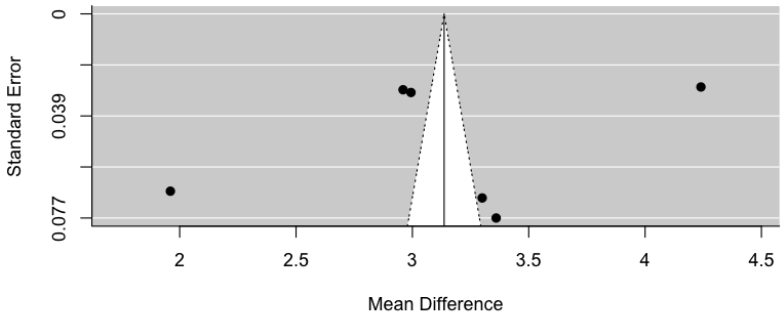


Figure 1.21. Funnel plot to identify publication bias and small study effects across the studies for Capacity to Change

Note. The dots represent each study. Dots placed outside of the funnel (i.e. the white pyramid) in the grey region demonstrate bias and therefore lead to an asymmetrical appearance of the funnel plot. More pronounced asymmetry represents greater amount of bias.

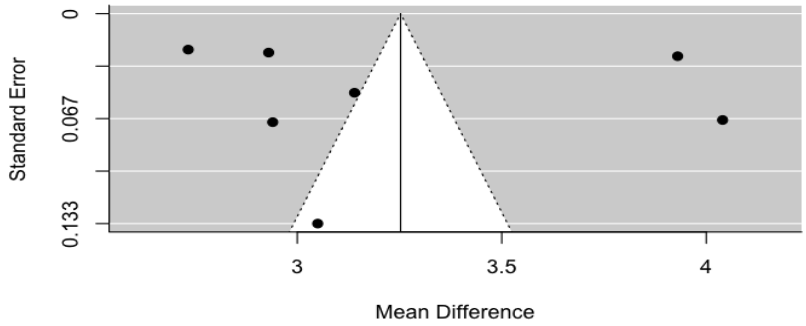


Figure 1.22. Funnel plot to identify publication bias and small study effects across the studies for Sexual Deviancy

Note. The dots represent each study. Dots placed outside of the funnel (i.e. the white pyramid) in the grey region demonstrate bias and therefore lead to an asymmetrical appearance of the funnel plot. More pronounced asymmetry represents greater amount of bias.

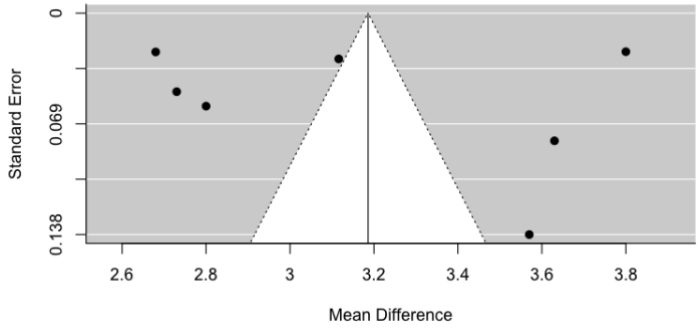


Figure 1.23. Funnel plot to identify publication bias and small study effects across the studies for Social Isolation

Note. The dots represent each study. Dots placed outside of the funnel (i.e. the white pyramid) in the grey region demonstrate bias and therefore lead to an asymmetrical appearance of the funnel plot. More pronounced asymmetry represents greater amount of bias.

Planned contrasts were carried out using sub-group analysis for each of the scales based on their quality indicators and are reported in Tables 1.6-1.9.

Table 1.6

Sub-group analysis based on quality indicators across studies using Severity and Dangerousness scale

		Number of studies	Random Effects Model		Hetergeneity			Between groups comparison
			Cohens D	**95% CI**	**Higgins I^2**	**Tau^2**	**Cochrane's Q**	
Selection bias	Low Risk	2	2.84	2.65; 3.03	77.4%	0.02	4.42	*Q=0.86*
	High Risk	3	3.77	1.82; 5.73	99.9%	2.99	1650.72	*df=1* *p=0.35*
Detection bias	Low Risk	3	3.83	1.93; 5.72	99.8%	2.81	1285.22	*Q= 1.15*
	High Risk	2	2.77	2.42; 3.12	93.4%	0.06	15.13	*df= 1* *p= 0.28*
Reporting bias	Low Risk	1	5.76	5.60; 5.92	Not reported	Not reported	0.00	*Q= 612.96*
	High Risk	4	2.81	2.64; 2.99	98.9%	0.03	265.15	*df= 1* *p= 0.0001**
Generalisability	Low Risk	4	2.81	2.64; 2.99	98.9%	0.03	265.15	*Q= 612.96*
	High Risk	1	5.76	5.60; 5.92	Not reported	Not reported	0.00	*df= 1* *p= 0.0001**

Note. Cohens D = effect size for comparison between the means, CI= Confidence Interval at 95%, Higgins I^2 = the percentage of variability in estimates of effect size that is attributable to between-study variation (heterogeneity), Tau^2 = variance of true effect

sizes, Cochrane's Q = measuring the differences between the different studies, Q = subgroup differences and df = degrees of freedom.

*Indicates *p* value scores that are statistically significant

The results demonstrated that between groups comparison in selection bias and detection bias were not significant. There was a statistical significance found in reporting bias, therefore suggesting low risk reported a higher effect size. However, there was only one study in low risk against four studies of high risk, therefore the results should be interpreted with caution. There was also a statistical significance observed within generalisability, therefore suggesting a larger sample produces a lower effect size. However, the effect size found, was not substantially different to the original effect size.

Table 1.7

Sub-group analysis based on quality indicators across studies using Capacity to Change scale

		Number of studies	Random Effects Model		Hetergeneity			Between groups comparison
			Cohens D	**95% CI**	**Higgins I^2**	**Tau^2**	**Cochrane's Q**	
Selection bias	Low Risk	3	3.64	2.93; 4.34	99.2%	0.39	241.62	*Q= 5.53*
	High Risk	2	2.63	2.22; 3.07	99.0%	0.14	209.40	*df= 1*
								*p= 0.02**
Detection bias	Low Risk	3	3.07	1.93; 4.20	99.9%	1.01	1524.38	*Q= 0.05*
	High Risk	3	3.20	2.92; 3.49	94.8%	0.06	38.63	*df= 1*
								p= 0.82

Reporting bias	Low Risk	1	1.96	1.83; 2.09	Not reported	Not reported	0.00	*Q= 20.42*
	High Risk	5	3.37	2.77; 3.97	99.7%	0.46	1338.41	*df= 1*
								*p= <0.0001**
Generalisability	Low Risk	5	3.37	2.77; 3.97	99.7%	0.46	1338.41	*Q= 20.42*
	High Risk	1	1.96	1.83;	Not reported	Not reported	0.00	*df= 1*
								*p= <0.0001**

Note. Cohens D = effect size for comparison between the means, CI= Confidence Interval at 95%, Higgins I^2 = the percentage of variability in estimates of effect size that is attributable to between-study variation (heterogeneity), Tau^2 = variance of true effect sizes, Cochrane's Q = measuring the differences between the different studies, Q = subgroup differences and df = degrees of freedom.

*Indicates *p* value scores that are statistically significant

The results demonstrated no significant difference between low and high-risk groups in detection bias. However, a significant difference was found in selection bias indicating that low risk demonstrated a higher effect size in comparison to the high risk. There was also a significant difference observed in reporting bias, therefore indicating that low risk reported a lower effect size. However, there was only one study of low risk, therefore the results should be interpreted with caution. A significant difference was also observed in generalisability, therefore indicating that low risk produced a higher effect. However, the results should be interpreted with caution as there was only one study in the high-risk group.

Table 1.8

Sub-group analysis based on quality indicators across studies using Sexual Deviancy scale

		Number of studies	Random Effects Model		Hetergeneity			Between groups comparison
			Cohens D	**95% CI**	**Higgins I^2**	**Tau^2**	**Cochrane's Q**	
Selection bias	Low Risk	4	3.51	2.99; 4.03	99.1%	0.28	343.65	*Q= 5.20*
	High Risk	3	2.88	2.71; 3.05	94.6%	0.02	36.98	*df= 1* *p= 0.02**
Detection bias	Low Risk	3	3.31	2.52; 4.09	99.7%	0.48	751.55	*Q= 0.04*
	High Risk	4	3.21	2.70;3.73	99.2%	0.27	360.89	*df= 1* *p= 0.84*
Reporting bias	Low Risk	1	3.05	2.79; 3.31	Not reported	Not reported	0.00	*Q= 0.75*
	High Risk	3	3.28	2.82; 3.75	99.6%	0.33	1427.49	*df= 1* *p= 0.39*
Generalisability	Low Risk	6	3.28	2.82; 3.75	99.6%	0.33	1427.49	*Q= 0.75*
	High Risk	1	3.05	2.79; 3.31	Not reported	Not reported	0.00	*df= 1* *p= 0.39*

Note. Cohens D = effect size for comparison between the means, CI= Confidence Interval at 95%, Higgins I^2 = the percentage of variability in estimates of effect size that is attributable to between-study variation (heterogeneity), Tau^2 = variance of true effect sizes, Cochrane's Q = measuring the differences between the different studies, Q = subgroup differences and df = degrees of freedom.

*Indicates *p* value scores that are statistically significant

The results demonstrated that there were no significant differences between groups comparison in detection bias, reporting bias and generalisability. However, a significant difference was found in selection bias, therefore suggesting that low risk reported a higher effect size.

Table 1.9

Sub-group analysis based on quality indicators across studies using Social Isolation scale

		Number of studies	Random Effects Model		Heterogeneity			Between groups comparison
			Cohens D	**95% CI**	**Higgins I^2**	**Tau^2**	**Cochrane's Q**	
Selection bias	Low Risk	4	3.24	2.61; 3.87	99.5%	0.41	552.29	*Q= 0.14* *df= 1* *p= 0.71*
	High Risk	3	3.10	2.72; 3.48	98.8%	0.11	161.91	
Detection bias	Low Risk	3	3.49	2.95; 4.03	99.4%	0.22	336.54	*Q= 2.91* *df= 1* *p= 0.09*
	High Risk	4	2.95	2.64; 3.26	97.7%	0.10	131.55	
Reporting bias	Low Risk	1	3.57	3.30; 3.84	Not reported	Not reported	0.00	*Q= 2.84* *df= 1* *p= 0.09*
	High Risk	6	3.13	2.68; 3.57	99.6%	0.30	1257.40	
Generalisability	Low Risk	6	3.13	2.68; 3.57	99.6%	0.30	1257.40	*Q= 2.84* *df= 1* *p= 0.09*
	High Risk	1	3.57	3.30; 3.84	Not reported	Not reported	0.00	

Note. Cohens D = effect size for comparison between the means, CI= Confidence Interval at 95%, Higgins I^2 = the percentage of variability in estimates of effect size that is attributable to between-study variation (heterogeneity), Tau^2 = variance of true effect

sizes, Cochrane's Q = measuring the differences between the different studies, Q = subgroup differences and df = degrees of freedom.

The results demonstrated that there were no significant differences across any of the bias's for Social Isolation. Further planned contrasts were conducted between other sub-groups which included continent and sample groups. Figures 1.24- 1.27 demonstrate the sub-group analysis for continent across the scales Severity and Dangerousness, Capacity to Change, Sexual Deviancy and Social Isolation respectively.

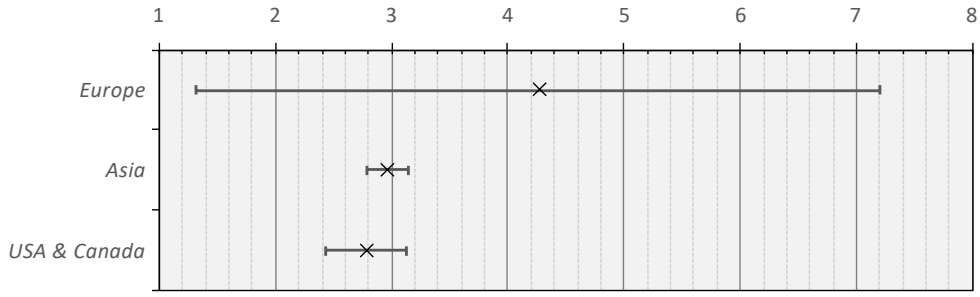


Figure 1.24. Sub-group analysis for continent between studies in Europe, Asia and USA & Canada for Severity and Dangerousness

Note. Comparison of the confidence intervals between the three continents. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results for sub-group analysis for continent across studies for Severity and Dangerousness found there was no significant differences found between the group comparison (Q= 1.59, df= 2, p= 0.45).

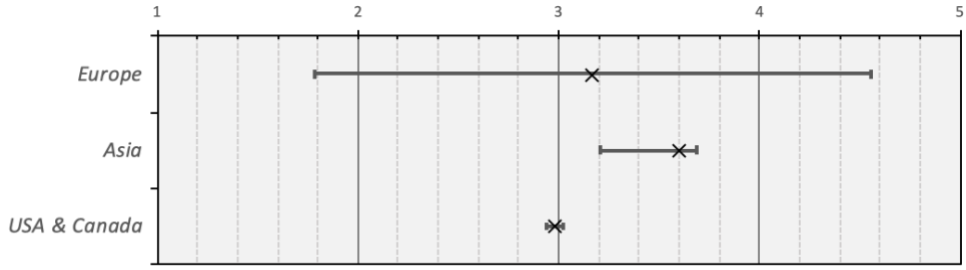


Figure 1.25. Sub-group analysis for continent between studies in Europe, Asia and USA & Canada for Capacity to Change

Note. Comparison of the confidence intervals between the three continents. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results for sub-group analysis for continent across the studies for Capacity to Change found a significant difference between the group comparison (Q= 22.97, df= 2, p= <0.0001). The results found that Asia (MD= 3.36, CI= 3.21; 3.51) scored significantly higher in comparison to Europe (MD= 3.17 , CI= 1.78; 4.56, tau^2 = 1.51, I^2= 99.8% , Q= 1049.87) and USA & Canada (MD= 2.98, CI= 2.94; 3.02, tau^2 = 0, I^2= 0.0% , Q= 0.67). However, the results should be interpreted with caution as there was only one study in Asia.

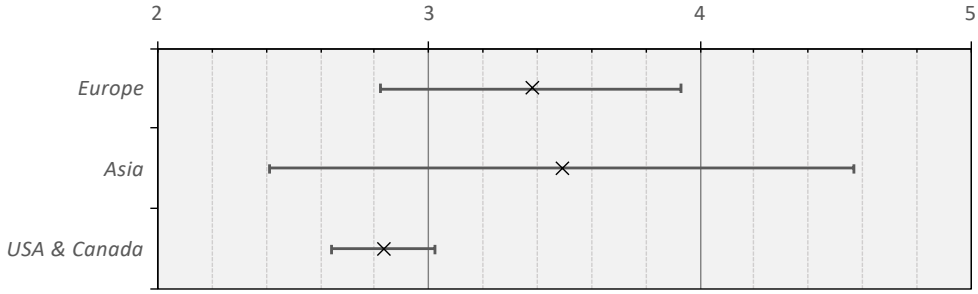


Figure 1.26. Sub-group analysis for continent between studies in Europe, Asia and USA & Canada for Sexual Deviancy

Note. Comparison of the confidence intervals between the three continents. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results demonstrated there were no significant differences between the sub-group analysis for continent for the Sexual Deviancy scale (Q= 3.83, df= 2, p= 0.15).

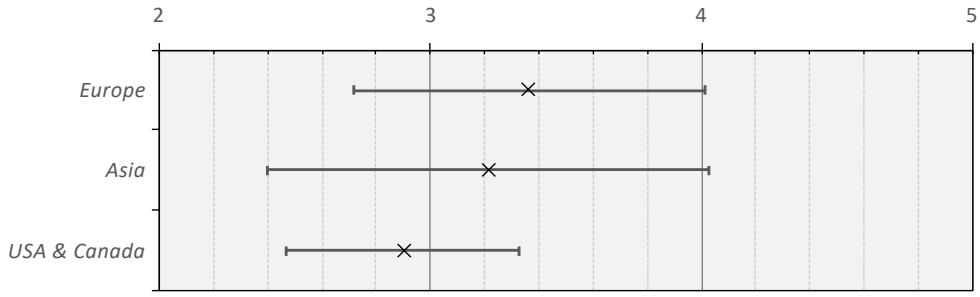


Figure 1.27. Sub-group analysis for continent between studies in Europe, Asia and USA & Canada for Social Isolation

Note. Comparison of the confidence intervals between the three continents. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results demonstrated there were no significant differences between sub-group analysis for continent for Social Isolation (Q= 1.22, df= 2, p= 0.54). Figures 1.28-1.31 demonstrate the sub-group analysis for sample group across the scales for Severity and Dangerousness, Capacity to Change, Sexual Deviancy and Social Isolation respectively.

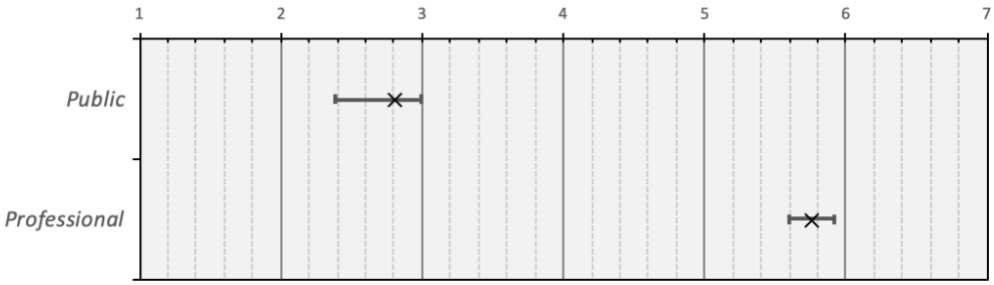


Figure 1.28. Sub-group analysis for sample group between the public and professionals for Severity and Dangerousness

Note. Comparison of the confidence intervals between the sample groups. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results for sub-group analysis for sample group across studies for Severity and Dangerousness found significant differences between the group comparison (Q= 612.96, df= 1, p= 0.0001). The professional group (MD= 5.76, CI= 5.60; 5.92) scored significantly higher in comparison to the public group (MD= 2.81, CI= 2.64; 2.99), therefore demonstrating that professionals believe sex offenders are more severe and dangerous than the public. However, these results should be interpreted with caution as there is only one study for the professional group.

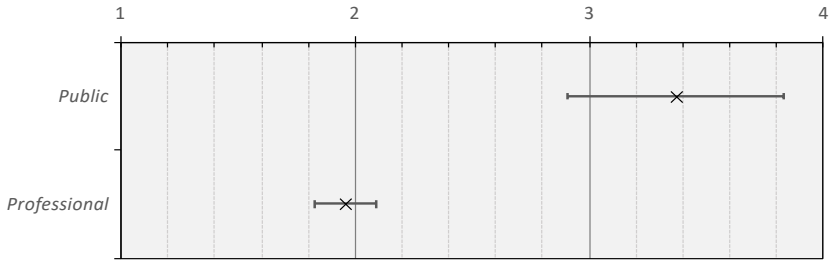


Figure 1.29. Sub-group analysis for sample group between the public and professionals for Capacity to Change

Note. Comparison of the confidence intervals between the sample groups. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results demonstrate a significant difference between sample group for Capacity to Change (Q= 20.42, df= 1, p= < 0.0001). The public group (MD= 3.37, CI= 2.77; 3.97, tau^2 = 0.46, I^2= 99.7%, Q= 1338.41) scored significantly higher in comparison to the professionals (MD= 1.96, CI= 1.83; 2.09). However, the results should be interpreted with caution as there is only one study in the professional group.

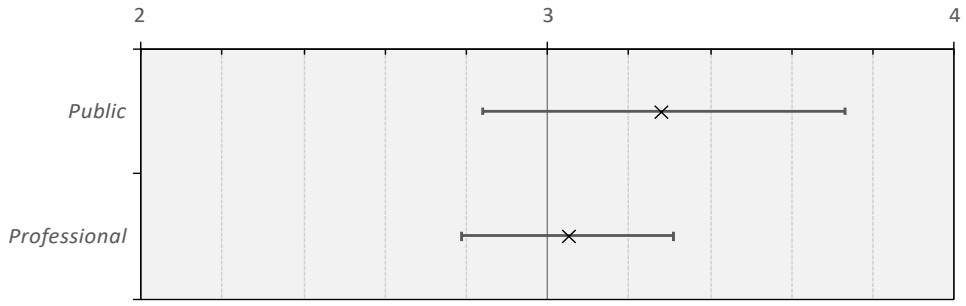


Figure 1.30. Sub-group analysis for sample group between the public and professionals for Sexual Deviancy

Note. Comparison of the confidence intervals between the sample groups. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results demonstrated there were no significant differences in the sub-group analysis between sample group for Sexual Deviancy scale.

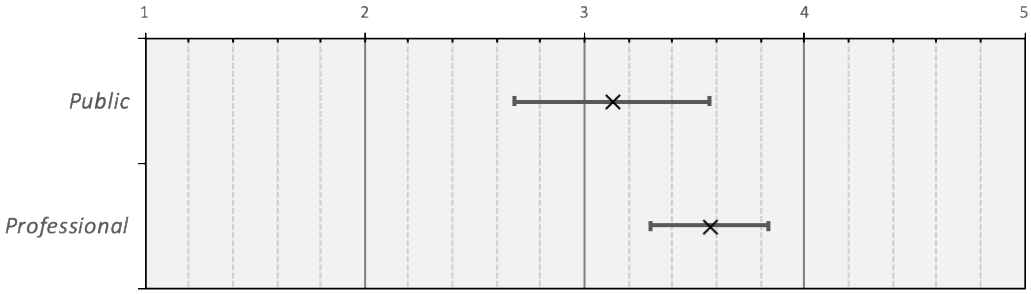


Figure 1.31. Sub-group analysis for sample group between the public and professionals for Social Isolation

Note. Comparison of the confidence intervals between the sample groups. The 'X' represents the Effect, with the lower confidence interval and upper confidence interval on either side.

The results demonstrated there were no significant differences between sub-group analysis for sample group for Social Isolation (Q= 2.84, df= 1, p= 0.09). A meta-regression was carried out for all four scales to test whether the year the study was published established a difference in the score across the scales. The results demonstrated no significant differences across all four scales. Therefore, this suggests that the difference in years did not impact people's attitudes towards sex offenders.

Discussion

Summary of results

The aim of this meta-analysis was to address two questions. Firstly, what is the general population's attitudes towards sex offenders in the community. Secondly, to identify whether there are any differences in attitudes towards sex offenders within specified subgroups.

Overall, the results demonstrated difficulties to draw definitive conclusions due to large amounts of heterogeneity. The CATSO scale ranged between 18-108 with higher scores indicating more negative attitudes. People's attitudes towards sex offenders in the community, based on the Total Score scale was approximately 56, therefore demonstrating attitudes in the middle. Interestingly, this does not support the literature which generally indicates that people's attitudes towards sex offenders are negative (Marteache, 2012; McCartan, 2010; Olver & Barlow, 2010; Rogers et al., 2011; Willis et al., 2010). In fact, the findings of the meta-analysis suggest that people's general attitudes are moderate and due to the methodology of this meta-analysis, the results appear more robust than previous findings.

The results demonstrated high heterogeneity (over 90%) across all scales due to the limited papers included within this meta-analysis, therefore the findings will be interpreted with caution. The results demonstrated that a leave-one-out analysis and the quality index made no significant difference across all the scales. Despite Kerr et al. (2018) being the highest contributor to heterogeneity across the majority of the scales, it

was still found appropriate to keep in the final sample as the leave-one-out analysis demonstrated no significant difference by removing it. Formal analysis for publication bias and small study effects was not possible across all the scales due to large amounts of heterogeneity. Thompson and Sharp (1999) suggested, understanding the possible reasons leading to heterogeneity can in turn help to increase the *"scientific value and clinical relevance of the results from a meta-analysis"* (p. 2693-2694). One reason for such large amounts of heterogeneity could be due to the diverse range of methodological approaches utilised across the studies in this meta-analysis. Further explanations could perhaps be understood as a result of diverse range of populations used, specifically age, gender and profession (i.e. in the case of Kerr et al., 2018), therefore evidencing different cultural attitudes and societal norms.

Sub-group analysis interpretation

In attempts to address the second aim of this research, the results of sub-group analysis will now be discussed. The sub-group analysis within quality indicators, continent and sample group, found some significant differences within some of the scales, specifically within Total Score, Severity and Dangerousness and Capacity to Change. However, the results demonstrated that where these significant differences were found, the actual amount of difference was minimal and therefore further interpretation was not beneficial.

Continent group

Differences were found within sub-group analysis of continent, however, these interpretations should be taken with caution. Within the Total Score scale for continent, people in Europe held significantly more negative attitudes about sex offenders in the

community than Asia and USA & Canada. McAlinden (2012) suggested that Europe have implemented more restrictive laws on sex offending and adhere to a medical model (i.e. use of chemical castration) towards sex offenders. Höing et al. (2016) found within all nine European countries in their study, that participants held significantly more negative attitudes about sex offenders in the community than other samples. However, they also stated that research exploring people's attitudes towards sex offenders is largely focused on UK and US populations, in comparison to European countries, therefore rendering it difficult to form conclusive findings.

However, within the Capacity to Change scale, people in Asia held more negative attitudes for sex offender's ability to change and be rehabilitated in the community (e.g. they support longer prison terms and have sex offenders wear tracking devices) than people in Europe and USA & Canada. Chui et al. (2015) found that Chinese participants held more negative views towards punishment of sex offenders, such as not being released from prison and losing rights to vote. A possibility for these results could be due to limited legislation surrounding management of sex offenders within Asian communities. This is not to generalise all Asian countries, as for example countries such as South Korea, Taiwan and China have sex offender registers in place and the Siu Lam Psychiatric Centre in a Hong Kong prison developed the first rehabilitative unit within East Asia (Hong Kong Correctional Services, 2018). However, for the majority of other parts of Asia, this is an area that requires political attention.

On the other hand, in Western societies, these matters are fundamental within legislation and have resulted in the development of specific rehabilitative treatment procedures

within the community. For example, monitoring sex offenders through the legislative measures (LaFond, 2005) and establishment of community-based treatment programmes for sex offenders (Marshall, Eccles & Barbaree, 1993).

Sample group

Differences were found within sub-group analysis of the sample group, however, these interpretations should be taken with caution as there was only one study using a professional sample included in the meta-analysis. The results demonstrated that for the Total Score and Severity and Dangerousness scale, professionals held more negative attitudes towards sex offenders and viewed them as more dangerous in comparison to the public. However, for the Capacity to Change scale, the public held more negative attitudes towards a sex offender's ability to change compared to professionals.

This could be possible due to the fact that professionals work more closely with sex offenders, such as through assessment and treatment, which can lead to greater insight towards their risks within the community in comparison to the public, who do not have the same insight and are likely to base their judgements from sources of information they have access to like the media and stereotypical views. King and Roberts (2015), found when they asked people about sex offenders "many are inclined to envision the media-proliferated stereotypical image of a violent, predatory male pedophile" (p. 2). Regarding the ability to change, the existing literature supports the view that professionals hold more positive attitudes about rehabilitation of sex offenders (Church et al., 2008; Willis et al., 2010).

Recommendations

The results highlight a number of gaps within the literature which have created unclear findings within this meta-analysis. Recommendations for future research will now be explored.

In the current climate, the public's attitudes have played a significant role towards the legislation of sex offenders. However, the results from this meta-analysis suggest people hold moderate and heterogenous attitudes about sex offenders in the community. Therefore, it can be argued whether people's attitudes should play such a significant role in the legislation process, as it is apparent that no clear attitude can be established. This is a result of the significant amount of heterogeneity demonstrated within this meta-analysis and therefore, evidences uncertainty of what people's attitudes really are towards sex offenders.

Instead, such decisions should be informed through evidence-based research by professionals who work with sex offenders to offer the most effective form of rehabilitative treatment within the community with the aim to reduce recidivism (Harper, Hogue & Bartels, 2017). Research has demonstrated that ensuring successful integration into the community can provide desistance from offending (Tewksbury & Jennings, 2010) and McGuire (2002) has demonstrated that using punishment and deterrence methods do not discourage offenders from committing further offences.

A further recommendation is for forensic professionals to educate and train people about sex offenders using evidence-based research to demonstrate effectiveness of

rehabilitation and treatment as well as dispel stereotypes. The results suggest that overall the public (in comparison to professionals) hold more negative attitudes towards the ability for sex offenders to change. Research suggests that the media plays a crucial role in enhancing a skewed perception in the public's attitudes towards sex offenders (Zilney and Zilney 2009), which in effect can create a cycle of hostility and negativity. Several issues relate to this cycle which include, legislative discussion (Harper & Hogue, 2014), support for punitive and restrictive policy (Koon-Magnin, 2015) and stigmatization of sex offenders (Willis et al., 2010). Therefore, forensic professionals, who hold more positive attitudes towards the ability for sex offenders to change through their experience of working with this offending population, can help dispel imprecise public attitudes about sex offenders by incorporating evidence-based research within their training to the public. For example, Wurtele (2018) demonstrated that by providing an educational course to university students about sex crimes towards children showed fewer stereotypes and more positive attitudes towards treatment and offender rehabilitation. Further, Simon and Arnaut (2011) found that after training individuals to work therapeutically with sex offenders improved attitudes in comparison to those receiving no or little training and Kleban and Jeglic (2012) found that using psycho-educational methods were successful in significantly improving attitudes towards sex offenders.

The literature demonstrates that there are varying attitudes held among professionals towards sex offenders (Hogue, 1993) and as a result this can impact professionals' judgement. Hogue (1993) reported that police officers expressed the most punitive attitudes, followed by prison officers, probation officers and then prison psychologists, therefore demonstrating that professional's attitudes become more positive as they are

more involved in the offender's rehabilitation. These differences in attitudes are believed to be a linked to the amount of treatment-based work done with the offenders as well as the possibility of their positions that could enhance more negative attitudes towards sex offenders (Olver & Barlow, 2010). Therefore, this further highlights the need for education and training to be delivered not just to the public but extended among staff working directly with sex offenders. An example of the efficacy of this was demonstrated by Hogue (1995) whereby it was found that training a range of prison service employees had a positive impact on their attitudes towards sex offenders.

There is a need for further research to be conducted exploring professional's attitudes towards sex offenders. Three papers were removed from this meta-analysis (all consisting of a professional sample), due to a lack of quantitative data required for the purpose of this review. As a result, this led to weak analysis between sub-group comparisons of professionals and the public as only one paper represented the professional group.

The results from this meta-analysis also demonstrated a lack of consistency in reporting data from the CATSO scale, which led to the removal of papers for this review, as well as creating discrepancies between the subscales. Therefore, future research should be consistent in reporting all the data from the CATSO scale. Further, as highlighted by Höing et al. (2016) there is limited research in understanding people's attitudes towards sex offenders outside of UK and US populations, therefore a future recommendation would be for more countries to explore this area using the CATSO scale.

Strengths and Limitations

A strength is that this meta-analysis reviewed the entire literature within the area being investigated. Despite using a relatively small number of studies, there was in fact a high number of participants within the studies themselves from which conclusions could be drawn. A further strength is in the way this meta-analysis was conducted, in which a thorough approach was adhered to by analysing all the available literature of the CATSO scale and full attempts were made to explore the heterogeneity that was evident. This meta-analysis can be regarded as an original contribution within research of this area.

A limitation of this meta-analysis is that there were discrepancies in reporting the means and standard deviations for each of the individual scales across the 11 papers. As a result, this impacted the final analysis and interpretation of the data. Another limitation is the inability to make conclusive interpretations between the sub-group analysis as a result of the limited studies available, therefore, underpowering their effectiveness. A final limitation is that this meta-analysis was restricted to papers only utilising the CATSO scale, whereas there are other reliable and valid outcome measures that assess attitudes towards sex offenders. Therefore, this reduced the number of papers that could be included within analysis.

To conclude, the aims set out in this meta-analysis were addressed, however due to large amounts of heterogeneity the findings required cautious interpretations. This highlighted both clinical and research implications that require future research in this field.

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II

EMPIRICAL PAPER

Staff's experience of factors supporting sex offenders with a learning disability in community settings

Abstract

Aims: Following the Winterbourne incident in 2012, the Government responded by implementing "Transforming Care" agenda (Department of Health, 2012). The initiative aimed to promote the reintegration of people with a learning disability (LD) back into the community. However, research found that this was particularly difficult to implement for those individuals who also present with sexual harmful behaviours (Vaughan, Pullen & Kelly, 2000). The aim of this research is to gain staff's perspective on what is helping LD sex offenders to reintegrate into the community and effectively reduce their risk of reoffending.

Method: 11 participants who work directly with LD sex offenders were recruited from an integrated team (Social Care and NHS Community LD team). Participants were interviewed and thematic analysis was used for this research to identify the emerging themes from the data.

Results: Three main overarching themes were identified to promote reintegration into the community: Professional (impact of professionals on the client), Personal (impact of relationships on client and their own abilities) and Environment (impact of access to community and living environment on client).

Discussion: Clinical implications include lack of communication between services, uncertainty of responsibility between services to manage the risk of reoffending behaviours and the need for more forensic training and education for staff. A future research recommendation is to directly interview the clients about what they believe is helping them to reintegrate into the community and prevent them from reoffending.

Introduction

Learning disability

The NHS webpage (2019) defines learning disability (LD) as a global impairment of cognitive function. It is a lifelong developmental disability, therefore these disabilities will be present from birth and can affect someone's entire life. It impacts an individual's ability to learn and function independently as an adult as a result of their impaired social and adaptive functioning (The British Psychological Society, 2015). The severity of the LD can vary and is categorised on an individual's intellectual quotient (IQ), such that the lower the IQ, the more severe the impairment.

Winterbourne incident/ Community reintegration

Following the footage of individuals with an LD and autism being abused by their carers in Winterbourne View Hospital, the Government responded and developed 'Transforming Care: A national response to Winterbourne View Hospital' (Department of Health, 2012). Since then, further initiatives such as 'Transforming Care for people with a Learning Disabilities-Next Steps' (NHS, 2015a) and 'Building the Right Support' (NHS, 2015b) were devised in order to develop community services and close hospital beds for people with learning disabilities (NHS, 2015, p.4). However, Taylor (2019) found that these initiatives were not successful in achieving their aims, such that the same number of people with an LD were still in hospitals in March 2019 since the implementation of the initiatives in 2015.

The principle behind the Transforming Care agenda aims to promote values and rights of people with learning disabilities, however this has proven to be more difficult to apply practically. Vaughan, Pullen and Kelly (2000) found that there is an issue of appropriate placements in the community specifically for sex offenders with a LD and being able to manage their (potentially sexually harmful behaviour) needs. They found there appeared to be issues in placement based on the severity of their learning disability and co-morbidity. They argued that community services need support and guidance from specialist forensic services and forensic teams in order to provide the best care to this client group and due to a lack of communication, this is not being achieved.

Researchers have noted there is a relatively high prevalence of sex offending behaviours among individuals who have a learning disability (Lindsay et al., 2002). For example, Gross (1985) found that between 21-50% of offenders with a LD had been involved in sexual crime. There is a need for intervention with this client group within the community. With the arising emergence of care policies within the Western world, there appears to be a decrease in custodial care for people with LD (Lindsay et al., 2002). Craig and Hutchinson (2005) suggested that people with a LD are at a greater risk of re-offending over a shorter period of time, such that the sexual recidivism rate of offenders with a learning disability is 6.8 times and 3.5 times more likely to occur in comparison to non-disabled sex offenders at 2 and 4 years' follow up.

Importance of staff and providing staff support

Due to the transition of sex offenders with a LD into the community, there is a rise in staff coming into contact with this particular client group. As a result of this, there has

been an increase in research highlighting the importance of providing staff, working with sex offenders, emotional support. Sandhu, Rose, Rostill-Brookes and Thrift (2011) conducted research on staff support and the emotional challenges faced when working with sex offenders. The study found that it was important for staff to receive adequate supervision, support and training, which as a result reflects upon the work, they complete with sex offenders in the community. They are classed as the frontline support for offenders in the community, therefore their supervision will ensure effectiveness in their performance. Recent literature has found that staff working directly with offenders with a LD can be exposed to a number of distressing factors such as stress, burnout, compassion fatigue and vicarious trauma (Rose & Walker, 2018) further highlighting the importance of staff support working with this client group.

Current initiatives to promote reintegration of sex offenders

In recent years, there has been a shift in promoting reintegration of offenders into the community. Ward and Stewart (2003) published an article in which they highlight the importance of adopting a Good Lives Model over the standard risk-need approach when reforming offenders. The Good Lives Model is a strengths-based strategy that helps to build on capabilities and strengths in people to help offenders reintegrate into the community. The model proposes that individuals commit offences as they are trying to attain a valued outcome into their lives (Good Lives Model, 2018). The model identifies eleven domains that have been researched to show the positive rehabilitation of offenders.

One such initiative that provides community services for sex offenders is Circle of Support and Accountability (CoSA). This initiative has been adapted from Braithwaite

and Mugford's (1994) model of offender reintegration and is underpinned by three main principles: *Support, Monitor and Maintenance* (Saunders &Wilson, 200) each of which are supported within the literature to reduce recidivist sexual behaviours. CoSA is set out to support high risk sex offenders newly released from prison to reintegrate into the community and prevent reoffending, with the aims to promote a healthy and pro-social lifestyle. Bates, Williams, Wilson and Wilson (2014) evidenced the effectiveness of this initiative in the UK, such that members not in the Circles cohort displayed significantly higher involvement in sexual recidivism.

However, the majority of these initiatives are created for adults without a LD. At present there is only one known initiative set up specifically for adults with a learning disability, which is Respond, which attends to young people and adults with a LD at risk of being involved in sexually harmful behaviours. However, the limitation of this initiative is that it only extends to London and has not been adapted across the UK. Therefore, it is hoped that with this research, findings can support the importance of staff support and services working with this population in the community.

Aims and Objectives

There has been limited research investigating the factors that help sex offenders with a LD reintegrate into the community and reduce recidivism, specifically using a qualitative approach. A study by Lindsay et al. (2002), describes a service for sex offenders with an LD, with the hopes to maintain their placement within the community. They found that it is possible to create a cost-effective community service for sex offenders with a LD and court ordered treatment (requiring reports) promoted clients' motivations to attend and

participate in treatment. However, this study was not able to identify which of the various characteristics of the service used within the study contributed specifically to the outcomes. Furthermore, the study used quantitative data from assessments completed by professionals. Therefore, there is room to address this current research through qualitative methods.

Day, Carson, Newton and Hobbs (2014) have conducted qualitative research and interviewed professionals working with sex offenders in the community to get their perspectives on managing sex offenders within the community. However, this study was conducted in Australia and primarily focused on professional's views on the impact on sex offenders from sex offender policies. The current study will be using professionals from a UK sample and will address different objectives. Furthermore, this study was based on professionals' experience of working with non-LD sex offenders, whereas this research intends on interviewing staff's experience of working with LD sex offenders.

The aim of the current study is to get a first-hand response, through interviewing staff, working with this client group in determining what they believe is helping clients to reintegrate into the community and prevent reoffending behaviours.

Methodology

Ethical Approval

Ethical approval for this research was provided by University of Birmingham Research Ethics Committee (Appendix C), NHS Health Research Authority (HRA) (Appendix D) and the Research and Development Department of the participating NHS Trust (Appendix E).

Proposed Analysis

The qualitative approach used for this research was Thematic analysis (Braun & Clarke, 2006). Thematic analysis is used in order to identify, analyse and report patterns (or themes) to provide a rich and detailed account of the data (Braun & Clarke, 2006) and is seen as the core method that is utilised within qualitative analysis. Recently, Braun and Clarke (2019) have revised thematic analysis and refer to it now as 'Reflexive Thematic Analysis' in order to capture certain aspects, that they felt overtime, was of significant importance within the process of using thematic analysis. In particular, they believed more focus was required on encapsulating the subjective experience of the author when analysing and interpreting their data. This was proposed by encouraging researchers to be more 'reflexive' in how they reach their conclusions and derive meaning of their data by demonstrating ways of how they analysed and interpreted their data such as by being open and transparent about the processes they used. Further, in order for researchers to openly describe their analysis process, Braun and Clarke (2019) emphasised the importance of researchers identifying their stance and position when attempting to

address their research question as well as understanding the philosophical assumptions that underpin thematic analysis.

It was felt that for the purpose of this research, thematic analysis would be the most suited methodological design to use in order to capture the perceptions of the staff's experiences of what is effective in reintegrating sex offenders with a learning disability into the community in depth in order to directly address the research question. As reported by Joffe (2012), thematic analysis is an effective way to conceptualise the phenomenon that is being studied. It was felt that this would not have been possible through the use of quantitative methods as just using statistical data would not sufficiently encapsulate the direct rich and detailed accounts of staff's experiences that were hoped from the research question as was possible through thematic analysis. Similarly, considerations regarding the use of Interpretative Phenomenological Analysis (IPA) was also undertaken, however it was felt that it was not suited for the intended aims of this particular research. It was felt that thematic analysis allowed more flexibility to the researcher according to the needs of the research (Braun & Clarke, 2006) such that this approach does not require such detailed theoretical and technological knowledge, as do other forms of qualitative analysis, and therefore provides more accessibility and ease to conduct for those new to the field of qualitative analysis (Braun & Clarke, 2006). Further, thematic analysis has been noted to be particularly useful in examining perspectives of different participants, highlighting similarities and differences and finally uncovering unanticipated insights (Braun & Clarke, 2006; King, 2004). This was seen to be highly relevant to the current research being undertaken, such that through interviewing a range of professionals it was

hoped to highlight any shared perceptions they may hold when working with sex offenders with a learning disability.

In order to investigate the aims of this research, it is important to highlight the theoretical underpinnings involved within thematic analysis. Thematic analysis has been described as not being tied to a particular theoretical approach, therefore allowing it to be used with a range of theories and epistemological approaches (Braun & Clarke, 2006; Joffe, 2012). However, thematic analysis has been noted to be best suited to theories with weak constructionism, i.e. a critical realist position, which essentially assumes that the way people engage with a particular issue is socially constructed, however the issue itself has a material basis (Joffe, 2012). This fits the approach that was taken for the purpose of this research in which the focus was on participants' thoughts and feelings regarding the issue being investigated rather than the reality of the issue (Joffe, 2012). Further, the approach was one that ensured to take into account the realities of the participants and understanding how the participants came to make sense of it (Coyle, 2016).

Procedure

Setting

Participants were recruited from an NHS Trust that caters to the needs of adults with a learning disability (both offenders and non-offenders), with the help of a supportive team of health and social care professionals. This includes occupational therapists, community learning disability nurses, social workers, clinical psychologists, health care assistants, speech and language therapists, dieticians, physiotherapists, psychiatrists and intensive support team (IST). It offers anyone over the age of 18 with a learning disability an

assessment of their needs. The team provides specialist health and wellbeing input to adults with learning disabilities whose needs cannot be met by mainstream services. The Trust offers support to people with learning disabilities who live in a range of community settings. These include residential settings, community homes, supported living housing and clients residing in their own homes.

Recruitment of participants

All participants were recruited from an integrated team consisting of Social Care and an NHS Trust Community Learning Disability Team. Participants were identified by the local collaborator by sending out emails across the team inviting staff, who work with this particular client group, to participate A brief summary of the research was provided within these emails as well as the inclusion and exclusion criteria set out for this research (see Table 2.1). Names and contact details of individuals who showed an interest to take part were passed onto the chief investigator to arrange meetings to explain the aims and procedure of the research.

Meetings were arranged and details within the participant information sheets (see Appendix F) were discussed with each participant and those who showed willingness to participate at this stage where offered to give consent (see Appendix G) or take up to 24 hours to decide. All participants agreed to give consent during the meeting. Once consent was obtained, convenient dates and times were set to conduct the interviews. Interviews took place using a semi-structured interview schedule (see Appendix H). Areas that were explored within the interview schedule included the living environment of the clients, professional involvement that is available to clients, whether they receive support from

their families or friends, the range of activities that clients have access to, what staff believe is helping prevent recidivism and finally future goals of their clients.

The interviews lasted for an average of one hour and were conducted between November 2019 to February 2020. All the interviews were recorded using a password protected digital audio recorder. To ensure anonymity of the participants, any inclusion of names and locations were redacted from the transcripts. Once the interview was completed, they were thanked for their time and offered the opportunity for the results to be shared with them if they wished.

Table 2.1

Inclusion and exclusion criteria for recruiting participants

Inclusion criteria	**Exclusion Criteria**
• Participants must be 18 years and older, with no upper age limit.	• Participants who cannot speak English will be excluded from the sample (to ensure that the chief investigator can obtain accurate and original information directly from the participants).
• Work directly with the client group. this can include support workers, care home managers and multi-disciplinary team members (i.e. psychiatrist, nurses,	

occupational therapists, social worker etc).
• Able to communicate, understand verbal information and read English.
• Participants have worked a minimum of one year with the client group.

Participants

11 participants were recruited, and their demographic information can be seen in Table 2.2. Braun and Clarke (2006) refer to how thematic analyses should be conducted, however little information is provided regarding data saturation and appropriate sample size for completing thematic analyses (Ando, Cousins. & Young, 2014). Guest, Bunce and Johnson (2006) found after interviewing 60 participants, data saturation was found at 12 interviews.

Table 2.2

Participant's age, professional background and number of years working within the Trust and with sex offenders with a learning disability.

Number of Participants	11
Sex of Participants	Female (n=7) Male (n=4)
Participant Ages	40-63 years (M= 48, SD= 9.89)

Professional Backgrounds	Social workers (n=3), community learning disability nurse (n=2), assistant practitioner (n=1), clinical psychologists (n=2), care home managers (n=2) and team manager (n=1)
Number of years working within the Trust	1-32 years (M=15, SD=10.66)
Number of years working with sex offenders with a learning disability	1-34 years (M= 12, SD= 8.87)

Note. N = number of participants, M= mean and SD = standard deviation.

Data Analysis

The data was analysed using Thematic Analyses and this was implemented using the 'six phases of analysis' as proposed by Braun and Clarke (2006). The steps have been outlined in Table 2.3 and have been adapted from the Phases of Thematic Analysis from Braun and Clarke's (2006, p. 87) paper.

Table 2.3

Six phases of Thematic Analysis (Braun & Clarke, 2006, p. 87).

Six Phases of Thematic Analysis	
1	Familiarizing to data: this includes transcribing the data (i.e. writing down the responses from the interviews)

2	Generating initial codes: coding interesting features of the data across the entire data set (sample of the table of initial codes in Appendix I)
3	Searching for themes: collating the codes identified (in phase 2) into potential themes (image of collating codes into themes in Appendix J)
4	Reviewing themes: checking if themes relate to the coded extracts and the entire data set in order to generate a thematic 'map' of the analysis
5	Defining and naming themes: ongoing analysis to refine specifics of each theme and overall story the analysis tells and to ensure a clear definition and name for each theme (themes generated by codes can be seen in Figure 2.1, 2.2, 2.3 and 2.4)
6	Producing the report: by ensuring the selection of vivid extract examples, final analysis of selected extracts, relating analysis back to the original research question.

During the process of data analysis, it is important to highlight how the final themes were developed to ensure credibility and transparency within the research. Braun and Clarke (2019) defined themes as a shared meaning that are underpinned through a core concept. They emphasised how themes do not simply emerge from the data, however, are developed through the researcher's analytic 'work' of coding and encompassing their own subjectivity. Braun and Clarke (2019) suggest that 'domain summary themes are organised around a shared topic but not shared meaning - they aim to capture the diversity of meaning in relation to a topic or area of focus…Theme titles are often reflective of data collection questions…or consist of one word that identifies the domain…' (p. 593). Within this research, this was the approach undertaken to reach the final overarching themes (Professional, Personal and Environment) as well as the associated sub-themes categorised under each of these overarching themes, in the hopes to capture the shared topic between each other. As reported by Vaismoradi, Jones, Turunen and Snelgrove (2016), the sub-themes share the same concept as the theme, however it focuses on one notable component.

Therefore, the 'level' at which the themes have been explored have been approached from a semantic level, i.e., 'the themes are identified within the explicit or surface meanings of the data, and the analyst is not looking for anything beyond what a participant has said or what has been written' (Braun & Clarke, 2006, p. 84). However, as highlighted by Braun and Clarke (2019) the level used within the development of the themes are neither 'either or' choices, but rather even the semantic level requires a degree of interpretation at the latent level (Marks & Yardley, 2004). This was demonstrated within some of the sub-

themes in the results section through the use of referencing from the transcripts where implicit meanings have been made (Joffe, 2012).

Methodological Considerations

It is important to acknowledge that the origins of qualitative methodology is premised on the underpinnings of philosophical traditions such as phenomenology, pragmatism and constructivism, which all suggest that the knowledge that is obtained, either through the world or from the researcher themselves, is to some degree influenced by the researcher's own perspective (i.e. through culture, language and purpose) (Yardley, 2008). Therefore, when considering matters surrounding validity of the research process, specifically within qualitative methods, it has been argued that attaining 'objective' knowledge is unachievable (Yardley, 2008).

Over the years, qualitative researchers have proposed steps that can be taken by researchers to demonstrate that qualitative approaches have been applied to high standards in order to ensure validity and credibility (Yardley, 2008) in which validity refers to the inferences obtained from the participant's realties rather than the data (e.g. in quantitative research) (Hammersley & Atkinson, 1983). Examples of these steps have been highlighted by Yardley (2008) which include 'sensitivity to context', which is done through evidencing awareness of the participant's perspectives and setting as well as the language used by them in the context of the research and how the researcher interprets this. For the purpose of this research, the researcher held familiarity with the participants' setting and perspectives by having work experience in a professional capacity in mental health environments specific for those who have a learning disability as well as being

aware of the language used in such environments. Creswell and Miller (2000) refer to 'the lens used by the researcher', which is a similar concept in which they refer to the researcher as an 'inquirer', utilising their own 'lens' to determine credibility of the research through processes such as calculating the length to remain within the field to collect the data, data saturation to ensure adequate establishment of themes and analysing the data to ensure 'a persuasive narrative' (p.125). They further elaborate how the researcher's lens is also influenced based on the researcher's paradigm assumption which can fall within three paradigms; postpositivist, constructivist or critical (Guba & Lincoln, 1994). The researcher's paradigm assumption held for the purpose of this research leaned towards a critical perspective, in which the researcher attempted to discover the hidden assumptions of the narrative accounts in line with how they are constructed, read and interpreted (Creswell & Miller, 2000). As a result, the researcher ensured that reflexivity procedures were highlighted to ensure the credibility of the research. A 'second lens' was described by the authors, which involves including the views of the participants by actively involving them in the interpretation process to ensure their realties are accurately captured (also known as 'member checking'). Finally, a 'third lens' can be adopted, in which the credibility of the interpretations can be assessed by an individual who is not associated with the research process.

Another step identified by Yardley (2008) is 'commitment and rigour', which is achieved by evidencing an in-depth analysis through the data that is collected. Creswell and Miller (2000) suggested a way to evidence this is by ensuring that the setting, participants and themes are described in rich detail in order to present credibility. This was applied within this research, by ensuring that steps undertaken during participant recruitment,

identifying the setting and devising final themes were described clearly. Further, Yardley (2008) highlighted 'transparency and coherence', which is evidenced in a way which ensures that the reader is able to clearly see how the researcher's final interpretations are concluded from the data. This was demonstrated within this research by highlighting the phases of thematic analysis that the researcher undertook from the point of data collection to the final interpretations and development of themes as well as providing evidence of the researcher's influence when analysing the data. Finally, 'importance and impact' was highlighted, which is evidenced through demonstrating how the knowledge presented is beneficial in regard to its practicality or in shaping how the world is perceived.

Creswell and Miller (2000) reported that peer debriefing is a useful process to ensure credibility within a qualitative approach and this involves seeking someone who is familiar with the study to review the methods utilised and ask investigative questions about the method used and interpretations concluded (Lincoln & Guba, 1985). This was a step that was undertaken within this research, such that the methodology applied was peer reviewed and a sub-section of the transcripts were analysed by the research supervisor in order to determine whether similar codes were obtained. The authors also refer to the process of triangulation as a credibility check and this process involves using multiple forms of evidence (such as observations, interviews or documents) rather than relying on a single form to reach final interpretations of the data being analysed. Due to resource restraints, the researcher was unable to perform this process, and this is highlighted as a limitation in the discussion section.

Braun and Clarke (2019) emphasised the importance of reflexivity within the process of thematic analysis. This is to ensure that the qualitative process undertaken was open and

transparent to the readers, which in turn can aid towards the credibility and validity of the research process (Creswell & Miller, 2000) as discussed above. The steps that were taken to demonstrate reflexivity within this research include transparency in how relevant codes were selected (i.e. phase 2 in Table 2.3). A sample of the coding categorisation can be seen in Appendix I. Further steps to ensure reflexivity include demonstrating an image of how the final themes were developed through the process of grouping the sub-themes into categories bearing similar relevance (i.e. phase 3 in Table 2.3). This can be seen in Appendix J. Finally, a reflective statement (seen in Appendix K) was included to demonstrate how the researcher's own subjective experiences and beliefs potentially influenced the research process.

Results

The analysis revealed three key overarching themes: *'Professional', 'Environment'* and *'Personal'* and each of these included a set of sub-themes (Figure 2.1). Figure 2.2-2.4 demonstrate the codes that fall under each of the sub-themes. According to Pattson's (1990) dual criteria for judging categories, the themes consisted of both internal homogeneity and external heterogeneity, therefore demonstrating consistent meaning within a set theme as well as a clear distinction from other themes identified.

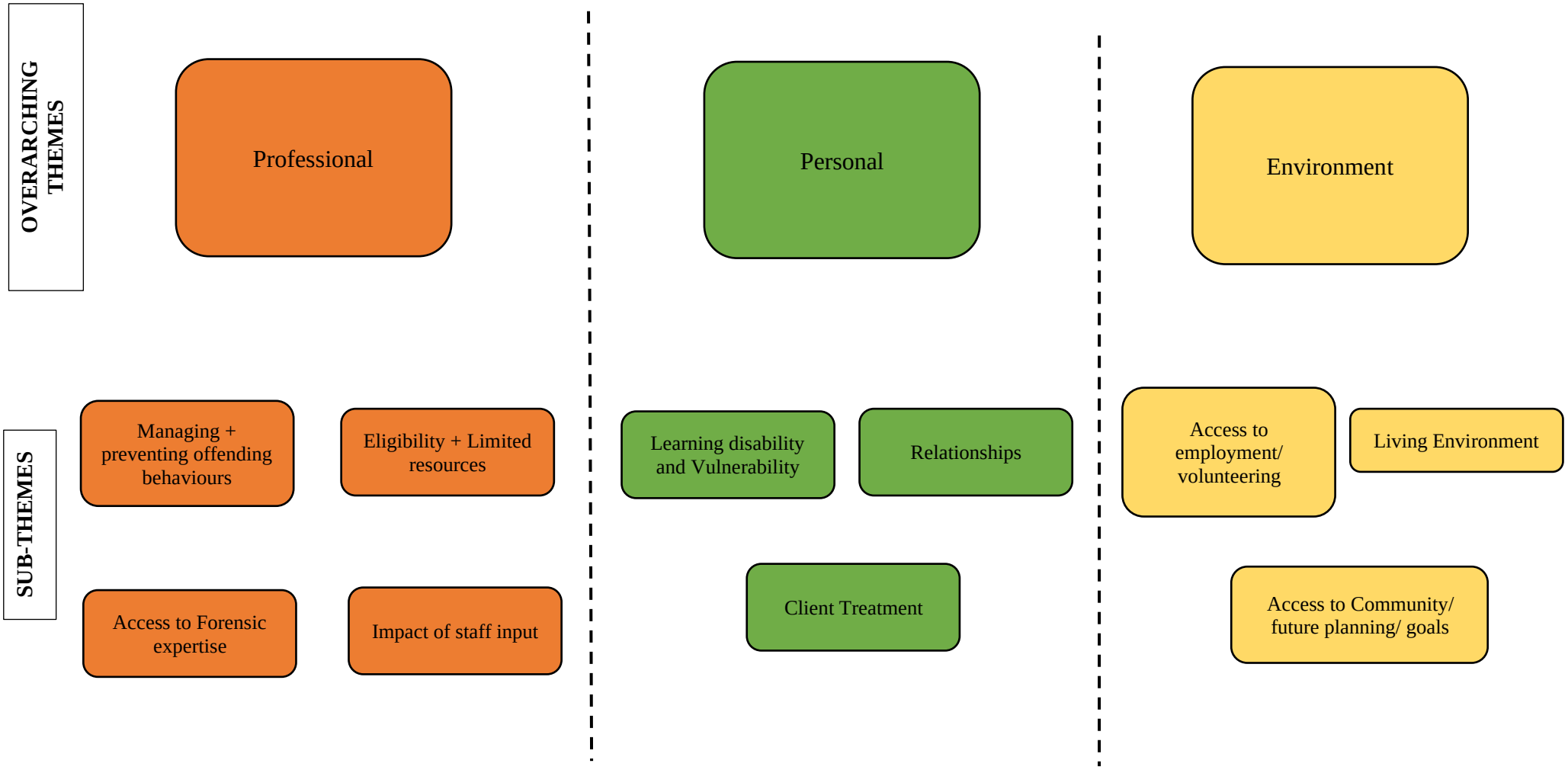

Figure 2.1. The overarching themes and sub-themes identified from the analysis.

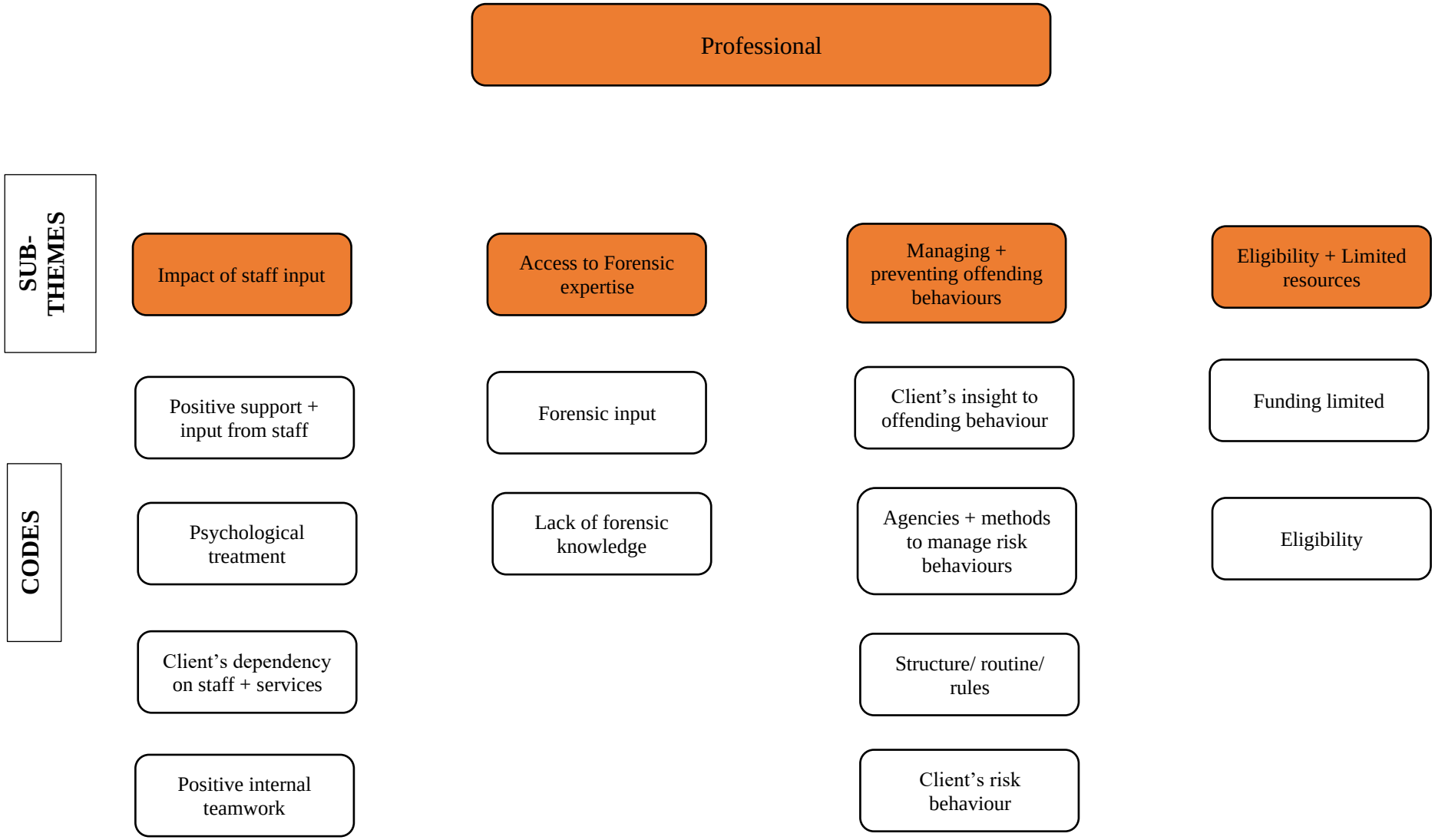

Figure 2.2. Codes constructing each sub-theme in Professional.

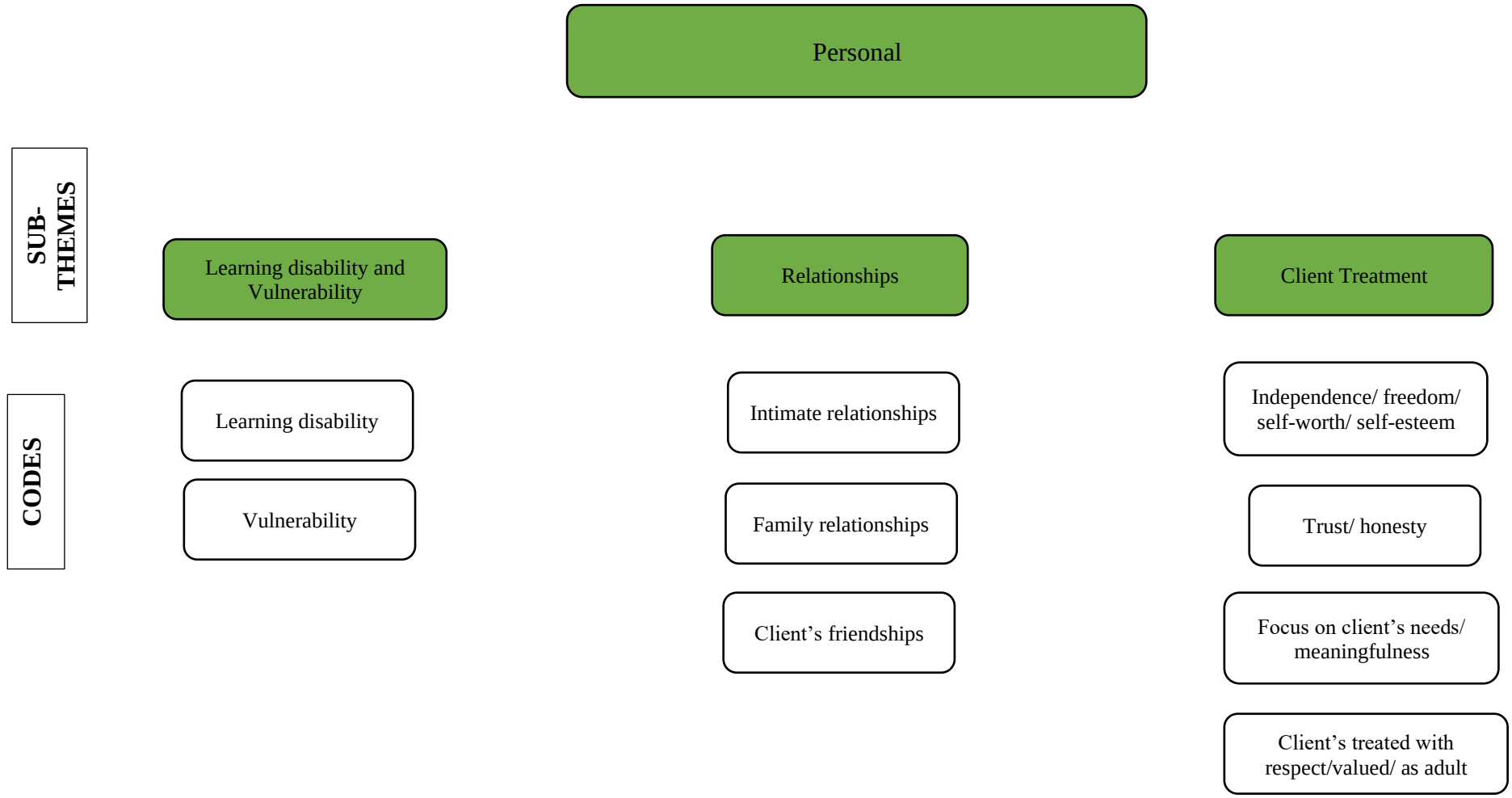

Figure 2.3. Codes constructing each sub-theme in Personal.

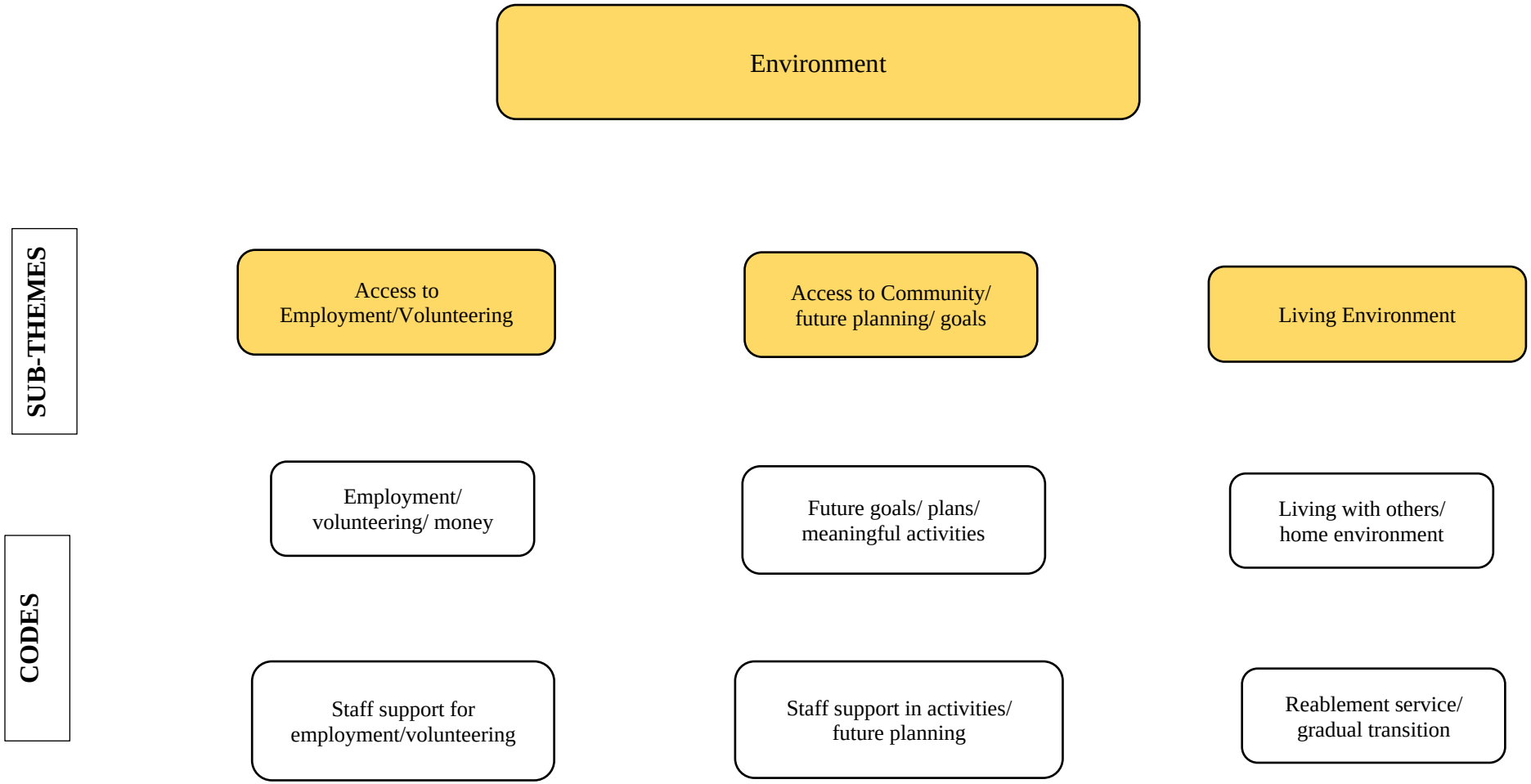

Figure 2.4. Codes constructing each sub-theme in Environment.

Theme 1: Professional

This theme highlights the input from differing professionals, such as day support staff, MDT professionals from the Trust, probation and the police, in helping clients to reintegrate into the community.

1.1 Impact of staff input

It is important to note here, that the term 'impact' is used as this sub-theme heading, to represent the 'hoped impact' perceived by the participants regarding their input upon the clients. Across the participants, a consistent pattern was identified in which the involvement of staff working with the clients was deemed to play a significant role in reducing the risk of reoffending and supporting client's needs to effectively live in the community. The degree of this support varied from both helping clients to meet their daily living needs to support through **psychological treatment** and other multi-disciplinary team (MDT) members to address their sexual behaviours.

Participants highlighted the benefits of 1:1 therapy, in which it helped the clients address a better understanding of themselves as well as the nature of their relationships:

> *…all of them were kind of accessing individual psychological therapy erm, depending on what needs they had, so one of them it was around kind of schema therapy, one of them was CBT for social anxiety, erm, one of them was more psychological assessment for understanding his capacity around relationships and marriage and things like that. (P6, line 125-129)*

Erm, but also some individual work for at least two of them, because they're people who are really struggling with their kind of sexual identity and their sexual orientation and in order to get that they're going to have to do, erm, they might need some support kind of processing those feelings and understanding themselves. (P6, line 402-406)

Benefits of sex education in order to re-educate clients about appropriate relationships:

I do a lot of sex-ed stuff for individuals and I do a lot of, I give out condoms to people and part of my schpeel is talking about consent, how old should someone be, so individuals who I don't know so well, I can then gauge, do they know no means no, do they really know how old an individual should be, how do I identify how old someone is, stuff like that? And the internet stuff, which is a big problem for us. (P2, line 644-649)

And finally, group work aimed at addressing their sexual offending to help reduce the risk of reoffending and address difficulties leading to their offending behaviour:

So, psychology, I worked alongside the psychologist and we ran a group for a period of time just to help people to understand their sexualised behaviour and how it impacts on the individuals. (P2, line 342-344)

It involved a lot of things. It was psychoeducation… it was around a combination of things, it was around their offending behaviour…the offending cycle and sort of trying to sort of work out what is going on for them, erm, it was also looking at sort of erm, victim empathy…just sex education as well. Just always a session on

that, it was just understanding erm, different types of abuse and their vulnerability because again for most of them it's not just, and their abuse past as well…them to understand well what is abuse…looking forward as well sort of the future and how sort of their behaviour might be holding them back or the fact that people on sex offender's register and things like that are keen to move on and be employed, erm and do things like that and social skills. Relationships, appropriate relationships coz that was the, one of their difficulties for most of them was just that lack of understanding their ability to establish these positive friendships and appropriate adult relationships. (P10, line 394-409)

Other perceived benefits that were noted across participants included the **positive support input by the staff**. This included the use of effective communication, someone clients can talk to and having a positive rapport with the staff members:

…communication, so sometimes we need to reformat information, and so the guy who moved from supported living erm, into residential care couldn't comprehend the law, you know under 16's are a definite no no, erm, so we had to sort of devise some visual stuff for him to look at, which worked really well. (P2, line 322-325)

I think the clients that I have worked with, one of the reasons they have got into the situation that they have got into is because they has been no support network, there has been no one to talk to, there has been no one to explain things to them, so I think the positive side of it is that there are people about. (P4, line 70-73)

I think it's the support they have from their own support staff. I think it's having staff within our service that have been here for a long while and have known them for a long while. So, you sort of know their history and their stories of how things have, I think if people didn't know them so well, they probably wouldn't be as open to come and talk about issues. (P3, line 855-859)

It was noted that the **positive nature of internal teamwork** as well as being an integrated team (i.e. social care and mental health team) played a significant factor towards the efficacy of how they worked with the clients to promote their reintegration into the community. Participants felt that having all members of the multi-disciplinary team under one roof allowed a collaborative formulation from differing professional expertise to best assist in understanding how to work with clients:

I think the fact that this is a joint social care setting. The fact that we are working with an individual who we know has some inappropriate behaviours, and we can literally walk down the corridor and talk to a relevant professional. (P2, line 378-380)

Yeah, so generally when you have the expertise, of different professionals, erm, I just think every team should have that really, because you're, to make decisions for somebody you can't just do that, oh yeah so I am coming from my social work perspective, which will come for me to help someone in the community, but jointly you are making a really balanced decision…(P9, line 410-414)

However, participants also noticed the drawbacks of staff input and this was primarily the **clients' dependency on staff and services**. As a result of this dependency, participants noticed that the clients would often blur boundaries and perceive staff members more as family. Participants were able to reflect that this was often due to clients experiencing chaotic and disruptive childhoods growing up:

> *Yeah, I think two of them have become so used to having professionals involved all the time that they had become part of their extended systems erm, and so actually the thought of not being involved with psychiatry and psychology and etc, or just the learning disability team in general would have been quite distressing for them if they ever got to the stage where they were ok. (P6, line 108-112)*

> *Yeah one or two of them do think we are their family and we have to try and put the boundary in. (P1, line 744-745)*

> *'I'm your social worker not your mum'. But they fall into that pattern of feeling like someone cares about what happens to them you know, which is, I think that is lovely and makes me feel like we are doing our job properly really and giving people the support, they need. (P1, line 747-750)*

1.2 Access to Forensic expertise

A common theme identified among participants was they felt they **lacked forensic knowledge** and they are not equipped with specialist forensic skills or training that is required in terms of dealing with this client group. Furthermore, it was also highlighted

that managing the forensic risk of these clients did not fall under the duty of the community care team and was something they were not funded for, but rather the role of the police, Public Protection Unit (PPU) or probation:

> *Yeah absolutely. Because if you asked a lot of the team members in the learning disability community team here, would you feel equipped enough to do some work with someone around their sexual offending, they would say no, that's not, I don't see that as part of my role, we don't have the training in it, wouldn't know where to start, how long are we going to sit with this, does the risk sit with us indefinitely, those kind of questions.(P6, line 323-328)*

> *Yeah, I think the stuff I have been talking about and what we offer, erm, our service, our LD service is not commissioned, erm, to work with erm, sex offenders, we are not really commissioned to work with any forensic issues. So, anything that we have been doing over the years doesn't really come under… (P10, line 509-512)*

Therefore, managing a group of high-risk clients, at imminent risk of reoffending, and not having the expertise or resources to manage such risks left the majority of the participants feeling uncomfortable and placed a great amount of pressure on staff to prevent reoffending:

> *Because if I get something wrong or if my staff get something wrong there is all of that as some child could end up being molested, somebody ends up losing money because someone has stolen from them and you don't want that to happen.*

That's the biggest pressure of the job, it's trying to read something that's how it. (P5, line 655-659)

Participants referred to the recent introduction of services provided by a forensic community team to assist the community LD team with clients who are deemed high risk and have convicted sexual offences. Overall, participants felt that the introduction of **forensic input**, through forensic specialists, have been beneficial in aiding the community LD team, however, there remain uncertainties as to what support they can offer. This, therefore, has left participants feeling uncomfortable with the fact that high risk individuals have the freedom to access the community without proper risk assessments in place nor have the adequate expertise to manage it themselves:

...you know on a basis of someone makes a referral in terms of a particular bit of behaviour and again we know have the forensic community team, but we have been able to get an update on our risk assessments and do them properly finally which is hugely beneficial, erm, but yeah in terms of other stuff, therapeutic stuff no we don't really. We still don't have that resource to be able to do that and any kind of on-going meaningful work. (P7, line 656-661)

Yeah and it feels kind of what can we actually do and make a referral to the community forensic service and turn around and say we don't have the resources to do anything about it. So, where does, it's sitting with the risk. (P7, line 716-718)

1.3 Managing and preventing offending behaviours

Participants felt that the **risk management** of clients was being effectively achieved in the community through the **input from agencies** such as the police, PPU and probation and also felt that these agencies worked collaboratively with their teams. Participants felt that the police, in particular, had a good rapport with the LD clients, as a result of being a small community with a limited LD population, therefore had established an effective manner in communicating the consequences of their actions if they reoffended again:

> *…so we have links with, there's a police officer that works locally who does erm, keep a monitoring eye on the sex offenders that we work with and at times that person will go see them and have a bit of a chat with them and remind them about the risks and just sort of get them remembering what they need to do and what they can and can't do…(P1, line 448-452)*

> *We also meet with probation and the team from the police. Some of them are still being monitored quite closely and we work closely with them. Has to be open. (P4, line 206-207)*

The participants also identified the benefits of court orders and the sex offender register as it provided staff some guidance on how to manage their risks effectively in the community:

> *It is difficult for them to have that access. Again, you know sometimes court orders state not allowed to be in certain areas, so we have to manage that. They can't*

actually stop them, but we also know what the consequences are if they break that court order. (P4, line 176-180)

I said unfortunately you have to because that's the law, because you're on the sex offender register and you can't do that anymore because of what you did. (P7, line 649-651)

I would try and make these psychological interventions a, registered, erm, thing so that if he doesn't go, he can be recalled to prison, a registered activity I think and PPU were like and probation were like we can't do that. Can we just ask, because if we can do that and he knows he has to go to these sessions, it may be that he will then start to engage, you know, through the fact that he is just having to be there. (P11, line 309-314)

However, participants still felt that at times there was a lack of communication between services and homes relating to the management of risk behaviours and prevention of reoffending:

…we found out that everybody had a risk assessment, everybody had a separate risk assessment, and we were like why? Well what's on your risk assessment, and people had different things on their risk assessments, and I was like sorry can we just, I don't know make one risk assessment together, that we all can share and we all take responsibility for and you know we all think you know we've all

contributed to so that all of the information is there and you know maybe that would make more sense. (P11, line 242-248)

…being able to keep the services talking to each other, that is something that can be very frustrating. It is when homes think that we don't need to know, and we spend 5 days a week with them, we have more waking hours than anyone else, so actually we do need to do know. So yeah, it is hoping that the services keep talking to each other. (P4, line 398-402)

A difficulty that participants faced was regarding the management and support of both the risk and care needs of participants. Participants felt that their clients were capable of attending to their care needs (i.e. self-care, housework etc) however, the level of support they had put in place was more to aid their risk needs and prevent further reoffending even though they are not funded to do this:

That's, that's been the issue we have wanted, so we are managing their support effectively by giving them lots of, lots of support, whereas the pressure we are under now is that, obviously with those care packages, if you take out their forensic needs, and you look at both of those gentleman, they are very very capable, they are very much at the mild end of the learning disability spectrum, so you know in terms of their social, person care, they look after themselves, they can budget, they can dress, do all the personal hygiene, all the kind of personal care, so, and we got 12 hours of 1:1 with them every day or 5-6 days a week, so what on earth is that all about. So there's this kind of, you know, in terms of the

level of care they get is disproportionate to what would on the surface be their needs, so then we have these discussions about okay yes, but there is a forensic risk there and we have an argument so who is responsibility to manage the forensic risk, it's not social care needs so what are we paying for it. The NHS is going to say, you know, they don't come under continuing health care, and they are not going to come under continuing health care, so erm, this is where the tension is at the moment in terms of how do we manage that risk potentially, whilst you know, having that significant cut in resources that I think is keeping that risk safe. (P7, line 90-106)

If these guys could manage with less support they would already be in supported housing because it's cheaper for social services, but it's the degree of input that these guys need and the risk they present that's keeping them where they are. (P5, line 850-853)

The importance of the effectiveness of monitoring was highlighted by all participants through regularly checking in on clients with a known history of displaying sexual risk as well as redirecting clients if their risk behaviours increased:

So, staff do go in and sort of, knock on the door and check on him regularly, make sure he's ok and just sort of try to decipher what he's doing because he does watch a lot of pornography. Erm, so they just make sure anything he is watching is appropriate. (P2, line 9-12)

Erm, I guess across the different environments, erm, I mean sort of residential and supported living is the oversight of the support I guess, there is that degree of monitoring and known risk and people who support them know what that risk, obviously, who they live with don't, which is obviously correct. Erm, but yes, so they have that oversight from professionals. Erm, yeah and then they are able to redirect an individual who is starting to go down that route, they can redirect them, they can remind them of you know, what could potentially happen. Erm, obviously it's not fail safe, erm… (P8, line 884-391)

Participants also felt that some **clients held insight towards their offending behaviour** and attempted to manage their own risk behaviours and this was usually through learning from their experiences (i.e. through treatment or having gone through the criminal justice system):

…he understand, you know, the first thing he said about that the stuff that I did, I suppose the good thing for him is that he's got that understanding and actually he's learnt from his experiences, he's learnt from standing in court in front of a judge and having the living, absolutely being, crapping himself, because I was sitting in court with him, and the judge basically said to him if I see you before me me again you are going to be going to prison for a long time serving [laughs] I think that absolute those words and for him that was absolute kind of ok this isn't a game anymore, I am not going to get away with this because I am going to hide, I can't hide behind my learning disability. (P7, line 341-349)

What is helping them from reoffending, erm, I think that they have all had their big wake up situations, erm, with police involvement, erm, or even court erm, you know being on trial, erm, or being in prison. So, you know, these people very much is I am never ever going to end up in court again, erm, so they've had their big wake up situation. (P10, line 852-856)

However, responses also demonstrated that this is not always the case and those with no insight towards their risk behaviours, due to limited understanding because of their LD or not identifying their behaviour as a risk, are the individuals who need the most support in place and are at higher risk of reoffending:

There has been one occasion, and again it was down to the fact that the person didn't think their behaviour was offending behaviour, erm so it was erm, lack of capacity and understanding that what they were doing was erm, something that wasn't an offence. (P1, line 842-845)

…he has been offered sex offender treatment on... He's always declined it, refused to engage in it, because he doesn't do things like that. Classic kind of like, red alert stuff, you know, someone who is completely in denial about their behaviour but yet his carers and support workers will say every time he sees a small child he's watching them and he tries to engage them into conversation, he's getting excited but he still saying I am not like that, I wouldn't do things like that. Well actually you have convictions that say you do. Erm, he's in his 70's now, but he

still got that ideation there, he's still refuses to engage or acknowledge he's risky. You know, and we are talking about cutting his package. (P7, line 226-235)

There were interesting views regarding the nature of the **client's risk behaviours** such that some of the participants felt that the nature of the sexual behaviour displayed by clients, were just "*laddish behaviours"* namely due to the fact that a high percentage of their client group were young males, with LD and they would copy things they watched on the television:

But it was him just being a lad and I think you can watch something late at night with you watching these, people go away and people are watching them on holiday and you see what happens and it's just normal people will, or girls are flashing and doing whatever, they see all of that and it's just like a joke and it really, I think he really struggled with that because they then had to report it and then he got into bother again…(P3, line 878-883)

So when we look back at those incidents where he sexually assaulted his carers, they were really, he was a 19 year old lad, he's got these young, very attractive, he's got his carers the same age as him, they are young girls, very attractive, he's a bit of a, you know, he can have a laugh and jokes, so he's having a bit of, and I think it felt as though he just misinterpreted and was very clumsy in how... (P7, line 358-363)

However, other participants referenced more serious risk behaviours that are still present within their clients and posed a more serious threat:

> *And also, the way he was doing his searches changed because he would originally go onto google search, now he done it on his laptop on google search, and that got took away by the police. He then changed it to search via YouTube or through his phone, and that got found out, they both got took away, so he does change... (P8, line 490-493)*

> *...the risk is that he is still actively interested in children and he has got a very much child focused risk. (P7, line 27-29)*

> *...his carers will reliably say that every time a small child gets on a bus with him, they have to re-direct him to his iPad or his newspaper as he follows them around the bus [laughs]. That's absolute. He might be elderly, and he might well be slowing down, but you know I wouldn't leave him unsupervised with a child. (P7, line 248-252)*

Participants also highlighted both the advantages and disadvantages of having a **structure/ routine/ rules** in place to support clients' reintegration into community and how boredom can play a significant role in increasing risk behaviours within clients:

I think they like the structure it offers, and one of them definitely says it helps him feel that he is less likely do behaviour which is inappropriate because there is slightly more regulations within residential care, so their fine. (P2, line 45-47)

...you know I have been discharged from hospital, but effectively all it's changed is that I am in a bungalow in the community and I still can't go out, I can't do this, and I can't do that. (P7, line 585-587)

Yeah a few of the guys we have, if they didn't have the activities to go to then the risk of increased behaviours and inappropriate behaviours would definitely be there. (P2, line 228-229)

Participants also felt that clients found it difficult to communicate when they are struggling with sexual preoccupation or sexual thoughts/ urges and instead they are more likely to observe behavioural changes out of character, which would suggest that something is bothering them:

It is almost very normal signs of things going wrong, so silence, anger, but it can be body movements, it can be people being fidgety, anything that they not normally doing and then it is a case of we, you know, gently try and find out what's going on but to also to signpost again and sometimes talk to them about it, but definitely get in there first. (P4, line 368-372)

…if one of our client is displaying behaviours or use of language, we referred someone the other week, because he said something to the police when they were talking and he had used a term, simple term and that sent alarm bells ringing, and he said he had been "having a lot of thoughts of having fun with children", he uses the word "fun". Flags straight away, or he comes home from a day centre and he goes straight in the shower, flag. (P5, line 471-477)

1.4 Eligibility and limited resources

Across all participants there was a consistent theme regarding difficulties of **funding limitations** when working with a complex set of clients and this places further pressures among the staff to ensure that they adequately meet their care needs yet also manage any additional risk needs that these clients may pose to the best of their abilities:

Yeah they've got to save across the adult services, so at a time when demands are going up, we've got to save, so that'll mean yet more, and that's the problem, the needs for some, particularly for people I think with this combination, those needs don't rapidly change, you know, the idea of giving someone 6-12 weeks of intensive support and then cutting their package in half, which is how things are kind of perceived. (P7, line 775-780)

Participants also felt that there are strict guidelines in terms of **eligibility** for support under the Care Act. Many clients, that have both forensic and social care needs, unfortunately cannot be adequately supported with their forensic needs:

Ok so do you need help washing, do you need help [laughs], it doesn't allow for, oh by the way you know you've got a really unhealthy interest in children, that is not allowed for him in what they can assess, you know that's a problem. (P7, line 171-174)

Yeah it is, so that's part of it, I think then that's when the difficulty lies, because as social services we have our own Care Act criteria, to work within the Care Act, we have a criteria to meet eligible needs to meet the Care Act, there is no eligible need for risk to other people, so it's all about risk to yourself or things like that. So, then it's thinking a bit more creatively about how we can support that person because social services will not fund support to protect other people because that's not what we do, that should be a police power or PPU or whatever, so that's then where we have this difficulty about ok well how can we manage this and how can we be clear about what we are doing and what we paying for and funding essentially. (P11, line 185-193)

Theme 2: Personal

This theme highlights the different input that clients receive from close relationships around them, such as intimate, family and friends. It also highlights the input and support that can help clients towards their reintegration into the community.

2.1 Learning disabilities and vulnerability

Across participants they felt that the severity of the **client's LD** played an important role towards their reintegration into the community. They reported that it had a negative impact, as it often left clients open to **vulnerability**, mainly through financial abuse, from

members in the community who clients perceived as friends. Further clients found it hard to integrate into the community and be treated equally as other people:

> *Erm, well, I often find that people will socialise with other people, they like the idea I'm going to a nightclub or I'm going to the pub, it feels so it's, the people I work with want to obviously be independent adults and they want to do the same things that other people do, but have often found that they are not easily integrated into society or included in and feel a little bit like they don't know how to be with other people…(P1, line 282-287)*

> *I would imagine it would always be that he would have some form of support popping in, because he is very vulnerable from friends. The risk is that if he had somewhere on his own with no support, he would probably end up in the same situation that we met him which was people financially abusing him and you know all sorts of things going on so. (P3, line 921-925)*

Participants reported that the main thing clients wanted is to have a normal life like anyone else and do not want to stand out:

> *But yeah, I think it is always wants to be the same as anybody else, that's the big thing, we want to be in this sort of, relationship or not. And a lot of our clients do see that as the normal, which I suppose in life is that people get older, they meet somebody, they have a family, they have a house, they have pets. (P3, line 945-948)*

Erm, well I think anything that makes them stand out and feel like people are really noticing they've got a learning disability, so I have noticed that they don't like particularly going out in a group to go food shopping and coming back as a group…(P2, line 346-348)

Participants reported that community members did not want sex offenders to be reintegrated into the community, particularly within their neighbourhood:

I think keeping people in the community is probably just the sheer will of the people who support them, their families and you know the professionals around them at large, because although the community think they are up for care in the community, once they find out there's a sex offender next door and they have got additional needs or they have just got additional needs they don't want them there anymore. (P11, line 597-602)

A lot of the participants also felt that the client's sexual risks/ behaviour was a result of their limited understanding due to having a learning disability:

I think his was more a, he couldn't assess the individual's age at the time. And I think that's probably true with a lot people with a learning disability actually, they associate with younger people because I think they communicate better with the people that age, find them less intimidating potentially, erm, and I think that's where a lot of their problems come in to be honest. (P8, line 209-213)

2.2 Relationships

This theme was found to be an important one among the participants and consisted of relationships **intimately**, with their **family** and within **friendships**. Participants felt that the clients' intimate relationships served more than one benefit both in regard to their own relationship fulfilment and also reducing the risk of reoffending to meet those needs:

> *Now he's in an adult environment, erm, he's formed a relationship with one of his peers, it's a consenting, it's a safe relationship, it's a consenting relationship and actually I think I would guess, and I am guessing, because I don't have the knowledge, it feels like his risk has reduced because he is in a consenting you know full on relationship and that's seems to be meeting his needs to be it crudely. Certain people feel that he's less, appears to be the kind of predatory risky type behaviours of, like sneaking around and all that kind of, so seems to have reduced, so seems to be, and he's maturing in himself to be honest... (P7, line 297-304)*

> *And having a girlfriend, or the people I'm thinking of, erm they're all male and have somebody who's their girlfriend and a relationship with someone that cares about them is also important, I think. (P1, line 342-344)*

There was a trend in responses regarding support staff's anxiety to promote these **intimate relationships** with the fear that such individuals (i.e. with sexual risks) should not be in relationships:

> *...a lot of the providers they don't want to stop people but they are worried that they are going to get into trouble, because you allowing them, if you live in*

supported living are you going to get into trouble because you are allowing the lad to bring his girlfriend home who has also got a learning disability and they are going to be at it in the bedroom and oh my god what is going to happen. Well if you know that both of them understand it then that's not a choice, that's their room and if they want, we should be encouraging, and we have done that with people, we have arranged in the past like that people go stay in a hotel and they have done, and that's how it should be, encouraging, but people get worried they are going to get into trouble and even staff don't always see that this is an adult, he may have a learning disability but he's still got the same needs and wants to do the same things, you can't just say no. (P3, line 729-740)

Participants also felt that clients struggled to form relationships themselves and often misread signals placing them in risky situations:

Whatever it is, to do that in an appropriate way and just misreading people and not understanding and what is yeah, what is appropriate and inappropriate in whatever it is, how you interact with people and age appropriate and you know, these adults don't focus on the teenagers, how do you know whether somebody is an adult, it's not always easy nowadays. (P10, line 412-416)

Participants felt that the client's **relationships with family** could be beneficial, however at times they were perceived as a hindrance towards reducing their risks. Families were described as holding limited insight towards the client's level of risk and were too lenient

when the clients visited their homes. Most participants also reported that the majority of clients did not have contact with their families as a result of abusive upbringings:

> *Usually it's a negative effect I'm afraid. Erm, it's funny because I hadn't really thought about it, to try and think about all these people at the same time and that it does seem to be the pattern that families are either wanting money from them or erm, once, yeah, what's in it for them to have contact with them and they're not necessarily a good influence. They might have their own offending behaviours. But yeah in general I can't really think of anybody who has a massively positive outcome from being in contact with their families unfortunately. (P1, line 607-613)*

> *Erm, one of them very much values seeing his family and that's a really important part of his life. Erm, but they are also a big risk factor for him, erm, so when he has been staying with them in the past, they will put him in situations where he is more likely to offend or that would breach the conditions of his community treatment order and things like that. And they would not inform anyone about that, he would come back, erm, after having seen them and say oh I have been to the children birthday party, and it's like no what, why didn't you say anything. But he was not, erm, his family dynamic would not have allowed him to be assertive enough to say that this not okay, I need to leave this environment, so they were putting him in really risky situations. (P6, line 154-163)*

Obviously, some have had awful childhoods, awful upbringings and that is partially the cause of where we are, so that's not to have too much contact, so it is a very difficult strain normally relationship. (P4, line 261-263)

The **client's friendships** often tended to be on a superficial level, such that they were commonly being financially exploited rather than genuine friendships. Participants felt that the clients were particularly vulnerable to this risk and required staff monitoring to prevent this from occurring. Most clients considered the community team more as their friends. On the other hand, some participants felt that clients did try to make social connections either through their volunteering placements, jobs or social events but these friendships were very much limited within the learning disability population:

So, its minimal friendships apart from those who want to target them to get something from them and try to use them in some way. (P1, line 646-647)

But yeah, they have friends that, they sort of have round and things, and he has his work colleagues, so people he works with, people he goes to day service with…he had quite a group of friends that didn't have learning disabilities but were street wise lads and a little bit dodgy…They were hanging around causing problems and he often, he gets into a lot of bother about, his money…he gets so much and the amount of times they have given him money and he has a bought a bike and then a week later he sells the bike and often that is to friends and they are just using him…(P3, line 626-636)

Limited outside of their, there's limited friends, I would say, very limited. Most our clients tend to look to the carers as their peers and friends rather than their you know what we would perceive as their peers. (P7, line 839-841)

2.3 Client treatment

Participants highlighted that way staff treat clients, plays an important role in helping them to reintegrate into the community. Through positive staff modelling, they felt it helped the clients to build upon their **self-esteem** and promote their ability to secure jobs, relationships and **meaningful activities** as a means to better their future and help reduce further reoffending. This was through encouraging clients to be more **independent** and take on more responsibility, in a supportive yet safe way:

I think the service has been set up so that the staff team there, their role is to encourage him to be as independent as possible. So what they should be working on is getting him more into the habit of, this is your own house, you have to do certain things, whereas before he knew he had to clean his room and it was a bit like when you live at home and everyone nags me to clean my room and that actually getting him to think if you have your own place you are responsible for the cooking and the shopping and you've got to budget your money, you've got to keep things clean, do your washing, all the things, so it's just encouraging him little by little he's going to gain more independence hopefully. (P3, line 913-921)

The home where he is, because he says, he's very mild in terms of LD, the home have actually given him lots of opportunities which has been really good for his

self-esteem. They have encouraged him to do stuff and they have done stuff which initially we thought was risky. They have encouraged him to do college courses, which we were initially thinking oh that's risky, and they have done it and they managed it. (P7, line 305-310)

It's about building on his self-esteem and self-worth and things like that and his confidence. I think that's ultimately what will reduce his risk. That's what's crucial and it's about supporting it that works, it's about the meaningful activities. (P9, line 582-584)

Clients have benefited most from interactions with staff where they feel they can **trust** staff, staff are **honest** with them and where staff **treat them as adults**:

But it is also, I think probably being honest, this is why we are doing this, we are honest early and it's not just about protecting them but it's about protecting everyone around them, and we do not shy away from the fact that they have offended and what would happen if they re-offend, which is really serious for some. (P4, line 336-340)

Erm, so they managed to build that, that trust, with them and talk about how their feeling and erm, if they have got any concerns, erm, particularly the gentleman who lives by himself… (P8, line 219-221)

It has been a good experience for them. They need to be treated as adults. I think a lot of times they weren't treated as adults in the past, so actually being treated as adults, having that freedom… (P4, line 23-25)

Participants also reflected on the importance of encouraging support staff to avoid being too over controlling in regard to how they manage and support the clients. But rather, to encourage an appropriate balance of support and independence to manage their daily needs and risks:

It is about getting that balance, it's not about being over-restrictive, sometimes I feel the law expects social care, you know who's going to have a handheld person now to stop him reoffending, that's clearly not realistic is it. (P9, line 190-192)

…bit challenging and sometimes the staff do tend to make it feel like it's their house. It's the good ones that don't do that, so they always have to be reminded, people, some of the clients that we work with say that the staff don't remember that this is my house, I pay the rent here, but they are giving me all the rules, so it feels like, you've got to be much more enabling really in the way that they work, and yeah I think as soon as you start saying these are the rules of the house that, that's starts putting people's backs up because they don't feel consulted or involved and that has happened and that's where it's gone wrong really. (P1, line 187-194)

Theme 3: Environment

This theme highlights the benefits of clients accessing the community for leisure and employment purposes, both through support and themselves, to effectively reintegrate into the community. It also highlights the importance of their living environment to enable their resettlement into the community independently.

3.1 Access to employment/ volunteering

Participants spoke about the importance of **employment and volunteering** as it encourages clients to reintegrate into the community and help prevent future reoffending. It gives them structure and encourages a meaningful routine to engage in, which as a result helps distract them from the need to reoffend:

> *Yeah, so I know, a couple of the clients are you know they are keen to have jobs and they look for that. (P7, line 874-876)*

> *…but there's someone else who feels really good about the fact that they do voluntary work and that they're working and that they got a real focus and purpose and they feel valued by other people. (P1, line 328-330)*

However, the nature of the employment is one that staff would have to risk assess and ensure is safe for both the public and the client:

> *Yeah I mean that particular individual wants to get a job but it's all things such as working at the holiday camp and where there will be lots of young children, erm, and is really his main goal to get a job but as I say if he tries and said actually*

I need a job here, no I want to work at a holiday camp, what about this, he said no I want to work at the arcades, it's always in an environment where he will have access to children. (P8, line 521-526)

Participants felt that the main drive encouraging clients to get employment was in order to obtain **money**. Participants felt that the clients valued having their own money and being able to spend it freely on whatever they would like:

…so having access to their own money and being able to spend it when they want and say that's the things that are important to them and have the opportunities to go on holiday with support or any kind of activities or buying new clothes that sort of thing, having erm, people who help them develop a sense of worth and they feel valued by…(P1, line 707-711)

However, unfortunately, participants reported that clients struggled to secure employment as a result of having a learning disability and even more so for those with additional forensic risks as well:

Employment is you know, is very difficult, any meaningful kind of employment, paid employment is one that is non-existent, and an awful lot of effort goes into trying to get people to get paid employment but realistically it just doesn't happen. (P7, line 469-472)

…my first port of call to develop some work is let's look at some voluntary work and he's come straight back to me and said I am not sure about this and we need

to look at his risks, so straight away it's shut down, straight away. (P9, line 219-222)

Participants spoke about their attempts to **support clients into employment and volunteering** as well as through transition schemes offered by day centres or through the newly set up employment advisors:

And [name of county] have just re-vamped their employment service within learning disability, so that's, they have got their focus there and the day services we access, and now we have got more work based focused stuff. I mean the guy who just got this 14-hour job recently, that is through the day service he attends. They supported him and started him up and supported him to apply for some jobs. (P2, line 775-779)

3.2 Access to community/ future planning/ goals

The participants reported that clients engaging in **meaningful activities**, such as accessing the community, clubs, day services, going on holidays (mostly local) helped structure their day to allow them to feel as though they are contributing to the community. Further, this was perceived to help prevent clients from displaying reoffending behaviours, which often stemmed from boredom:

And the guy in residential goes to day service, I think 5 days a week. He gets the bus and goes to a day service, I am trying to think where he goes, I think he goes to [name of company] which is a small factory type setting where they do

carpentry and jewellery making, all sorts of stuff. So, he is out 5 days a week getting the bus and back. (P3, line 293-297)

And they still enjoy, erm, going out with staff as well and I suppose thinking about the residential ones and the supported living, they have staff holidays or staff support or facilitate holidays so most of them go on holiday as well and they have days out and go to, oh, what else are they into, truck fairs, and you know, what's the name of the green lorries, Stobart, Eddie Stobart, you know they went to that thing, and they go to events related to that. Erm, big keen fans. (P10, line 150-155)

Some participants felt that the range of activities and opportunities available for individuals with a LD is limited and that more could be offered:

…so, they're limited, it's not like as good as it could be, the college isn't brilliant I don't think for people, and erm, so it does tend to be those sorts of things and that getting into voluntary work really is the most. (P1, line 238- 240)

Participants also reported that clients working towards **future goals** helped promote their reintegration into the community and gave them a sense of purpose. Many of the responses, regarding future goals, consisted of clients wanting to "*live in his own flat, wants to be independent, wants to have a girlfriend, he wants to have a family" (P3, line 902-903)* and finding paid employment:

…well one of them keeps telling me he wants to get married and have children and settle down and have his own family that's what, that's quite a proportion of them actually, over half of them just want an ordinary life where they've got a place of their own. They do tend to say they want to get married and have children, in fact I can think of three who do say that, so an ordinary life really is what people want and to be part of, erm, you know, some people don't necessarily want to get a job, but they do want an ordinary life and they, I think, erm, yeah I think that's mostly the goals for life, is to have an ordinary life and settle down and have a family. (P1, line 860-867)

I think on the whole, find work actually get a job and their own money. Say goodbye to us lot. In a sad way, they don't, with the gentleman at the moment we have just helped him, he has got a two day job, last month he got his first month wage check and never seen anyone so happy in his life, so that is primary the goal for them. They want to get away from where they are, have that complete independence and move on. (P4: line 389-394)

Despite responses indicating that clients aspired to be more independent, participants felt that the majority of the clients required ongoing **staff support with accessing the community**, helping out with day-to-day functional things such as budgeting their money (*"If he has money, he will just spend it….Yes, so the support is more around sort of financial budgeting, paying bills" (P3, line 813-817)* , prevention from being financially exploited, shopping and bus timetables as well as **support to achievable targets in attaining their future plans**:

...so there's particular people who I can think of who do need a staff member to go with them but it's more for functional things like because they need assistance when they are going food shopping or with their money and erm, how much they are going to spend when they are there. Erm, or that they don't feel able to plan and execute something on their own. Even leisure activities, erm they might be able to go walk into the local shop or you know go nearby, but in terms of actually us making arrangements to do something with their time they maybe need support with that. (P1, line 27-34)

...some people will be like oh I want like [laughs] here, living in residential care with loads and loads of support, I want to live by myself, and you're like okay there are like 50 steps between that and this, so what are we going to focus on first and you'll sit down with them and go through goals and stuff with them and then some people like we talked about, that day their goal is to get to the end of it. (P11, line 753-758)

But yeah, it is the glue that sticks it all together really is the staff are helping them organise it and get them there and make sure they've got enough money and all those sorts of things that makes it work. (P1, line 674-676)

3.3 Living environment

Responses across participants illustrated that the client's living environment also played a positive factor in supporting their reintegration into the community. All of the participants' clients **lived with others** and this was either through living in supported

accommodation with other individuals with a learning disability, with family or a partner. Participants spoke about the importance of making the clients' **living environment as much of a home** as possible, particularly for those individuals who have come from quite neglectful backgrounds in order to help them achieve stability and eventually move forward in their lives:

> *As a six bedded unit and it's designed to be as much of a home as possible. So, for them it's my house, it's your home, so it is a home environment. (P5, line 10-11)*

> *They all live with other people. Yeah. Like I said, the ones who live with family and also the one that lives in his own flat now, he lives with his girlfriend and yeah, so nobody lives, they all live with. Nobody lives alone alone. (P10, line 88-90)*

Participants reflected on understanding the frustration and the difficulties of managing a house of individuals with LD that did not choose to live with one another:

> *I think their biggest achievement is the fact that they are living in the same house and there has never been any violence. I think that, that is a huge thing to see for completely split personalities, completely different likes, tastes, dislikes, histories, family's backgrounds, to be thrown together and not, they will sort like occasionally socialise and play games… (P5, line 600-604)*

Participants also highlighted that clients living in these community set ups, would generally reside in such accommodations for a long period of time before they are

gradually transitioned forward. This was down to a number of factors, namely being either the client themselves were not ready to move and were comfortable in the set up that was arranged, clients not wanting more responsibilities or due to the fact that they were assessed as not being suitable to move on as a result of their extensive care needs and risk needs:

> *Obviously, the gentleman who has just moved in with his girlfriend, that was recent, but prior to that he has been in the service many years, he has been known to [name of psychology staff member], she knows exactly who I mean. He lived there for a quite a few years. The other gentleman who has just gone into re-ablement service, he was in his previous supported living for probably about 7 or 8 years and he's only moved there in the last few months, and the guy in residential has been there at least for the last 5 years. (P3, line 54-60)*

Participants spoke about the benefits of the **reablement/ enablement service** that has recently been set up in the community to help encourage and promote reintegration for clients with a LD through teaching them skills to live independently and eventually move into independent accommodations:

> *We have, in [name of town], we have recently set up an Enablement Service, so we have got 5 individuals whose plan is to live in a home, for this house for 2 years and they will skill themselves up to move into their own flat. So, I go review them every 6 weeks, so we have an action plan every week, every 6 weeks, what one thing are you going to try and do by yourself for the time I come back next time. So, it might just be washing up that someone don't need to remind me to*

wash up coz I will do it, you know stuff like that, so it's just skilling people up. (P2: line 697-704)

Discussion

This study set out to explore staff's perspective of factors promoting the reintegration of their clients (sex offenders with a LD) into the community and as a result prevent reoffending behaviours. Three main overarching themes were discovered, which were *Professional*- input from differing professional networks around the client, *Personal*- close relationships around the client as well as the clients own ability to rehabilitate into the community and *Environment*- the living environment and services available to clients to resettle into the community independently.

Professional

There is a vast amount of evidence within the literature indicating the efficacy of sex offender treatment in reducing recidivism (Gallagher, Wilson, Hirschfield, Coggeshall & MacKenzie, 1999, Hanson, Morton & Harris, 2003; Illescas & Genovés, 2008;), however there is limited evidence highlighting the effects of treating sex offenders with a LD in the community (Langdon, 2010; Murphy et al., 2010). The results suggest that providing clients with adapted versions of sex offending treatment groups within the community, which encouraged victim empathy, building appropriate relationships and sex education, helped the clients gain insight towards their offending behaviours. Jennings and Sawyer (2003) reported that group therapy has been recognised globally as the treatment mode of choice with sex offenders, and this supported P10's comment *"…but there is something different between doing a group and be with two or three others or having that individual work or people have had a combination of the two" (line 364-365).* Clark and Erooga (1994) found that this type of treatment helped to enhance the rehabilitation process through *"facilitating the breakdown of denial, increasing motivation to change,*

encouraging the development of interpersonal skills and by providing clients with a safe, supportive…environment" (p.70).

The results found that some clients were under court orders/restrictions and these hindered access to certain activities in the community, which impacted their ability to reintegrate into the community, as supported by Day, Carson, Newton and Hobbs (2014, p.180). Lindsay et al. (2002) found that court ordered treatment did help to promote an individual's participation in treatment. However, Mandeville-Norden and Beech (2004) reported that many offenders who have committed low-tariff offences may not be ordered to engage in community therapeutic intervention, due to the non-serious nature of the offences. The results suggested that some clients were not subject to such orders/restrictions, making it more difficult to motivate engagement with treatment:

> *I would try and make these psychological interventions a, registered, erm, thing so that if he doesn't go, he can be recalled to prison, a registered activity I think and PPU were like and probation were like we can't do that. Can we just ask, because if we can do that and he knows he has to go to these sessions, it may be that he will then start to engage, you know, through the fact that he is just having to be there. (P11: line 309-314)*

Beech, Frienship, Erikson and Hansom (2002) found that Cognitive Behavioural Treatment was more effective in reducing recidivism than just probation supervision alone. However, the participants identified that it was difficult to run adapted groups due to a limited number of LD individuals presenting with sexual behaviours at one time.

Birgden, Owen and Raymond (2003) reported that positive staff attitude is important in reducing offending behaviour as this can promote relapse prevention to succeed. The results supported this finding and found that having a positive network of professionals around the clients was beneficial as this allowed them people to talk to and help explain things that perhaps had led them into trouble in the past. Further, the relationship between staff and clients was more effective when staff were familiar with their clients' histories. However, on the other hand, the results suggested the issue of clients becoming overly dependent on services, which can lead clients to become comfortable within the arrangements set up and hinder their ability to progress independently. It was also suggested that this perhaps stemmed from clients experiencing abusive and chaotic upbringings (Tewksbury & Connor, 2012).

Positive staff attitudes were also evident in the relationship between the police, staff and the clients. Participants reported that the input from the police was both supportive and authoritative towards the clients to help prevent them from reoffending and would relay information sensitively to the LD clients. Further, they reported that the working alliance between themselves and the police was positive, whereby both agencies worked collaboratively and shared expertise in managing the client's risk behaviour. These findings differ from what the literature suggests regarding attitudes of authoritative figures (i.e. the police), which is that they tend to often be more stereotypical and negative towards sex offenders (Lea, Auburn & Kibblewhite, 1999).

The results highlighted the importance of the input from forensic experts working alongside the community team, specifically for clients with active sexual risks, as the

community team felt they did not have the expertise nor training to manage client's offending behaviour. Day et al. (2014) evidenced that there tends to be a lack of communication between services, and it often feels one-sided, which as a result leaves a lot of pressure on support workers and other members of staff, who have no training in forensic knowledge, to prevent further risk. Further, this supports the findings from Vaughan et al. (2000) whereby they also found that there was an issue in appropriately accommodating LD individuals with sexual offending behaviours into the community and a need for more support from specialist services to community providers, which was often not achieved through a lack of communication.

Despite the introduction of forensic services, participants felt that the input being offered was limited and more was required from these specialists in order to manage higher risk individuals presenting imminent risk to the public, who currently were being managed through higher packages of support. Further, participants expressed that the management of client's risk was not something they were funded to do under the Care Act but rather the responsibility of the police and probation. However, they would often find themselves in situations whereby they were required to manage the risk and this left participants feeling under pressure to prevent reoffending.

English, Pullen and Jones (1997) emphasised the importance of collaborative interagency teamwork to provide effective management of sex offenders in the community. They reported that collaborative teamwork can help to achieve better communication, facilitate information sharing, help exchange expertise, reduce the same work being done and finally help to reduce staff burnout. The results supported these findings in reference to

the internal teamwork being carried out within the integrated community LD team and to some extent the benefits of working alongside forensic specialists, probation and the police. However, participants felt that input from agencies such as probation were limited regarding risk management of clients and in fact duplication of work (i.e. in the form of risk assessments) was still occurring.

Personal

Abbott and Marriott (2013) reported that recently the Government is moving towards ensuring that people with a LD are able to lead their own lives and be provided the same opportunities as anyone else. The results support this finding and found that most clients want to live ordinary lives within the community and do not want their LD to stand out. Isherwood, Burns, Naylor and Read (2007) also reported similar findings and highlighted that participants wanted a normal life, which could be achieved through a routine and having activities to keep them occupied in order to prevent them from getting into trouble.

Further the results found that the client group where highly vulnerable from being financially exploited, which the clients misunderstood as genuine friendships. This was also supported in the study by Isherwood et al. (2007) in which responses from participants suggested that their peers were often central towards encouraging them to offend and took advantage of their LD.

Participants, despite wanting clients to have control and access to their own money, reported being concerned about the risk of clients being financially abused by members of the public. Therefore, they felt that clients would need on-going support to help them manage their finances. This was supported in Abbott and Marriott's (2013) study,

whereby there were concerns by staff of exploitation and financial abuse among individuals with a LD as well as safeguarding issues on daily tasks. They further found that more than 50% of individuals with a LD fail to have control of their own money and Suto, Clare, Holland and Watson (2005) reported that by providing individuals with education and support, it can facilitate them in making their own financial decisions.

The literature highlights that the public's attitude towards sex offenders is generally negative and more punitive than other types of offenders (Harper & Hogue, 2015; Higgins & Ireland, 2009; Hogue, 1993; Johnson, Hughes & Ireland, 2007). The public often push for longer sentences and are not keen for sex offenders to reintegrate into the community, particularly within their neighbourhood (Burchfield & Mingus, 2008). The results supported this finding with one participant highlighting this in their response:

> *…because although the community think they are up for care in the community, once they find out there's a sex offender next door and they have got additional needs, or they have just got additional needs they don't want them there anymore. (P11, line 599-602)*

The majority of the participants also considered that the client's risk of sexual behaviours/ offending is most likely due to their LD, such that the clients have limited insight towards their offending behaviours and lack sexual knowledge (supported by Michie, Lindsay, Martin & Grieve, 2006).

Participants further reported that close relationships around the clients played different roles and varied in regard to their effectiveness in promoting reintegration into the community. Tewksbury and Connor (2012) reported that strong family support acts as an important factor for sex offenders. However, the results suggested that family often played a negative role towards the reintegration of clients into the community. Most family members either had no contact with the clients, and for those who had contact, did not adhere to restrictions that were implemented to manage the client's sexual risk, therefore placing clients in high risk situations and increasing chances to reoffend.

In regard to friendships, there were mixed responses, with some participants reporting that clients were encouraged to build their own social networks to help them reintegrate into the community. Some clients were able to develop meaningful social networks, either through people they met in day centres or arranged social events. However, most of these friendships were limited within the LD population and perceived as just acquaintances.

Client's intimate relationships was reported as an important factor. Research suggests that intimate relationships can promote a sense of security and emotional comfort within individuals and can provide benefits such as resilience to stress, improve self-worth, mental and physical health (Fehr & Perlman, 1985). Further, Marshall (1989) suggested that failure to develop appropriate intimate relationships can lead to loneliness, hostile attitudes and aggressive behaviour. However, participants reported that clients struggled to form appropriate relationships as a result of their LD or due to limited opportunities to meet someone. Those who had managed to form consenting relationships demonstrated less riskier behaviours.

Another difficulty was due to support staff's anxieties to promote these relationships as they were worried, they would get into trouble. Craft (1987) reported that the most common myths regarding sexuality are found among the LD population, such that they are often perceived as being like children or sexually inappropriate and therefore, deprived of their ability to form intimate relationships. Further, Rohleder (2010) reported that caregivers who have to work around sex and sexuality among individuals with a LD can cause an increase in anxiety, due to the fear of harm being caused to others and in order to safeguard the individual's vulnerabilities.

Staff reported that clients appreciated more freedom, independence, trust, being treated as adults, honesty from staff and to be motivated into engaging into activities that enhanced their self-worth and self-esteem. Gibbson (1991) defined empowerment as a "*social process of recognising, promoting and enhancing people's abilities to meet their own problems and mobilise the necessary resources in order to feel in control of their own life"* (p. 359). Further, Jenkins and Davies (2006) reported the encouragement of client autonomy for people with intellectual disabilities. As a result, participants felt that by enabling clients in this manner it helped reduce their risk. This is supported within the literature through the Good Lives Model (Ward & Gannon, 2006) which promotes the *"enhancement of offenders' capabilities to attain primary human goods*" in order to reduce their need to revert to offending behaviours (p.79).

However, participants also highlighted that staff can become over controlling and need reminding to foster an appropriate balance. Malin (1997) reported that staff can fall into a trap between their caring role and promoting freedom for clients. Therefore, it is

recognised that staff can struggle to identify whether individuals have the ability and insight to make their own informed decisions (Jenkins & Davies, 2006).

Environment

Participants reported that gaining employment was an important factor across all clients and it created a meaningful purpose as well as an opportunity to reintegrate into the community. The literature supports this finding as employment has been recognised as a positive factor that encourages community adjustment as well as demonstrating that it reduces recidivism (Darakai, Day & Graffam, 2017; Laub & Sampson, 2001).

Participants further reported that the client's main driving factor to acquire employment was in order to obtain money. Due to receiving limited finances through their benefits, clients wanted to make more money through employment and have the freedom to spend this wherever they wished. Emerson, Malam, Davies and Spencer (2005) reported that the majority of people with a LD do not have control over their money and it is often someone else's responsibility to decide how much they can spend. This often is a result of assuming that people with a LD find it difficult to conceptualise money (Williams, Abbott, Rodgers, Ward & Watson, 2007).

One of the biggest issues reported by participants was the difficulties for people with a LD to secure employment, regardless of their offending history. Boardman, Grove, Perkins and Shepherd (2003) reported that individuals who accessed mental health services were more likely to encounter barriers to obtain employment, however those with severe learning disability were found to be the most disadvantaged. Copeland, Chan,

Bezyak and Fraser (2010) reported that prejudicial attitudes from employers acted as a barrier towards the employment of people with a LD.

Participants spoke about supporting clients into finding employment or volunteering opportunities and the importance of this for their client's reintegration into community. They highlighted a new service set up to help clients' transition to become more independent as well as help them to secure employment through work schemes set up through employment advisors. On the whole, participants identified that the client's transition through supported accommodation was gradual and could take many years before they were assessed as being independent enough to live alone.

Participants also reported that for some clients, having a routine and structure in place helped prevent boredom which has been shown to increase risk of reoffending behaviours. This was facilitated by staff who supported clients to access the community, arranging group trips, holidays and helping to set up access to day centres. This was supported in Isherwood et al. (2007) study, whereby a preference to having routine and structure was identified and the placement helped achieve this through arranging different sessions to keep the participant engaged, which ultimately prevented them from reoffending.

Participants reported that future planning and setting goals was also carried out during the client's annual review and this was found to be beneficial in motivating clients to work towards a goal such as gaining independence. This was supported in a study by Cott (2004) whereby they stated that active involvement of clients should be encouraged, allowing them to set important goals, outcomes and priorities with their health care

professionals. Participants reported that the majority of clients expressed that their main goals for the future centred around wanting their own home, having a girlfriend/partner and securing paid employment.

Recommendations

The findings from this study have identified a number of areas that require future research. Each of these will be discussed below.

Clinical implications

The results demonstrated that there is an apparent conflict and uncertainty in roles regarding the risk management of individuals with a LD that present sexually harmful behaviours. The integrated team, specifically social care, are only commissioned and funded to manage the care needs of the clients under the Care Act, however participants felt that there are times whereby they are expected to prevent reoffending behaviours and this is an area they are not trained in or have the professional expertise to do.

Furthermore, the results demonstrated that there is not enough forensic service input and there continues to be a lack of communication between the different agencies involved in managing the risk of these individuals within the community. Therefore, this research highlights that there is a need for the different services to review their responsibilities and be clear on their roles. It also highlights the need to extend the parameters of eligibility/ criteria assessment of the client's care needs by revising the Care Act to incorporate 'risk towards other' as an additional criteria. This team is a unique collaboration of social care and mental health, therefore it can be argued that an extension in roles/ parameters of care

should be facilitated in order to ensure the most effective care for clients and public protection.

In order for this to be effective, all staff should be offered more training and education to work with sex offenders with a LD, particularly around risk management in the community. This was highlighted as a need from the current research, whereby staff felt they lacked forensic knowledge to work with this particular client group and is supported in the literature (Sandhu et al., 2011).

Future research

This research focused on gaining staff's perspective of factors that promoted the reintegration of sex offenders with a LD into the community. Therefore, there is room for future research to be carried out in which clients are directly interviewed and asked what they believe is helping them to reintegrate into the community and as a result prevent reoffending behaviours. The results also found that it is very difficult for LD sex offenders to acquire employment, therefore further research can be done to investigate the factors preventing this particular client group from securing employment and how this can be mitigated to help promote their reintegration into the community. This research used qualitative methodology to address the aims of this research, therefore future research using quantitative methods would be beneficial to statistically support the findings within this study.

Strengths and Limitations

A strength of this research is that this type of qualitative study is the first of its kind to investigate factors promoting the reintegration of sex offenders with a LD into the community. A further strength is that the participant group was a mix of professionals, which ensured that a diverse range of perspectives could be obtained, and this prevented a single professional group to dominate the responses and perhaps skew the analysis. Another strength of this research is that participants were recruited on the basis that they had more than a year's worth of experience working with sex offenders with a LD and this ensured that participants had a wealth of experience working with this client group to get the most accurate perspectives.

A limitation of this research lies within the methodology of using thematic analysis due to the fact that participants' responses and the author's own analytical interpretations were subjective and therefore provide no causality between the participants' responses and the aims of this research. Another limitation of this research is the lack of using triangulation methods, such as tree graphs and concept mapping, which help to increase the validity and reduce subjectivity of the qualitative methods used (Jonsen & Jehn, 2009).

To conclude, this research set out to investigate staff's perspectives on factors that are promoting the reintegration of sex offenders with a LD into the community and as a result reduce reoffending behaviours. Three main overarching themes emerged from the analysis; Professional, Personal and Environment. A number of key clinical implications were identified and future areas of research that would be beneficial to understand this area and better manage working with this client group.

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III

PUBLIC DOMAIN BRIEFING PAPER

META-ANALYSIS:

DO PEOPLE WANT SEX OFFENDERS TO REINTEGRATE INTO THE COMMUNITY?

The term **"sex offender"** can invoke feelings of **"anger, disgust and fear"** among the general public (Olver & Barlow, 2010). The public tend to hold **negative views about sex offenders** (Levenson, Brannon, Fortney & Baker, 2007) and stereotypical views which often stem from **sensationalised media reports**.

Why is this important?

- The public's opinion plays a major role in creating policies to manage sex offenders in the community (Shackley, Weiner, Day & Willis, 2014).
- Negative attitudes towards sex offenders and placing stricter measures on them has shown to increase the risk of them reoffending again (Tewksbury, 2005).

What am I trying to research?

- **Understand people's attitudes** towards the reintegration of sex offenders into the community.
- Are there any differences in attitudes based on;
    - The **continent** they come from.
    - The **sample group**: professionals vs general public
    - Do attitudes change over the **years**

How did I do this?

- A review of all the literature available using the **Community Attitudes Towards Sex Offenders (CATSO) scale**.
- Only **11 papers** were found eligible for this research.

What did I find?

- A definitive conclusion was not possible as all the papers found very different results due to the limited amount of papers available in the literature.
- Therefore, results were interpreted with caution.
- **People's attitudes towards sex offenders:**
    - Scoring on the CATSO scale: Scores range from **18 to 108**, with higher scores indicating more negative attitudes
    - Overall, participants scored approximately **56**- which suggests their attitudes towards sex offenders lie in the middle
- **Differences in Continent, Sample Group and Year:**
    - No reliable findings were found across these groups

Recommendations

- Further research using the CATSO scale and ensure that all data from the scale is reported.
- Further research using more professional samples to understand attitudes- this is limited in the literature.
- More training and education to the public through professionals working with sex offenders to ensure accurate and evidence base knowledge is shared.

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EMPIRICAL PAPER:

REINTEGRATING SEX OFFENDERS WITH A LEARNING DISABILITY: STAFF'S PERSPECTIVE

In 2012, the maltreatment of learning-disabled (LD) individuals in **Winterbourne care home** led to the development of a Government initiative, **"Transforming Care"** (Department of Health, 2012). As a result, there was an **increase in the transfer** of clients with a **LD** from **secure settings into the community**.

Why did we do the study?

- All sex offenders with a learning disability will eventually return to the community.
- Vaughan, Pullen and Kelly (2000) found moving LD individuals, particularly those with sex offending history, into the community was not as straight forward and finding appropriate accommodation proved difficult
- Currently, there are very limited initiatives available to promote reintegration of sex offenders with a LD into the community

What did we want to find out?

- What are the positive factors that promote reintegration of sex offenders with a LD into the community?
- Do these factors also help sex offenders with a LD from reoffending?

How did we do this?

- Interviews were conducted with 11 staff members about their experiences of working with sex offenders with a LD in the community
- Interviews were audio recorded and transcribed in order to identify common themes and patterns among the responses to answer the research question.

What did we find?

- Three main overarching themes identified were: **Professional, Personal** and **Environment** (see Table 1)

Table 1

Demonstrating the three main overarching themes and the sub-themes within them.

PROFESSIONAL	PERSONAL	ENVIRONMENT
Managing and Preventing Offending behaviours	**Learning Disability and Vulnerability**	**Access to employment/volunteering**
Access to Forensic Expertise	**Relationships**	**Living Environment**
Eligibility and Limited resources	**Client Treatment**	**Access to Community/ future planning/ goals**
Impact of staff input		

What does this tell us?

- **Professional** (see Table 2):

Table 2

Results from Professional Theme

PROFESSIONAL
Psychological treatment and sex education were seen as beneficial.
Court orders and restrictions were both useful in some respects but also could hinder reintegration into the community.
Positive staff attitudes towards the clients were beneficial and allowed them someone to talk to. However, risk of clients becoming over dependent on services and staff as a result.
Good network of professionals and support around the clients.
However, there is a lack of communication between social care and criminal justice services to manage clients' risk.
Forensic specialists' input was very beneficial, particularly to aid with the management of risk in these clients. However, felt more was required.

- **Personal** (see Table 3):

Table 3

Results from Personal Theme

PERSONAL
Clients want ordinary lives and don't want to stand out.
Highly vulnerable to financial abuse Community not overly optimistic on reintegration of sex offenders with a LD.
Client's risk behaviour is a result of their LD and lack of insight towards their offending behaviours.
Family are mostly a negative impact, friendships are mostly within their LD population or superficial (financially exploited) and the clients struggle to form intimate relationships due to lack of opportunity as well as anxieties from support staff.
Client's appreciate more freedom, independence, trust and being treated as adults to improve their self-esteem.
Staff can be over controlling at times.

- **Environment** (see Table 4):

Table 4

Results from Environment Theme

ENVIRONMENT
Securing employment was the biggest factor that all clients wanted as well as having their own money to spend.
However, securing employment for these clients was very difficult.
Initiatives to help clients find jobs through work schemes and encourage independence through Enablement Service was beneficial.
Routine and structure were found to be both helpful- such as prevented boredom and reoffending, however also a hinderance- such as preventing them from being independent.
Future planning was positive for reintegration with the most common goals being: having their own home, a job, money and a partner.

Recommendations:

- Clinical implications include: Lack of communication between services, uncertainty of responsibility between services to manage the risk of reoffending and need for more forensic training and education for staff
- Future research: interview the clients directly to get their perspective on what is helping them to reintegrate into the community and the use of quantitative methods with the hopes to support these findings

For further information you can contact the author:

✉ [redacted]

linkedin.com/in/fajar-fawad-726a42111

References

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APPENDICES: META-ANALYSIS

Appendix A: Data extracted from the studies

Study	Country	Sample Group	Sample Size	CATSO Scales Used	Means (Standard Deviation)
Chui et al., (2015)	Hong Kong	Community sample	202	• Social Isolation • Sexual Deviancy	3.63 (1.13) 4.04 (0.96)
DeLuca et al., (2018)	USA	Community sample	518	• CATSO Total Score	59.94 (10.89)
Höing et al., (2016)	Europe	Community sample	1,874	• Social Isolation • Capacity to Change • Severity and Dangerousness • Sexual Deviancy	3.8 (1.04) 4.24 (1.2) 2.76 (1.14) 3.93 (1.17)
Jung et al., (2017)	USA and Canada	Community sample and University students	844	• Social Isolation • Capacity to Change • Severity and Dangerousness • Sexual Deviancy	2.68 (0.70) 2.96 (0.84) 2.60 (0.43) 2.73 (0.66)
Kerr et al., (2018)	United Kingdom	Professional	77	• CATSO Total Score • Social Isolation • Capacity to Change • Severity and Dangerousness • Sexual Deviancy	62.56 (8.76) 3.57 (1.21) 1.96 (0.59) 5.76 (0.7) 3.05 (1.17)
Malinen et al., (2014)	New Zealand	University students	29	• CATSO Total Score	57.9 (9.09)

Rogers et al., (2011)	United Kingdom	Community sample	235	• Social Isolation • Capacity to Change • Sexual Deviancy	2.73 (0.75) 3.3 (1.07) 3.14 (0.77)
Rosselli & Jeglic (2017)	USA	University students	559	• CATSO Total Score	55.03 (8.94)
Shackley et al., (2014)	Australia	Community sample	484	• CATSO Total Score	53.11 (10.15)
Spoo et al., (2018)	USA	University students	862	• CATSO Total Score • Severity and Dangerousness • Sexual Deviancy • Social Isolation • Capacity to Change	54.09 (8.88) 2.96 (0.51) 2.93 (0.76) 3.12 (0.87) 2.99 (0.91)
Willis et al., (2013)	New Zealand	Community sample	401	• CATSO Total Score • Social Isolation • Capacity to Change • Severity and Dangerousness • Sexual Deviancy	54.54 (9.5) 2.8 (1.16) 3.36 (1.55) 2.96 (1.83) 2.94 (1.38)

Appendix B: Quality Criteria

Risk of Bias	Definition	Low Risk of Bias	Unclear Risk of Bias	High Risk of Bias
Selection Bias	Selection bias in epidemiological studies occurs when there is a systematic difference between the characteristics of those selected for the study and those who are not. It also occurs in intervention studies when there are systematic differences between comparison groups in response to treatment or prognosis. Intervention studies are especially susceptible to selection bias unless particular efforts are made to minimise it. Randomisation cannot be applied to observational studies or within-subject intervention designs and the effects of selection bias in these studies should be	The source population is well described, and the study reports the characteristics of the sample. For example, age, occupation, ethnicity, gender, highest education qualification and been a victim or know someone who has been a victim of sexual abuse. The recruitment method is clearly reported and well defined. For example, where and how the participants were recruited and country the study took place in. Participants were recruited from a community sample. For	The characteristics of the study population are not clearly reported, or some characteristics are not reported. The recruitment process of individuals is unclear. Target sampling was used. For example, participants recruited were students or professionals.	The characteristics of the study sample are not reported. The recruitment process of individuals has not been reported.

	considered and, potentially, penalised.	example, members of the public.		
Detection Bias	Detection bias refers to whether the design of the study is optimised to detect the effect in question. Ratings of design bias shown therefore reflect the position of the study design within the hierarchy of possible designs, with less optimal designs receiving some penalty.	The outcome measure is clearly defined. For example, stating the author of the CATSO, how many items are in the measure, what the measure assess, the different scales, and how the measure is rated (i.e. using a 6-point Likert scale). Cronbach alpha has been reported indicating validity and reliability (above 0.7) for the full outcome measure.	There are some definitions of the outcome measure used. Cronbach alpha has not been reported or has only been reported for some subscales.	The outcome measure is not clearly defined. The outcome measure used had poor reliability and validity reported- Cronbach alpha score was below 0.7.

Reporting Bias	Reporting bias refers to systematic differences between reported and unreported findings. Within a published report those analyses with statistically significant differences between intervention groups are more likely to be reported than non-significant differences. This sort of 'within-study publication bias' is usually known as outcome reporting bias or selective reporting bias and may be one of the most substantial biases affecting results from individual studies (Chan 2005).	All descriptive and/or summary statistics are presented. For example, providing the means and standard deviations of the total CATSO scale as well as for the individual 4 subscales. Displayed data in figures or tables. For example, results of the CATSO and demographics of the participants. The outcome measure has been consistently implemented across all participants.	Reported only some of the descriptive and/or summary statistics. For example, it only reports means and standard deviations for some of the subscales. Reported only some of the data in figures or tables. For example, either only the CATSO scores or participant demographics. It is not clear if the outcome measure has been implemented consistently across all participants.	Not reported descriptive/summary statistics of the outcome measure. For example, no evidence of means and standard deviations across the CATSO. Data is not displayed in figures or tables. Outcome measure has not been consistently implemented across all participants.
Generalisability	Generalisability describes the extent to which research findings can be applied to settings other than that in which they were originally tested. This includes any differences between the study participants and	Sufficient sample for generalisation and representative of target population. For example, a population size greater than 100.	Sufficient sample for generalisation but with some idiosyncratic features. For example, a sample size between 30-100.	Small sample with or without idiosyncratic feature. For example, a sample size less than 30.

	those persons to whom the review is applicable.

APPENDICES: EMPIRICAL PAPER

Appendix C: University of Birmingham Research Ethics Committee Approval

UNIVERSITY OF BIRMINGHAM

FINANCE OFFICE

Miss Fajar Fawad
School of Psychology
University of Birmingham

20 May 2019

Dear Miss Fawad

Project Title: **Staff's experience of factors supporting LD sex offenders in community**
IRAS ID: **259816**
Sponsor Reference: **RG_19-011**

Under the requirements of UK Policy Framework for Health and Social Care Research, the University of Birmingham agrees to act as Sponsor for this project. Sponsorship is subject to you obtaining a favourable ethical opinion, HRA approval and NHS R&D management approval where appropriate.

As Chief Investigator, you must ensure that local study recruitment does not commence until all applicable approvals have been obtained. Where a study is or becomes multi-site you are responsible for ensuring that recruitment at external sites does not commence until local approvals have been obtained.

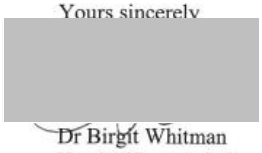
Following receipt of all relevant approvals, you should ensure that any subsequent amendments are notified to the Sponsor, University REC, HRA and relevant NHS R&D Office(s), and that an annual progress report is submitted to the Sponsor, University REC and NHS R&D departments where requested.

Please ensure you are familiar with the University of Birmingham Code of Practice for Research (http://www.birmingham.ac.uk/Documents/university/legal/research.pdf) and any appropriate College or School guidelines.

Finally please contact researchgovernance@contacts.bham.ac.uk should you have any queries.

You may show this letter to external organisations.

Yours sincerely



Dr Birgit Whitman
Head of Research Governance and Integrity

cc: Dr John Rose (Academic Supervisor)

University of Birmingham Edgbaston Birmingham B15 2TT United Kingdom
w: www.finance.bham.ac.uk

Appendix D: NHS HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Fajar Fawad
University of Birmingham
School of Psychology
Edgbaston
Birmingham
B15 2TT

Email: hra.approval@nhs.net

18 September 2019

Dear Miss Fawad

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Staff's experience of factors supporting sex offenders with a learning disability in community settings**
IRAS project ID:	**259816**
Protocol number:	**RG_19-011**
Sponsor	**University of Birmingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **259816**. Please quote this on all correspondence.

Yours sincerely,
Gemma Oakes

Approvals Specialist

Email: hra.approval@nhs.net

Copy to: *Dr Birgit Whitman*

Appendix E: Ethical Approval from Participating NHS Trust

Dear Fajar

Acknowledgement of study in Norfolk Community Health & Care Trust

Full Study Title: 2019GC19 (IRAS 259816) Staff's experience of factors supporting sex offenders with a learning disability in community settings

This email confirms the research office has registered the above referenced study for information and we are happy for you to approach the above site.

Once your study has completed, we would be grateful if you could forward a copy of the final report, a one page lay summary and any publications associated with the study to snccg.randdoffice@nhs.net, for dissemination. May we take this opportunity to wish you well with your research and we look forward to hearing the outcomes for the study. Please note the reference number for this study is **Ref: 259816** and this should be quoted on all correspondence.

Kind regards

Clare Symms

Research Management and Finance Lead

Norfolk and Suffolk Primary and Community Care Research Office

Appendix F: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of Project: Staff's experience of factors supporting sex offenders with a learning disability in community settings.

Researcher: Fajar Fawad, University of Birmingham.

Introduction

My name is Fajar Fawad and I am a Trainee Forensic and Clinical Psychologist enrolled at University of Birmingham.

I am conducting this research to find out what factors support sex offenders with a learning disability living in community settings from re-offending. The purpose of this project is a requirement as part of my doctoral qualification. The University of Birmingham are funding this project.

You have been invited to take part in this project as you have been identified as someone who works closely with the identified sample group mentioned above (i.e. a sex offender with a learning disability living in a community setting).

What do I have to do?

Consent

You will be approached by one of the psychologists working in one of the five Community Learning Disability Teams (CLDT) from the Norfolk Community Health and Care NHS Trust (NCH&C) and they will present this information sheet to you. You will have at least 24 hours to decide if you would like to take part in this project. If you choose to take part then you can let the psychologist know and they will inform me. If you agree to take part in this project after reading this information sheet, then I will ask you to sign a consent form. You will be provided a copy of this consent form and I will keep a copy.

Interview

The process will involve an interview with a series of questions asking what you think helps support the clients to live in the community and what factors are preventing them from re-offending. The interview is expected to last up to an hour and can be completed in one visit. The interview will take place within one of the CLDT offices. These interviews will be digitally recorded and information that you provide will be used in my project.

What will happen to the information I give you?

University of Birmingham is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. University of Birmingham will keep identifiable information about you for 5 years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and

accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information by contacting the University of Birmingham at this email address:

NCH&C will collect information from you for this research study in accordance with our instructions.

NCH&C will keep your name and contact details confidential and will not pass this information to University of Birmingham. NCH&C will use this information as needed, to contact you about the research study, and to oversee the quality of the study. Certain individuals from University of Birmingham and regulatory organisations may look at your research records to check the accuracy of the research study. University of Birmingham will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

NCH&C will keep identifiable information about you from this study until completion of the project.

During the interview I will digitally record our conversation. I will then upload this recording onto a University of Birmingham secure server. This is to ensure it is kept safe, secure and to prevent your information being lost. I will then transcribe (type up our entire conversation) everything we said. Any information that is disclosed and is classed as personal information will not be included in the research and will be redacted in the transcripts. Your name will not be used and instead will be anonymised (using a code or another name) to ensure that you are not identifiable. Direct quotes will also be anonymised. I will then transfer this anonymised information onto an encrypted USB, which only I will know the password and then transfer onto a password protected laptop, which only I will know the password. I will then analyse the anonymised information and hope to answer my proposed research question. My academic supervisor at my University, John Rose, will also have access to these transcripts as well as any regulatory body.

This information will be kept throughout the duration of the project. Once the project is completed, I will delete all information that I have on my password protected laptop. Anonymised electronic files will be kept for 10 years from publication, as per American Psychological Association and University of Birmingham guidelines. Upon completion of the research, transcripts will be kept by John Rose. Paper records will be destroyed one year after completion of the research.

What if I say no?

Your participation in this project is entirely voluntary and you have the right to refuse to participate without giving a reason. This will have no impact on your professional role. You have the right to withdraw even after giving consent.

What if I become upset during the interview?

In case you become upset during the interview, we will stop the interview. You will be given a choice to have a break or we can resume the interview at a later date. If you require further support, then this can be provided by services offered by Patient Advise and Liaison Service (PALS). Their contact details are listed at the end of this form.

If you have any further concerns during the process of the project, then you are welcome to email them to me.

Will I know the results?

On completion of this project, I can explain the results to you if you would like to know them.

Risks and benefits

There are no immediate benefits to you from participating in this project. However, your answers will help establish what things help sex offenders with a learning disability to live in community settings and as a result help prevent reoffending behaviours.

Please note if any information is disclosed during discussion which is felt may put service users, yourself or colleagues at risk this will be reported to management within the Trust.

You could become upset talking about some of your clients (perhaps based on their past offences) and if does occur then we can stop the interview and re-schedule it for another day. If you need extra support, then you will be redirected to services offered by Norfolk Community Health and Care NHS Trust.

Reimbursements

You will not be given any reimbursements for this project.

If you have any further questions, then please feel free to email me.

Thank you.

Fajar Fawad
Trainee Forensic and Clinical Psychologist
Email: fxf670@student.bham.ac.uk

PALS contact information:
Telephone: 0800 088 4449
Email: pals@nchc.nhs.uk

Appendix G: Consent Form

CONSENT FORM

Title of Project: Staff's experience of factors supporting sex offenders with a learning disability in community settings.

Researcher: Fajar Fawad, University of Birmingham.

	Please initial each box
1. I understand that I will be asked questions relating to factors that I believe have helped clients to live in the community and helped prevent reoffending behaviours.	☐
2. I agree for our conversations to be recorded.	☐
3. I understand that I do not have to take part in this research and am free to withdraw at any time during the research interview.	☐
4. I understand that I can stop my participation in this research even if I agreed in the start.	☐
5. I agree for the things I say to be used in Fajar's research.	☐
6. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.	☐
7. I understand that any information that is felt may put service users, myself or colleagues at risk this will be reported to management.	☐
8. I understand that I can contact Fajar at any point during this project if I have any questions or concerns and if I become upset support services can be offered to me.	☐
9. I agree to everything stated above and would like to participate in this research.	☐

.....	.....	.....
Name of participant	Date	Signature

.....	.....	.....
Name of researcher	Date	Signature

You can keep a copy of this consent form for your records.

I will be keeping a copy of this form at my University.

Appendix H: Interview Schedule

The following questions are aimed to find out about the place your clients (people who have are sex-offenders/ who have displayed sexual harmful behaviour/history of sexually offending behaviour) live in, the types of support they are getting from people around them, things that are helping them to not reoffend again and plans they have for their future. The focus of these questions is to understand what is helping them live in the community.

Living environment

- Tell me about the places in which client(s) you work with /have worked with live in
  PROBE: type of setting and level of security.
- What was the client(s) experience of living there?
- How long do clients usually reside in these settings?
- What type of settings have clients lived in prior to their current home?
- Do clients usually live alone or with other people?
  PROBE: positive influences or negative influences.
- What do you feel that your clients like about the place they currently live in?
- What do you feel that your clients don't like about the place they currently live in?

Access to activities

- What types of activities are available to the clients you work with / have worked with?
- What do you feel that your clients enjoy about these activities?
- What do you think that your clients like/dislike doing?
- Are staff present when clients take part in activities?
- Are clients able to do things without staff support?
  PROBE: how can staff help
- How much help do clients usually get?
- Do you feel your clients are happy with the amount of help they get?

Professionals involvement

- Can you tell me about the different professionals who work within this Trust?
- Who are they?
- What do they do?
  PROBE: what are their jobs?
- Do you feel your clients get along with them?
- Do your clients receive any input from psychology/psychiatrist/OT/social work/nursing?
  PROBE: what do they do?
- Do you feel your clients are able to talk to staff?
- Are your clients involved in any treatment programme?
  PROBE: psychological treatment, medical treatment.
- What do clients do when they have difficulties?
- Is there anything that this Trust offers which is different in comparison to other providers/ settings?

Support from family and friends

- Are your clients in contact with their family?
- Do you feel family contact supports your clients or hinder their progress?
- Do families come and visit?
  PROBE: Do they live far? What do they do when they visit?
- Do your clients have any friends that visit them / they meet up with?
- In your opinion, what impact do friends visiting have on your clients?
  PROBE: what do they all do when they come?

Personal skills

- What are some things your clients usually enjoy doing?
  PROBE: In daily routine?
- What are some things you feel your clients are good at doing?

- Do you think your clients are getting their needs met here?
- What do you think is helping your clients live in the community?
- Can you tell me some of the things that your clients are able to do by themselves?
- Can your clients go out and buy things for themselves?
  PROBE: are your clients supported when they go out?
- Do you think your clients feel more independent here in comparison to previous settings they may have lived in?

Prevention of re-offending

- What do you think has helped your clients from re-offending while they have been here?
- How do you think you've helped your clients from re-offending?

Future goals and plans

- What are some things that your clients would like to do in the future?
- What sort of help do you think your clients would need to do this?
- What types of places would your clients like to go after here?
- What types of jobs/work (if any) have your clients spoken about for the future?
- What types of things would your clients want to focus on in their life?
- Do you feel your clients usually plan for the future?
- Is there anyone who helps your clients with future planning?

Appendix I: Sample of table of initial codes generated

Support into employment	P1 line 222 P2 line 777-779 P3 line 286-287 P4 line 444-448, 450 P5 line 891-893 P10 line 722-724, 724-730 P11 line 549-555
Support into volunteering	P1 line 222-223, 934-936 P2 line 273-277 P4 line 454-455, 455-458 P6 line 76-79 P9 line 219-222 P11 line 120-125, 217-219, 524-529, 531-533
Support for needs/ support to prevent risk behaviours/ need vs risk	P2 line 280-281, 281-285 P4 line 309-310 P5 line 103-105, 112-115, 117-119, 639-643, 723-727, 800-803, 850-853 P6 line 31-32, 84-86, 86-88, 92-94, 221-223, 362-364, 364-370 P7 line 68-73, 75-78, 85-88, 90-98, 98-99, 163-164, 189-194, 200-206, 208, 210-215, 242-245, 561-562, 564-566, 567-576, 578-579, 703-705, 743-748, 798-803, 918-921, 923-924 P8 line 120-122, 133-137, 146-148, 282-283, 368-370, 384-386, 388-390 P9 line 55-56 P10 line 194, 195-200, 220-223, 233-236, 287-290, 296-297, 303-308, 420-424, 761 P11 line 14-19, 23-28, 64-69, 78-79, 125-127, 226-229, 664-666, 687-699
Pressure on staff to prevent further offending	P5 line 655-658 P9 line 190-192 P10 line 535-536 P11 line 199-205, 209-216
Accessing community/ clubs/ BBQ/ beach/ city trips/ holidays w/staff/ activities	P1 line 225, 237-238 P2 line 206, 208-209 P3 line 346-348 (s.o register), 355-356, 744-745, 746-747 P7 line 463-467 P8 line 69-70, 87-89, 587-592 P10 line 138-143, 147, 150-155, 675-677, 677-678, 678-683 P11 line 217-219, 127-131
Using staff for access/ plan/ support activities/ need for staff	P1 line 240-243, 666-672, 674-676, 708-709 P2 line 203-204, 260, 263-264 P3 line 323-326, 340-342, 342-344, 344-345, 750-752 P4 line 182-183 P5 line 330, 681 P6 line 74-75, 239-241 P7 line 281-282, 282-284, 555-557, 580-582 P8 line 86-87 P9 line 297-298

Appendix J: Image of collating codes into themes

Appendix K: Reflective Statement During Interviews and Analysis

Interviews

I held differing assumptions, expectations and observations in both the pre-interview phase and during the interviews. Before beginning interviews, I hoped to obtain a mix of professionals as participants in order to obtain a variety of their experiences working with the client group. Further I wondered how my role, as a trainee psychologist, might impact/influence the responses by the participants, i.e. would they attempt to answer my questions in ways to facilitate my research or were their responses genuine experiences. I also held some anxieties around participants not offering enough data to me during the interviews, which as a result would impact upon my analysis. During interviews, I observed that I received positive feedback from most participants regarding my efforts to complete research within this Trust, as this was something they expressed was very much needed. Further, I noticed as the interviews continued, there were varying personalities emerging amongst the participants, such that some appeared more risk-averse than others when talking about this client group and I wondered how their responses may impact on the analysis.

Analysis

During this stage, some of the assumptions I went in with following the interviews were factors such as families generally not being a positive influence, there not being enough employment opportunities for individuals with an LD (regardless of displaying sexual harmful behaviours) and finally the lack of forensic expertise and support for members in the community team.