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THE EFFECTIVENESS OF ASSESSMENT INSTRUMENTS IN MEASURING CHANGE IN PERSONS WITH AN INTELLECTUAL DISABILITY WHO HAVE SEXUALLY OFFENDED

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Vanessa Mary Burrett

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Abstract

The present research was designed to examine a set of assessment measures for their effectiveness in evaluating risk and treatment needs in a small sample of intellectually disabled sex offenders (IDSOs). IDSO assessment and treatment is a developing field in terms of research and practice. Many of the current assessment measures and treatment models used to date have been based on models for the non-ID offender population (Lambrick, 2003). Measures included in the present study were: the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR), STATIC-99, the Sexual Violence Risk – 20 (SVR-20), the Assessment of Sexual Knowledge (ASK), the Questionnaire on Attitudes Consistent with Sex Offending (QACSO), and the Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend – Sexually (ARMIDILO-S).

A within-subject pre-post design was utilised, with participants acting as their own controls. Participants were assessed on all measures in the pre-treatment phase, and on the SVR-20, ASK, QACSO and acute items of the ARMIDILO-S in the post-treatment phase. Treatment involved engagement in a SAFE-ID group (modelled on the SOTSEC-ID treatment program) over a 7 month period. Although the sample was small, some changes in risk-relevant variables were found. Expected changes were found with the SVR-20, ASK and the client and environmental protective factors of the ARMDILO-S. Unexpected changes were found with the QACSO and the client and environmental risk factors of the ARMIDILO-S. Further research is suggested, including the use of a larger sample.

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The effectiveness of assessment instruments in measuring change in persons with an intellectual disability who have sexually offended

The evidence basis in the field of intellectually disabled (ID) sex offender assessment and treatment is relatively under-developed compared to analogous areas with non-ID sex offenders. For example, the ability to provide accurate assessment, the development of specialised treatment programmes, and the evaluation of treatment outcomes are key areas where the evidence base to support clinical practice with intellectually disabled sex offenders (IDSOs) is deficient by comparison to non-IDSOs (Wilcox, 2004).

Programmes aimed at increasing and developing skills in the ID offender population are generally constructed from models designed for the non-ID mainstream population. Such is the case for the specialist area of IDSOs, whereby methods of assessment and treatment have largely been adapted from work with mainstream sex offenders (Lambrick, 2003; Keeling, Beech & Rose, 2007).

The programmes developed for mainstream offenders are often based on the principles of the "risk-needs-responsivity model", which is an intervention philosophy developed by Andrews & Bonta (2003) and proposed as useful with IDSOs (Keeling et al., 2007). Under this model, an assessment of the offender's risk for reoffending determines the level of treatment intensity that an individual requires. The needs component of the model relates to an individual's dynamic risk factors that can be targeted in treatment. Finally, the responsivity principle holds that treatment should be offered in a manner that is best suited to an individual's learning style to enhance his treatment response, and to minimize any factors that may impede an individual’s engagement in treatment (Andrews &

Bonta, 2003). Following this model for IDSOs would mean that assessments help in determining risk for re-offending as well as ascertaining the dynamic risk factors to be targeted in treatment that are specific to ID individuals. Treatment would be offered so that individuals with cognitive deficits are able to understand and interact with the treatment process, and make positive gains (Keeling et al., 2007).

Wilcox (2004) asserted that the common methodology of adapting mainstream forms of assessment and treatment for ID use may be an ill-informed strategy. He noted that although cognitive-behaviour therapy (CBT) based treatment programmes have been found to be effective with the mainstream sex offender population, their ineffectiveness with some types of sex offenders (e.g., those with a psychopathic personality disorder) provides reason to hesitate before assuming the programme would be suitable for IDSOs. Conversely, Harris and Tough (2004) stated that a lack of evidence to show stable and static factors that predict recidivism in the general population as predictive of recidivism in the ID population does not mean those factors are to be completely disregarded. They cited the validation of the RRASOR and STATIC-99 by Tough (2001) as evidence that assessment instruments developed for the mainstream population are applicable to the IDSO population.

Nonetheless, it makes sense that the risk and needs issues for IDSOs are different - both qualitatively and quantitatively - from non-IDSOs. For example, while both IDSOs and non-IDSOs may engage in grooming potential victims (hence a risk and treatment needs issue), non-IDSOs would be able to engage in more sophisticated grooming strategies with potential victims, perhaps using internet chat rooms to engage children in sexual discussions. In this example, both

the ID and non-ID sex offenders have "grooming of potential victims" as a treatment and risk issue, but the issue differs in important qualitative ways that should inform treatment.

Historically, treatment with IDSOs was grounded in behaviour therapy. As perceptions of the ID population in general evolved, cognitively based therapies became viable options, particularly for individuals with mild and borderline levels of intellectual functioning. With these changes came a greater focus on enabling individuals to develop social skills and sexual knowledge (Wilcox, 2004; Clare, 1993). Earlier treatment programmes (for example Haaven, Little, & Petre-Miller, 1990) focussed on ensuring active participation from group members during the process of learning, incorporating social skill development as well as other experiential modules (Wilcox, 2004). Boer, Dorward, Gauthier and Watson (2003) utilized a modularized approach to IDSO treatment following the lead of Haaven et al. (1990). Boer et al. (2003) expanded the Haaven model by using more traditional sex offender treatment applications adapted to ID clients (e.g. relapse prevention).

More recently, the Sex Offender Treatment South East Collaborative – Intellectual Disability (SOTSEC-ID; Sinclair, Booth & Murphy, 2002) group was formed in order to support therapists offering treatment for IDSOs. Therapists operating from different sites throughout England currently use a set of core assessment measures to gather pre and post treatment information and a prescribed treatment manual for the group programme. The latter is based on cognitive behaviour therapy and was developed specifically for intellectually disabled men at risk of sexual offending (Sinclair et al., 2002). Therapy addresses treatment needs which include sexual deviancy, lack of sex knowledge,

dysfunctional attitudes, antisocial lifestyle, mental health presentation, poor social functioning, limited relationships, poor impulse control, and low self-efficacy (Sinclair et al., 2002; Keeling et al, 2007; Lambrick, 2003).

However, the pre-post assessment measures utilized by the SOTSEC-ID framework has not been empirically validated, nor does it utilize any risk assessment measures; therefore the current research was designed to assess some relevant variables that would, theoretically, change over treatment in a programme modelled on the SOTSEC-ID programme in New Zealand. It is expected that following treatment these variables would change in such a way that would reflect changes to an individual's risk of reoffending. These variables include: sex knowledge, dysfunctional thinking, empirically-validated client risk factors and empirically-guided contextual risk factors.

Sex knowledge

Galea, Butler, and Iacono (2004) suggested that the discomfort of others leads to a failure by those responsible for the care of individuals with ID to discuss issues around sexuality. Instead, sexual behaviour is seen as inappropriate or deviant, and is suppressed. This can make it difficult for individuals with ID to develop age appropriate socio-sexual knowledge and skills (Galea et al., 2004). Further, as ID individuals often live in controlled environments and are unable to engage in age appropriate sexual activity, they may be more prone to evidence inappropriate sexual expression (Harris & Tough, 2004).

Galea and colleagues (2004) described individuals with ID as somewhat limited in their level of sexual knowledge and amount of experience. These limitations can also extend to intimate human interactions whereby an individual

with an intellectual disability may not be aware of social conventions, and may have difficulty finding appropriate partners with whom to form intimate relationships. The "counterfeit deviance hypothesis" of sexual offending presupposes that a sexual offense could be caused by a number of factors which include poor social skills and a lack of sexual knowledge and awareness (as described in Lindsay, 2005). However, in research surrounding this hypothesis one study found no significant differences between ID sex offenders and ID non-offenders on a test of sexual knowledge (as discussed by Lindsay, 2005), and another found the ID sex offenders to have significantly more knowledge than ID controls (Michie, Lindsay, Martin & Grieve, 2006). Research has also indicated that individuals with ID have a generally negative perception of sexuality and hold conservative attitudes about sexual behaviour (Galea et al., 2004).

Ascertaining an individual's level of sexual knowledge and attitudes towards sex is an important part of assessment with IDSOs. As a group, the ID population is vulnerable to being sexually victimized and at a greater risk for unplanned pregnancy or exposure to sexually transmitted diseases. In order to reduce their level of vulnerability, they need to be educated around these issues so they are equipped with the knowledge of how to protect themselves (Galea et al., 2004).

Assessment of sexual knowledge should cover several key areas – sexual interests, socio-sexual behaviour, and attitudes and thoughts concerning sexual issues (Clare, 1993). Assessment of sexual interests includes gaining a sense of the individual's preferences and what arouses them; for example children, teenagers or adults, or the use of aggression or violence in a sexual act (Clare, 1993; Thornton, 2002). Assessment of socio-sexual behaviour includes

ascertaining their basic sex knowledge, awareness of sexual thoughts and behaviours, and their ability in social interactions (Clare, 1993; Boer, Tough & Haaven, 2004). Attitudes, thoughts and feelings about sex and sexual offending based on actual past offending are likely to have played a key role in the individual's current offending. Therefore it is necessary to find out the individual's thoughts and beliefs about his victim(s) and anyone else affected by his behaviour, and his perception of the effect of his behaviour on them (Clare, 1993). Parenthetically, this thesis has utilized the male pronoun when referring to IDSO's since the majority of such known offenders have been male (e.g., Lindsay, 2009).

Dysfunctional thinking

A key component of current cognitive-behavioural treatment approaches for sex offenders involves working with and challenging cognitive processes around sexuality and sexual behaviour. The assessment of beliefs and attitudes related to sexual behaviour form an important part of understanding an individual's offending pathway and informing treatment targets (Boer et al., 2004; Lindsay, Michie, Whitefield, Martin, Grieve, & Carson, 2006; Lindsay, 2009). Cognitive distortions develop from learned behaviour and may represent a conflict between sexual desires and norms imposed by society (Broxholme & Lindsay, 2003). An example of a cognitive distortion for a child sex offender may be the belief that children understand what sex is and are able to consent to engaging in sexual activity. A sex offender who prefers adult women may believe that a woman who smiles at them and is friendly wants to have sex with them.

Cognitive distortions, in particular denial and minimization of the offence and circumstances surrounding it, are described as a way for an offender to justify his behaviour (Thornton, 2002). Families of non ID adolescent sex offenders often support the offender in denying and minimizing the offence, and it has been suggested that families of individuals with ID follow a similar pattern (Lindsay, 2005). Research has indicated that distorted attitudes are linked to sexual recidivism in non-ID sex offenders, and that distorted attitudes are more prevalent in child sex offenders (Thornton, 2002). Lindsay, Elliot and Astell (2004) identified antisocial attitudes, denial of offending, attitudes accepting of sexual crimes, and poor response to treatment as being related to suspicion of re-offending in their sample of IDSOs. Lindsay and colleagues (2006) also identified cognitive distortions as a risk factor in their sample of IDSOs, and went on to conclude that the type of distortions an offender holds are likely to be consistent with the type of offence for which he has been convicted.

Risk relevant client factors

A number of factors specific to an individual are associated with increased risk of sexual recidivism. These factors are often referred to as stable dynamic factors, suggesting that whilst they are more longstanding than acute factors (those that can change rapidly, e.g., within hours or days) they are still amendable to change with intervention (Hanson & Harris, 2000). Knowledge of the relevant factors is again informed by the non-ID offender literature therefore the application of them to the intellectually disabled population is somewhat experimental. Hanson and Harris (2000) identified several key predictors of sexual re-offending in their study examining non-ID sex offenders. They found

that recidivists were more likely to have poor social support systems, lead an antisocial lifestyle with greater negative social influences, experience difficulty with intimate relationships, be non-compliant with supervision, and lack the ability to manage their own risk effectively (Hanson & Harris, 2000). Whilst research concerning the relevance of these factors to the ID population is limited, Lindsay, Elliot, et al. (2004) found that antisociality and poor treatment compliance were factors that were relevant to recidivism in a sample of IDSOs.

However, the application of risk factors from the non-ID literature requires that some be redefined to ensure they are relevant to the type of presentation seen in the ID population. Boer et al. (2004) described some of these factors in a more suitable manner whereby the cognitive and social deficits seen in the ID population are taken into consideration. For example, when considering employment for an individual with ID, one would not expect that they maintain a regular full-time position but that they are able to engage in activities such as educational or skill based day programmes or work in a volunteer capacity. This ensures that they avoid boredom, continue to develop skills, and thereby reduce their risk of reoffending (Boer et al., 2004). Green, Gray, and Willner (2002) conducted research on men with learning disabilities some of whom had been convicted for inappropriate sexual behaviour. Their findings indicated that those individuals who were convicted of sexual offences were more likely to not be engaged in employment or structured daytime activities. Other examples of relevant individual risk factors are an individual's knowledge of their offending cycle and relapse prevention plan, self-management of one's sexuality, general coping ability, impulsivity, self efficacy and management of mental health,

substance abuse, relationship skills, and impulsiveness (Boer et al., 2004; Lindsay, Elliot, et al., 2004, Thornton, 2002).

Risk relevant contextual factors

Contextual (or environmental) factors are those that are external to the individual and outside one's control, but have the ability to impact on an offender's risk of re-offending. Environmental factors are considered necessary in making a full assessment of an individual's risk; items that have previously been considered important include employment difficulties and compliance with supervision requirements (Boer, McVilly & Lambrick, 2007). The ID population presents a unique situation whereby environmental variables can be viewed as more important than with the non-ID population because of the dependence of ID individuals on structured, controlled environments (Boer et al., 2007). Therefore, the potential for environmental variables to impact on an ID sex offender's level of risk is greater. Boer and colleagues (2007) asserted that the assessment of dynamic environmental factors along with dynamic client factors when examining risk for an IDSO would lead to an enhanced depiction and more effective management of risk. As with the risk relevant client factors, contextual factors need to be adapted in order for them to remain relevant to the intellectually disabled population. An example of the application of one of the previously mentioned factors to ID offenders is compliance with supervision requirements. A non-ID offender would be expected to manage and plan his own daily activities; however an ID offender may not be capable of this and would be likely to require assistance to ensure attendance at supervision and treatment appointments (Boer et al., 2007).

Boer et al. (2004) identified further contextual factors that are relevant to the ID population (e.g. staff attitudes towards IDSOs, communication among staff, staff knowledge and training, supervision consistency, and environmental consistency). Whilst these factors are not necessarily empirically-based specifically for the IDSO population, they are guided by the literature from similar fields. For example, Lambrick (2003) pointed out the distinctive nature of IDSOs environment in the sense that they are often heavily supervised or surrounded by other clients in their residence or day placements. The restriction this imposes on an individual with ID may be a factor that causes some frustration and emotional upset, therefore increasing their likelihood of acting in a challenging manner. In the case of a sex offender, Lambrick (2003) suggested that the lack of privacy may lead to behaviours reserved for private space (e.g. masturbation) being conducted in a public setting. Boer and colleagues (2004) also suggested consistency within settings (for example, at day placements) as important to individuals with ID as changes to routines and plans can cause emotional disturbance for the individual, leading to increased unpredictability in their behaviour, and increased risk.

Members of staff interact with IDSOs and impact their level of risk in several ways. Staff who are aware of an offender's risk factors can monitor these by working with an offender on a daily basis to develop appropriate skills and essentially decrease his risk of re-offending (Boer et al, 2004; Lambrick, 2003). The opposite of this, staff who have negative attitudes towards IDSOs and fail to actively engage with the individual, can lead to an increased risk of challenging behaviour and possible re-offending. The principles of positive behaviour support presuppose that all staff can have positive (or negative) influences on clients and

are central to the management of challenging behaviour (McVilly, 2002). Smith and Willner (2004) found a significant difference in the risk related decisions made by care managers and direct care staff in response to inappropriate sexual behaviour. Care managers were responsible for deciding on risk management strategies to be used with clients, while direct care staff were responsible for putting the strategies into practice. Direct care staff were found to attribute inappropriate sexual behaviour to attention seeking, inadequate management by other staff, and showed greater disgust and embarrassment towards the clients. In comparison, care managers were more likely to perceive the behaviour as driven by elevated levels of anger and to be sexually motivated. It then follows that the attributions made by staff can affect the way they respond to and treat clients. Lindsay, Elliot, et al. (2004) included allowances made by staff (showing leniency towards clients with regards to rules) and staff complacency as variables in their study with IDSOs because although they were not variables identified in the research, clinical experience had highlighted their value. The results showed that both variables were significant predictors of re-offending and suspicion of re-offending, and that of these two variables, allowances made by staff was the most significant predictor of re-offending.

Summary and Rationale

To summarise, IDSO assessment and treatment has largely been based on mainstream models of sex offender assessment and treatment. However, IDSOs present with unique characteristics that require that assessment and treatment methods be tailored to their needs in order to be effective. Key treatment areas

that have been identified by the literature are sex knowledge, dysfunctional thinking, risk relevant client factors, and risk relevant contextual factors.

A set of six measures was selected to assess the key treatment areas. The Rapid Risk Assessment for Sex Offender Recidivism (RRASOR; Hanson, 1997) and STATIC-99 (Hanson & Thornton, 1999) provide an assessment of static risk factors associated with general and sexual offending and provide estimates of baseline risk levels. The Sexual Violence Risk – 20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997) assesses static factors as well as incorporating some dynamic client related risk factors which should be responsive to treatment. The Assessment of Sexual Knowledge (ASK; Butler, Leighton & Galea, 2003) provides an indication of an individual's level of general sexual knowledge and the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO; Lindsay, Whitefield, Carson, Broxholme & Steptoe, 2004) provides an assessment of an individual's beliefs and attitudes regarding sexual behaviour. Finally, the Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend – Sexually (ARMIDILO-S; Boer, Haaven, Lambrick, Lindsay, McVilly & Sakdalan, 2009) assesses individual and environmental factors associated with risk of re-offending.

The purpose of the research was to examine the use of the set of measures with a sample of intellectually disabled sex offenders. The research design used was a within subjects pre-post comparison, with participants acting as their own control group.

It was expected that following treatment, scores on measures that incorporate dynamic variables (SVR-20, ASK, QACSO and ARMIDILO-S) would show positive change. In the SVR-20 this would be seen through a lower

score indicating a decrease in risk. In the ASK, positive change would be seen through higher scores indicating an increase in knowledge. In the QACSO, positive change would be demonstrated through lower scores indicating a decrease in socially unacceptable beliefs and attitudes. In the ARMIDILO-S, positive change would be demonstrated through a decrease in acute client and environmental risk factors and an increase in acute client and environmental protective factors.

Method

Ethical Approval

Ethical approval was obtained from the Department of Psychology Research and Ethics Committee at the University of Waikato.

Participants

Participants were recruited through the SAFE Network in Auckland where they had been identified as needing to engage in a treatment group specific to individuals with an intellectual disability who have a history of sexual offending or sexually abusive behaviour (SAFE-ID). The SAFE Network is a community-based organisation contracted to provide treatment services for sex offenders. The criteria for inclusion in the research were:

a) To have a current formal referral to attend treatment with the SAFE Network
b) To have a formal diagnosis of intellectual disability (as assessed by referral agency)
c) To have a history of sexual offending or sexually abusive behaviour (however, they did not have to have convictions for these behaviours)

The SAFE-ID treatment group was formed from individuals who had been referred to SAFE or another agency for treatment. Only four out of seven individuals from the SAFE-ID treatment group were able to be included in the research as the ethical approval obtained did not cover individuals referred by other agencies. Demographic information on the participants was collected from their treatment files and a summary of this information is shown in Table 1.

Table 1

Participant Demographic Information

Participant	Gender	Ethnicity	Age	Ever Married [a]	FSIQ [b]	Legal Status
1	M	New Zealand European	28	Single	58	Voluntary
2	M	New Zealand European	24	Single	59	Compulsory
3	M	New Zealand European	36	Separated	70	Compulsory
4	M	New Zealand European	36	Single	54	Compulsory

[a] Ever married was defined by the individual ever being in a relationship of two years

[b] Full scale IQ

All participants were male and of New Zealand European descent. The mean age was 31 years, and ranged from 24 to 36 years. All participants met criteria for mild to moderate intellectual disability according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). The Wechsler Adult Intelligence Scale-III (WAIS-III; Wechsler, 1997) full scale IQ (FSIQ) scores ranged from 54 to 70, and the mean IQ score was 60.25. Three participants had diagnoses of paraphilia and/or paedophilia, and one participant was diagnosed with antisocial personality traits

and Narcissistic Personality Disorder. The index offence of one participant was for indecent assault, two participants had index offences of rape and indecent assault, and one participant had no formal charges laid against him however, there were incidents of sexually abusive behaviour in his history. All participants had committed offences against children, and one participant also offended against an adult. Participant 1 was an informal client not under the Intellectual Disability Compulsory Care & Rehabilitation Act 2003 (IDCC&R Act; Ministry of Health, 2003) and resided in a community based supervised care facility, participant 2 was on a Secure Care order under the IDCC&R Act and resided in a secure hospital facility, and participants 3 and 4 were on Supervised Care orders under the IDCC&R Act, residing in community based supervised care facilities.

Materials

The materials used in the research were:

- Participant information sheet and consent form (Appendix A)
- Staff information sheet and consent form (Appendix B)
- SAFE-ID group treatment information sheet (Appendix C)
- SAFE-ID group treatment consent form (Appendix D)
- SAFE-ID group treatment information sheet for parents or caregivers (Appendix E)
- Psychometric measures: RRASOR (Appendix F), STATIC-99 (Appendix F), SVR-20 (Appendix G), ASK, QACSO, and ARMIDILO-S (Appendix H).

Measures:

The following measures were used in the present study:

The *Rapid Risk Assessment for Sex Offender Recidivism* (RRASOR; Hanson, 1997) is a brief actuarial measure comprised of four items: age at time of offence, previous sex offences, having male victims, and having unrelated victims. Points from each item are accumulated to arrive at a risk rating between 0 and 6, which correlates to their risk of recidivism over five and ten year periods. Hanson (1997) found the RRASOR to have moderate predictive ability (r = 0.27, AUC = 0.71) with a mainstream sex offender population, and further research since then has supported its use in predicting recidivism in the mainstream sex offender population (Bartosh, Garby, Lewis & Gray, 2003; Harris, Rice, Quinsey, Lalumiere, Boer & Lang, 2003; Barbaree, Seto, Langton & Peacock, 2001; Sjosedt & Langstrom, 2001). Tough (2001) demonstrated the RRASOR to moderately predict recidivism (r = 0.305) in a sample of 76 intellectually disabled sex offender recidivists and non-recidivists. There has been some doubt about its use with an intellectually disabled population (Craig & Hutchinson, 2005). More recently, Wilcox, Beech, Markall, and Blacker (2009) found that RRASOR was a poor predictor of sexual recidivism in their sample of 27 IDSOs.

The *STATIC-99* (Hanson & Thornton, 1999) is the fusion of factors from the Structured Anchored Clinical Judgement (SACJ; Thornton, 1997) and the RRASOR. It is a 10 item actuarial scale that assesses sexual deviancy and non-criminal factors in an individual's history. Items cover the individual's history of sexual and other offending, type of victims selected, age, and status of relationships. A total score (maximum of 12) is calculated and then matched to one of four risk categories; however any scores of 6 or greater are assigned the

maximum risk rating (Harris, Phenix, Hanson, & Thornton, 2003). Various studies have found the STATIC-99 to have good predictive ability for the general offending population in terms of its use in predicting both sexual and violent recidivism (Bartosh et al., 2003; Harris et al., 2003; Barbaree et al, 2001; Hanson & Thornton, 2001; Sjostedt & Langstrom, 2001). In research specific to ID populations, Tough (2001) found that the STATIC-99 poorly predicted sexual recidivism (r=0.08). However, more recently Wilcox et al. (2009) and Lindsay et al. (2008) found it to have moderate predictive ability with AUC scores of 0.64 and 0.71 respectively.

The *Sexual Violence Risk -20* (SVR-20; Boer, Hart, Kropp & Webster, 1997) is a 20 item structured clinical guideline that incorporates static and dynamic factors in the assessment of risk of sexual violence. The 20 items are divided into three areas: Psychosocial Adjustment (e.g. relationship problems), Sexual Offences (e.g. sex offence types) and Future Plans (e.g. negative attitude towards intervention). A list of items is provided in Appendix G. Items are rated as 'Y' indicating that that item is present, '?' indicating that it is possible the item is present or it is partially present, and 'N' indicating that the item is not present. For the purpose of this research, items that were scored as present (Y) were given a value of 2, items that were indicated as possibly or partially present (?) were given a value of 1, and items that were indicated as not present (N) were given a value of 0. Recent change can be assessed for items that have been scored as present (Y); this is shown by a positive sign (+) indicating an increase in risk and a negative sign (-) indicating a decrease in risk. Scoring also allows for 'Other Considerations', whereby aspects of an individual's life that are seen to be important in assessing their level of risk, but are not covered by the prescribed

items, may be noted and considered in the final risk rating. The final summary rating is made by the assessing clinician, and the individual is given a risk level of low, moderate or high. Sjostedt & Langstrom (2001) found that the SVR-20 predicted sexual recidivism worse than chance (AUC = 0.49) with mentally ill sexual offenders, however de Vogel, Ruiter, van Beek and Mead (2004) found the SVR-20 to be a strong predictor of sexual recidivism (AUC = 0.80) in a sample of non-ID sex offenders. Currently, there is no published research demonstrating the validity and reliability of the use of the SVR-20 with IDSOs (Boer, Frize, Pappas, Morrissey & Lindsay, in press).

The *Assessment of Sexual Knowledge* (ASK; Butler, Leighton & Galea, 2003) was developed in Australia, specifically for assessing sexual knowledge and attitudes towards sexuality in the intellectually disabled population. It is comprised of four sections – a Knowledge section, an Attitudes section, a Quick Knowledge Quiz (QKQ), and a Problematic Socio-Sexual Behaviours Checklist. The present study only utilized the Knowledge section due to time constraints. This section of the ASK assessment addresses knowledge of parts of the body, sexual behaviour in public and private settings, puberty, menstruation, menopause, masturbation, relationships, protective behaviours, sexuality, safer sex practices, contraception, pregnancy and birth, sexual health and screening tests, sexually transmitted infections, and issues around legal rights and behaviours regarding sexuality (Galea, Butler, Iacono & Leighton, 2004). Responses are scored as 2 for correct, 1 for partially correct and 0 for incorrect. Results from Galea et al. (2004) indicated that the Knowledge section had good inter-rater reliability with section total correlations between 0.83 and 0.99, and good test-retest reliability with section total correlations between 0.62 and 1.00.

The *Questionnaire on Attitudes Consistent with Sexual Offending* (QACSO; Lindsay, Whitefield, et al., 2004; Lindsay, Whitefield & Carson, 2007) was designed specifically for use with IDSOs. The QACSO assesses an individual's attitudes and beliefs related to sexual behaviour and offending. The items were divided into seven scales: rape and attitudes towards women, voyeurism, exhibitionism, dating abuse, homosexual assault, offences against children, and stalking and sexual harassment. Each scale contains questions related to intent, responsibility and victim awareness. Items are scored as 0 for a socially acceptable response, 1 for a "don't know" response, and 2 for a socially unacceptable response (Lindsay, et al., 2007). Items are divided into *A* and *B* items; *A* items were described by Lindsay, Whitefield et al. (2004) to have better statistical properties, were more able to differentiate sex offenders from other individuals, and contribute more to the concept being measured by each scale. The original version of the QACSO did not have the stalking scale and was tested on three groups – IDSOs, those with ID who had not sexually offended, and those without ID who had not sexually offended. Broxholme and Lindsay (2003) found that the QACSO had acceptable test-retest reliability on an IDSO sample (across the three groups subscale correlations ranged between 0.31 and 0.90, and overall scale correlations ranged between 0.84 and 0.96), good internal consistency (α = 0.95), and was able to discriminate between IDSOs and the other two groups. The seven scale version was tested on four groups – IDSOs, non-sex offenders with ID, non-offenders with ID, and non-offender non-ID controls (Lindsay et al., 2007). It was found that the test had good internal consistency (α = 0.79 to 0.86 for all scales except the homosexual assault scale. The authors suggest that it is possible that other beliefs may affect an individual's attitude towards items on this

scale. As with the earlier version, the test was able to differentiate between IDSOs and other groups (Lindsay et al., 2007). It has been suggested that the QACSO is also useful as a measure of treatment outcome (Keeling et al., 2007).

The *Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend - Sexually* (ARMIDILO-S; Boer, Haaven, Lambrick, Lindsay, McVilly & Sakdalan, 2009) is a structured guideline used to assess factors specific to an individual and their environment which are considered relevant to their level of risk and manageability. Initially developed for IDSOs, the ARMIDILO-S has since been expanded to facilitate use with any ID individual who presents with sexually offensive or sexually challenging behaviours. The ARMIDILO-S is broken down into sections covering stable dynamic and acute dynamic factors for both the client and their environment. Stable client factors cover compliance with treatment and supervision, sexual deviancy, mental health, and relationships, while acute client factors look at recent change in some of these areas. Stable environmental items include the staff involved in the individual's care (their attitude towards and level of knowledge about the individual), communication among staff, and the consistency provided by staff and settings. The acute items focus on recent changes in the environmental factors, for example changes in supervision and monitoring levels (Boer & Haaven, 2009). For each item, a risk rating and a protective factor rating is assigned. Risk ratings are assigned using a scale where '0' indicates the item is not a problem, '1' indicates it is somewhat of a problem or might be a problem, and '2' indicates that the item is definitely a problem. Protective factor ratings are assigned using a scale where '0' indicates the item is neutral, '1' indicates it could potentially be a protective factor, and '2' indicates the item is definitely a

protective factor (Boer & Haaven, 2009). Research by Courtney in 2008 indicated some support for the use of the general version of the ARMIDILO in terms of its discriminant validity between sexually violent and non-sexually violent ID offenders. There is ongoing research on the ARMIDILO with the Victorian Prison Service (Australia), but no data has been produced to date. In sum, there are no studies that have provided validation data for the current version of the ARMIDILO-S with IDSOs.

Settings

Pre and post assessments with the four participants were conducted at the Pohutukawa Unit of the Mason Clinic and at SAFE Network premises in Auckland. Interviews with staff for the ARMIDILO-S were conducted at various office locations in Auckland and via telephone interviews. The treatment group sessions were held at the Pohutukawa Unit of the Mason Clinic.

Procedure

Prior to participating in the SAFE-ID treatment group, individuals discussed the SAFE-ID information sheets (see Appendices C and E) with two group facilitators and were required to sign treatment consent forms (see Appendix D). Specific consent was then obtained by the researcher for inclusion in the current research project. A letter (see Appendix A) explaining the research and seeking the individual's consent was read to each participant by the author, in the presence of a SAFE-ID group facilitator and a staff member involved in their care. If an individual was willing to participate he signed the letter; this was also witnessed and signed by the staff member present.

Prior to beginning treatment, participants were assessed on the following measures: STATIC-99, RRASOR, SVR-20, QACSO, ASK, and the ARMIDILO-S. Following completion of the SAFE-ID treatment group participants were re-assessed on the following measures: SVR-20, QACSO, ASK and the Acute items of the ARMIDILO-S. Assessments were carried out by either a consultant clinical psychologist, registered psychologist, psychotherapist, or the author. Staff members involved in the management of each participant were contacted via email and sent an information sheet and consent form (see Appendix B) requesting their permission to be interviewed as part of the ARMIDILO-S assessment. Upon acceptance of the signed consent form, staff members were interviewed by the author in person (at times in the presence of SAFE-ID group facilitators) or via telephone. Towards the end of the treatment period staff were re-interviewed using the acute items of the ARMIDILO-S.

Not all sections of some tests were included in the research. In the SVR-20, the Psychopathy item (Item 3) was not included as the raters did not have the required qualification (as stated in the SVR-20 manual) to score the item. Only the Knowledge section of the ASK was utilized in the research as explained earlier.

The ASK and QACSO were administered verbally to participants. Post assessment administration of the ASK and QACSO was conducted by the author in order to minimise bias in the results, as those who had administered the tests in the pre-testing phase were involved in the delivery of the SAFE-ID intervention. However, administration by the author was supervised by a consultant clinical psychologist to ensure the tests were administered correctly.

Treatment

The SAFE-ID treatment program was based on the SOTSEC-ID program for men with intellectual disabilities who are at risk of sexual offending, developed in the United Kingdom. The aim of the SAFE-ID program was to provide specific treatment for IDSOs that would assist them with developing knowledge and skills that could contribute to reducing their risk of reoffending. The SAFE-ID treatment program was a collaborative effort by staff from SAFE Networks and the Intellectual Disability Offender Liaison Service (IDOLS) in Auckland. The program included the following components (Sakdalan & Collier, 2009):

- Defining group rules and group purpose
- Social skills and relationships
- Sex education
- The cognitive model - cognitive distortions, automatic thinking errors and cognitive restructuring
- A four stage model of sex offending
- General empathy and victim empathy
- Relapse prevention
- The DBT model – mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness

Treatment was conducted in a group setting with seven facilitators. Not all facilitators were present in every session however, there was always at least one male and one female in each session as required by the SOTSEC-ID programme. Facilitators included one consultant clinical psychologist, one registered psychologist, one registered psychotherapist, one occupational therapist, one

intern psychologist, one nurse, and one nurse/team manager. Key workers supported participants through the first two modules of the program which covered sex education and healthy relationships, and the cognitive model. After the first two modules, a group decision was made to not have staff present for future sessions however, one participant was required to have a staff member with him at all times as part of his secure care order. The program ran for seven months with group sessions held weekly for two hours, and additional individual psychotherapy or debriefing sessions available for participants when required.

Data Analysis

Statistical analysis was conducted using Microsoft Excel 2007 and SPSS Version 16.

Inter-rater reliability was calculated for each participant on the RRASOR, STATIC-99, and SVR-20. Ratings were completed by the author and an intern psychologist. Information used to score these tests was obtained from a review of the participants files. Source documents included psychological reports, specialist assessor reports, neuropsychological assessments, court liaison files, and discharge summaries. Before finalising scores for the RRASOR, STATIC-99 and SVR-20, a meeting was held with some of the SAFE-ID group facilitators to discuss any disagreements between the two raters. Adjustments were made to scoring where required.

Results

The aim of the research was to evaluate the effectiveness of a set of measures in assessing risk and treatment needs in intellectually disabled sex offenders. More specifically, the research set out to establish if changes in participants' thoughts and behaviour were reflected in scores on a set of assessment measures. All four participants completed the SAFE-ID treatment group; their results on the RRASOR, STATIC-99, SVR-20, ASK, QACSO and ARMIDILO-S will be presented in the following sections.

Rapid Risk Assessment for Sex Offender Recidivism (RRASOR)

The RRASOR was completed for each participant in the pre-treatment assessment phase of the research and was based on a review of available file material. As shown in Table 2, Participants 1, 2, and 3 were rated as moderate to high risk and Participant 4 was rated as moderate to low risk on this instrument.

The scoring rules for the RRASOR require that individuals have a conviction for at least one sexual offence to be assessed with this measure (Hanson, 1997). Participant 1 did not meet this requirement as he had no recorded convictions or charges for sexual offences. However, he did have a number of incidents recorded in his file that related to sexual acts for which charges had not been laid. For the purpose of this research, Participant 1 was rated using these recorded incidents instead of actual charges.

Table 2

Participants' pre-treatment scores on the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR)

	Maximum score	Participants 1	2	3	4
RRASOR Items					
Young	1	0	1	0	0
Prior Sex offences	3	2	2	3	2
Unrelated Victims	1	1	1	1	1
Male Victims	1	1	1	0	0
Total score	6	4	5	4	3
Risk Rating		Moderate -High	Moderate -High	Moderate -High	Moderate -Low

STATIC-99

The STATIC-99 was completed for each participant in the pre-treatment assessment phase of the research and was based on a review of available file material. As shown in Table 3, all participants were rated as high risk.

Table 3

Participants' pre-treatment scores on the STATIC-99

	Maximum score	Participants 1	2	3	4
STATIC-99 Items					
Young	1	0	1	0	0
Ever lived with	1	1	1	0	1
Index non-sexual violence	1	0	0	0	0
Prior non-sexual violence	1	0	1	0	1
Prior sex offences	3	2	2	3	2
Prior sentencing dates	1	0	1	1	0
Non-contact sex offences	1	0	0	0	0
Unrelated victims	1	1	1	1	1
Stranger victims	1	1	1	1	1
Male victims	1	1	1	0	0
Total score	12	6	9	6	6
Risk Rating		High	High	High	High

As with the scoring for the RRASOR, Participant 1 did not have recorded convictions for sexual offences however incidents that were recorded on his file for which he was not charged were included in calculating his STATIC-99 score. Had these incidents not been included, he could not have been rated using this instrument.

Sexual Violence Risk – 20 (SVR-20)

The SVR-20 was completed for each participant in the pre-treatment assessment phase of the research. Scores for each participant were based on a review of file material and meeting with the SAFE-ID team to discuss the ratings. Post-treatment ratings were assessed by the lead clinician (a consultant clinical psychologist) of the SAFE-ID group.

Table 4 presents the subtotal for each section and the total score for pre-treatment and post-treatment administrations (see Table 5, Appendix J for participants' pre and post-treatment scores for each item on the measure). As previously mentioned in the method, the psychopathy item was excluded from the research and only 19 items were scored.

All participants presented with slightly lower scores in the post-treatment assessment of the SVR-20. Individual changes will be described in the following paragraphs.

Participant 1: The total score for Participant 1 decreased by three points. The 'sexual offences' section decreased by one point as a result of less prominent attitudes that support or condone sex offences. The future plans section decreased by two points due to decreases on the 'lacks realistic plans' and 'negative attitude towards intervention' items.

Participant 2: The total score for Participant 2 decreased by two points with changes to his scores on five items. The 'psychosocial adjustment' section increased in score due to a disclosure that he was a victim of child abuse (information that was not previously known but arose throughout the treatment period). His score decreased to a 1 on the item 'attitudes that support or condone sex offences' and decreased to 0 on the 'escalation in frequency or severity of sex

offences', 'lacks realistic plans', and 'negative attitude towards intervention' items.

Participant 3: The total score for Participant 3 decreased by two points due to changes to items in the 'sexual offences' section. His scores on the 'escalation in frequency or severity of sex offences' and 'attitudes that support or condone sex offences' items decreased to scores of 0 and 1 respectively.

Participant 4: The total score for Participant 4 decreased by one point as a result of a reduction in his rating on the 'escalation in frequency or severity of sex offences' item.

A paired samples t-test was performed to ascertain if a significant difference existed between the pre and post-treatment scores on the SVR-20. However, no significant differences were found for any of the participants.

Table 4

Participants' pre and post-treatment sub-total scores on the Sexual Violence Risk – 20 (SVR-20).

		Participants							
		1		2		3		4	
	Maximum score	Pre	Post	Pre	Post	Pre	Post	Pre	Post
SVR-20 sub-sections									
Psychosocial Adjustment	20	15	15	14	16	11	11	12	12
Sexual Offences	14	4	3	5	3	6	4	6	5
Future Plans	4	3	1	2	0	2	2	3	3
Total score	38	22	19	21	19	19	17	21	20

Assessment of Sexual Knowledge (ASK)

The ASK was administered to all participants in the pre-treatment and post-treatment assessment phases of the research. Table 6 shows the participants scores on each section and their total score for pre and post-treatment administrations. For the purpose of this analysis a score was considered low if it was less than or equal to 50% of the maximum possible score for a section, and a score was considered high if it was 100% for a section.

Prior to the SAFE-ID group, participants generally scored low on the Sexual health – screening tests and Menopause sections. They scored highly on Public and private, and Safer sex practices. Following the SAFE-ID group, they continued to score low on Sexual health – screening tests and Menopause. They generally scored highly on Safer sex practices, Masturbation and Legal issues regarding sexuality – rights. The following paragraphs identify and describe the strengths and weaknesses for each participant in the pre and post-treatment administrations of the ASK.

Participant 1: In the pre-treatment administration Participant 1 scored low four sections: Menopause, Protective behaviours, Contraception, and Sexual health - screening tests. He scored highly on four sections: Public and private, Relationships, Safer sex practices, and Legal issues regarding sexuality – rights. In the post-treatment administration Participant 1 score low on 2 sections: Menopause and Sexual health – screening tests. He scored highly on six sections: Public and private, Menopause, Masturbation, Relationships, Safer sex practices, and Legal issues regarding sexuality – rights.

Participant 1demonstrated improvements in his knowledge of Parts of the body, Puberty, Menopause, Masturbation, Protective behaviours, Sexuality,

Contraception, and Legal issues regarding sexuality – illegal behaviour. The only section where he scored lower in the post-treatment administration was Menstruation.

Participant 2: In the pre-treatment administration, Participant 2 scored low on four sections: Menstruation, Menopause, Contraception, and Sexual health – screening tests. He scored highly on four sections: Public and private, Masturbation, Protective behaviours, and Legal issues regarding sexuality – illegal behaviours. During the post-treatment administration Participant 2 scored low on three sections: Menstruation, Menopause, and Sexual health – screening tests. He scored highly on seven sections: Public and private, Masturbation, Relationships, Protective behaviours, Safer sex practices, Legal issues regarding sexuality – rights and illegal behaviours.

Participant 2 demonstrated improvements in his knowledge of Parts of the body, Puberty, Menstruation, Menopause, Puberty, Relationships, Sexuality, Safer sex practices, Contraception, Sexual health – screening tests, and Legal issues regarding sexuality – rights. The only section on which he scored lower in the post-treatment administration was Sexually transmitted infections.

Participant 3: In the pre-treatment administration, Participant 3 scored low on two sections: Menopause and Sexual health – screening tests. He scored highly on six sections: Parts of the body, Puberty, Menstruation, Masturbation, Safer sex practices, and Pregnancy and birth. In the post-treatment administration, he scored only low on the Menopause section, but score highly on nine sections: Parts of the body, Puberty, Menstruation, Masturbation, Protective behaviours, Safer sex practices, Pregnancy and birth, Legal issues regarding sexuality – rights and illegal behaviours.

Participant 3 demonstrated improvements in his knowledge of Relationships, Protective behaviours, Sexuality, Contraception, Sexual health – screening tests, Legal issues regarding sexuality - rights and illegal behaviours. There were two sections where he scored lower in the post-treatment administration: Menopause and Sexually transmitted infections.

Participant 4: In the pre-treatment administration, participant 4 scored low on four sections: sexuality, pregnancy and birth, sexual health – screening tests, and legal issues regarding sexuality – rights. He scored highly on five sections: public and private, menopause, relationships, protective behaviours, and safer sex practices. In the post-treatment administration, participant 4 scored low on seven sections: puberty, menopause, sexuality, contraception, sexual health-screening tests, sexually transmitted infections, and legal issues regarding sexuality – rights. He only scored highly on the section on safer sex practices.

Participant 4 demonstrated improvements in his knowledge of Parts of the body and Pregnancy and birth but showed decreased scores on Public and private, Puberty, Menopause, Relationships, Protective behaviours, Sexuality, Contraception, Sexual health – screening tests, and Sexually transmitted infections.

Statistical analysis was conducted on the results of the ASK to detect if a significant difference existed between pre-treatment and post-treatment scores. As the data was non-parametric, a Wilcoxon Signed-rank analysis was carried out.

Results for Participants 1 and 2 were significant, $Z= -1.963$, $p < 0.05$and $Z= -2.830$, $p < 0.05$ respectively. Results for Participants 3 and 4 were not significant did not show an improvement in the comparison of pre-treatment and post-treatment scores, $Z= -1.615$, $p > 0.05$ and $Z= -1.850$, $p > 0.05$ respectively.

In examining the change in pre and post treatment scores, all participants showed at least one section of the ASK where they scored lower in the post treatment administration. As an individual cannot be considered to lose knowledge, these occurrences were coded as missing data and the Wilcoxon Signed-rank analysis was repeated.

Results from this analysis showed Participants 1 (Z= -2.536, $p < 0.05$), 2 (Z= -2.840, $p<0.05$), and 3 (Z= -2.375, $p < 0.05$) to have significant results. Results for Participant 4 were not significant (Z= -1.342, $p > 0.05$).

Table 6

Participants' pre and post-treatment section scores on the Assessment of Sexual Knowledge (ASK).

		Participants							
		1		2		3		4	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
ASK sub-sections	Maximum score								
Parts of the body	40	34	38	37	39	40	40	34	37
Public and private	12	12	12	12	12	11	11	12	10
Puberty	12	8	11	8	10	12	12	8	6
Menstruation	10	8	3	0	2	10	10	6	6
Menopause	4	0	4	0	2	2	0	4	2
Masturbation	10	6	10	10	10	10	10	8	8
Relationships	22	22	22	17	22	19	20	22	18
Protective behaviours	14	4	10	14	14	12	14	14	13
Sexuality	26	15	22	20	22	16	24	13	12
Safer sex practices	4	4	4	3	4	4	4	4	4
Contraception	30	13	19	8	17	21	22	17	15
Pregnancy and birth	8	6	6	6	6	8	8	4	5
Sexual health – Screening tests	16	4	4	0	4	4	14	1	0
Sexually transmitted infections	12	10	10	9	8	9	7	7	5
Legal issues regarding sexuality – rights	12	12	12	9	12	7	12	6	6
Legal issues regarding sexuality – illegal behaviours	16	12	14	16	16	14	16	14	14
Total Score	248	170	201	169	200	199	224	174	161

Questionnaire on Attitudes Consistent with Sexual Offending (QACSO)

The QACSO was administered to all participants in the pre-treatment and post-treatment assessment phases of the research. Table 7 shows the participants' scores on each scale and their total score for pre and post-treatment administrations of the QACSO. High scores on the QACSO are indicative of a greater level of cognitive distortions.

As a group, pre-treatment total scores on the QACSO were relatively low, ranging between 18 and 70 (the maximum possible score was 180) on *A* items, and 19 and 24 (the maximum possible score was 58) on *B* items. Post-treatment total scores ranged between 12 and 74 for *A* items, and 16 and 28 for *B* items. The Rape and attitudes to women scale was the only scale on which the scores for all participants decreased or remained unchanged (*A* items only). On the Exhibitionism scale all participants scores either increased or remained the same (*A* items only). Although all participants had offended against children, their scores on the Offences against children scale were low.

As the participants did not present with a high frequency of cognitive distortions in the pre-treatment administration, it meant they were not able to improve a lot in the post-treatment administration. This was particularly true for Participant 3 who presented with the lowest scores of the participants. The following paragraphs identify specific areas of interest in each participant's results on the *A* items of the QACSO.

Participant 1: Generally, Participant 1's scores on the QACSO scales were similar between the pre and post-treatment administrations. Two scales, Homosexual abuse and Stalking and sexual harassment, showed higher scores and

appear to be areas of risk-relevant concern. The Dating abuse and Voyeurism were scales where Participant 1 scored low in both administrations.

Participant 2: Whilst the total score for Participant 2 only increased by one point, there were small but non-significant changes to several of the individual scale scores in both the expected and unexpected direction. Expected changes occurred on the Dating abuse, Stalking and sexual harassment, and Rape and attitudes to women scales. Unexpected changes occurred on the Exhibitionism, Homosexual abuse, and Offences against children scales.

Participant 3: As previously mentioned, the scores for Participant 3 were low in the pre-treatment administration therefore it did not allow for a great improvement, however his total score did show a small decrease. The only scale where he scored highly was Dating abuse, however the post-treatment results showed that this decreased to a similar score as on the other scales. The Stalking and sexual harassment and Voyeurism scales changed in the expected direction (decreased) and the Homosexual abuse and offences against children scales changed in the unexpected direction (increased).

Participant 4: All individual scale scores for Participant 4 were high except for the Voyeurism scale. His score on the Rape and attitudes to women scale was noticeably higher; however it did decrease in the post-treatment results. The only other scale that saw a decrease in the expected direction was the Homosexual abuse scale. The Exhibitionism, Dating abuse, Offences against children, and Stalking and sexual harassment scales all changed in the unexpected direction.

Table 7

Participants' pre and post-treatment scores on the Questionnaire on Attitudes Consistent with Sexual Offending (QACSO)

			Participants							
			1		2		3		4	
Scale		Maximum score	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Rape and attitudes to women	A	32	4	3	14	9	2	2	18	10
	B	20	6	8	4	4	4	6	10	10
Voyeurism	A	26	0	2	6	6	2	0	4	4
	B	16	9	2	10	5	9	2	2	6
Exhibitionism	A	26	5	6	4	8	0	0	8	10
	B	6	0	4	6	6	4	4	4	6
Dating Abuse	A	16	0	0	2	0	9	3	10	12
	B	4	0	2	2	0	1	2	0	0
Homosexual Abuse	A	18	10	8	6	10	2	3	10	6
	B	6	2	2	2	2	4	2	2	4
Offences against children	A	30	4	4	4	6	0	2	10	16
	B	6	2	2	0	0	0	0	2	2
Stalking and sexual harassment	A	32	10	10	12	10	3	2	10	16
Total Score	A	180	33	33	48	49	18	12	70	74
	B	58	19	20	24	17	22	16	20	28

Statistical analysis was conducted on the results of the QACSO to detect if a significant difference existed between pre-treatment and post-treatment scores. As the data was non-parametric a Wilcoxon Signed-rank analysis was carried out.

Analysis was initially performed using only *A* items as these were described by Lindsay, Whitefield and colleagues (2004) as the items with "the highest, most acceptable statistical properties" (pg. 3). Results from the statistical analysis demonstrated that none of the participants showed a significant difference in their scores on the QACSO.

A subsequent analysis was carried out which included the *A* and *B* items; *B* items were described by the Lindsay, Whitefield and colleagues as having "reasonable statistical properties" (2004, pg. 4). Again, results from this statistical analysis showed that none of the participants demonstrated a significant difference in their scores on the QACSO.

Assessment of Risk and Manageability of Intellectually Disabled IndividuaLs who Offend – Sexually (ARMIDILO-S)

The full ARMIDILO-S (stable and acute client and environmental items) was completed for all participants in the pre-treatment assessment phase. For each participant this included a file review, an interview with staff involved in the participant's care, and an interview with the participant. In the post-treatment assessment phase only the acute client and environmental items were assessed to ascertain if changes had occurred since the pre-treatment assessment.

Participant 1: The staff member interviewed as part of the ARMIDILO-S was the manager of a vocational service attended by Participant 1. The residential service provider declined to be involved in the research therefore the information

obtained about Participant 1's environment was limited to his activities at the vocational service.

Table 8 shows the pre-treatment factor ratings for Participant 1 on the ARMIDILO-S. The stable client items risk rating was high; noteworthy items were offence pathways, emotional coping ability, and mental health. Participant 1 did not have an understanding of the pattern of behaviour that led him to offend or the factors that increased his risk of offending. He was unwilling to discuss his offending or the circumstances surrounding the offending in the interview. He had difficulty coping with emotional situations, reacting with frustration or anger. He acknowledged that anger was problem for him and this was supported by the staff member interviewed. Participant 1 was on medication for a mental illness, however he was unsure of the symptoms that indicated to him that he was deteriorating and should seek additional support.

The acute client item protective ratings were slightly higher than the risk ratings. Of note in this section is a change in Participant 1's level of supervision whereby he was allowed independent time twice a week to go for a walk.

The protective ratings on the stable environmental items were also slightly high than the risk ratings. Significant protective factors were the relationship of the interviewed staff member with Participant 1, and her knowledge of his history and behaviour. An important risk factor in this section was communication among supervisory staff as there appeared to be some weaknesses in the information sharing process between the different service providers for Participant 1 that potentially increased his risk of re-offending.

On the acute environmental items, risk ratings were higher than protective ratings. Participant 1 experienced a loss of social support due to his mother

suffering from a serious injury. Risk was also increased by Participant 1's disclosure about planning and access to a potential victim.

Table 8

Participant 1's pre-treatment factor ratings on the ARMIDILO-S.

	Risk	Protective
Stable Client Items		
1. Supervision compliance	0	1
2. Treatment compliance	1	1
3. Sexual deviance	2	0
4. Sexual preoccupation/hypersexuality	1	0
5. Offence pathways	2	0
6. Emotional coping ability	2	1
7. Self-efficacy	1	0
8. Relationships	1	1
9. Substance abuse	1	0
10. Impulsivity	1	0
11. Mental Health	2	1
12. Unique Considerations	1	0
Stable Client Items Sub-total	15	5
Acute Client Items		
1. Changes in compliance with supervision/treatment	0	2
2. Changes in sexual preoccupation/hypersexuality	0	0
3. Changes in victim-related behaviours	1	0
4. Changes in emotional coping	1	0
5. Changes in use of coping strategies	0	1
6. Changes to unique considerations	0	0
Acute Client Items Sub-total	2	3
Stable Environmental Items		
1. Attitude towards ID individuals	0	2
2. Communication among supervisory staff	2	0
3. Client specific knowledge by supervisory staff	0	2
4. Consistency of supervision	1	1
5. Situational consistency	1	0
6. Unique considerations	0	0
Stable Environmental Items Sub-total	4	5
Acute Environmental Items		
1. Changes in social relationships	2	0
2. Changes in monitoring	0	2
3. Situational changes	0	0
4. Changes in victim access	2	1
5. Changes in access to intoxicants	1	0
6. Unique considerations	0	0
Acute Environmental Items Sub-total	5	3

Tables 9 and 10 show a comparison of the pre-treatment and post-treatment ratings for Participant 1 on the acute client and acute environmental sections respectively. On the acute client items Participant 1 presented with an increased risk and increased protective factors post treatment assessment. The increase in risk factors was the result of an increase in sexual preoccupation and an incident where sexually inappropriate comments were allegedly made towards a female the participant knew from his vocational service. He also began a relationship with a female and alluded to plans to have sexual intercourse with her in the future. The change in Participant 1's protective factors was marked, increasing by six points. He developed coping skills to help him deal with inappropriate thoughts related to children and the build up of sexual thoughts in his mind. A relationship with a female, who Participant 1 was suspected to have been grooming, has progressed to a friendship. He has learnt about and is aware of situations where he is at greater risk of offending (known in the SAFE-ID treatment as 'risky situations') and avoids these settings where possible.

Changes in Participant 1's acute environmental items are positive with a decrease in risk factors and increase in protective factors. The decrease in risk came as a result of being able to re-engage with his mother and utilise her support, and a lack of interest in and access to intoxicants. The change in protective factors includes an improvement in social relationships (shown through relationship with his mother and new girlfriend), decrease in monitoring, positive responses to changes in the location of one of his vocational services and to new support staff.

Table 9

Pre-treatment and post-treatment acute client item ratings on the ARMIDILO-S for Participant 1.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute client items				
1. Changes in compliance with supervision or treatment	0	0	2	2
2. Changes in sexual preoccupation/hypersexuality	0	1	0	2
3. Changes in victim-related behaviours	1	1	0	2
4. Changes in emotional coping	1	0	0	1
5. Changes in use of coping strategies	0	0	1	2
6. Changes to unique considerations	0	1	0	0
Acute Client Items Sub-total	2	3	3	9

Table 10

Pre-treatment and post-treatment acute environmental item ratings from the ARMIDILO-S for Participant 1.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute environmental items				
1. Changes in social relationships	2	0	0	1
2. Changes in monitoring	0	0	2	1
3. Situational changes	0	0	0	1
4. Changes in victim access	2	2	1	1
5. Changes in access to intoxicants	1	0	0	0
6. Unique considerations	0	0	0	0
Acute Environmental Items Sub-total	5	2	3	4

Participant 2: Three staff members were interviewed as part of the ARMIDILO-S for Participant 2. A key worker, who was involved in his daily care (but not involved with management and care plans), and a primary nurse, who oversaw his care and was involved in his management and care plans, were interviewed for the pre-treatment administration of the ARMIDILO-S. The primary nurse was unavailable for the post-treatment acute items interview as she was no longer employed by the service. As a result, the support worker who worked with Participant 2 on a regular basis and supported him throughout the SAFE-ID group (as a requirement of his Secure Care Order) was interviewed for the post-treatment acute item interview. For the pre-treatment assessment, Participant 2 was interviewed over two sessions as he was unable to cope with completing the full interview in one session. He also displayed some apprehensiveness and reservation in discussing his offending and sexual behaviour; therefore only limited information was obtained in the pre-treatment interview.

Table 11 shows the pre-treatment factor ratings for Participant 2 on the ARMIDILO-S. The stable client items risk rating was high, with scores given for every item except unique considerations. Of significance were his ratings on the sexual preoccupation item, emotional coping ability, and impulsivity items. Participant 2 was noted to frequently masturbate and had hidden inappropriate images of females in his room. He was easily angered and would respond with outbursts of verbal abuse and threats. His impulsiveness was demonstrated through his offending behaviour and an attempt to abscond shortly after his admission to inpatient care. Supervision and treatment compliance were items that

were noted as possible risk factors but also as protective factors because whilst he could be defiant towards staff and disruptive in group settings, he also responded well to specific staff, was able to deescalate, and could work hard on tasks set for him. Self-efficacy was noted as a possible protective factor because Participant 2 had a physical disability and a speech impediment, however these did not appear to affect him as much as one may expect and he presented as outgoing and confident.

In the acute client item ratings, protective ratings were higher than risk ratings. In the interview with Participant 2, he was apprehensive to discuss subjects related to his offending and sexual behaviour which made it difficult to assess recent change (staff were also unable to provide any relevant information to inform risk). The only acute risk factor identified was a change in his emotional coping ability; this was related to the effect the illness of a family member had on Participant 2. A noteworthy protective factor was a change in his compliance with supervision which came as a result of gaining leave for ground walks and positive attendance in group and individual treatment sessions.

The stable environment items showed a greater number of protective factors than risk factors; however there were key risk factors that were important in Participant 2's management. There appeared to be a lack of communication between staff in the treatment sessions and staff involved with his daily care, which resulted in a lack of awareness of the true level of risk Participant 2 presented. A lack of consistent supervision created some uncertainty and frustration for Participant 2 which resulted in him becoming irritable and angry. Protective aspects of Participant 2's environment included an honest and generally positive response about him from the two staff members interviewed, and a sound

knowledge demonstrated by both staff of his behaviour patterns, triggers, and risk factors. As Participant 2 resided in an inpatient facility, his environment was relatively stable and consistent. He generally responded well to staff instruction and was not afforded preferential treatment by any of the staff.

The risk and protective factors for the acute environmental items were balanced. Risk factors included difficulty that Participant 2 had in making friends, some lack of support from his family, and a preference for certain staff to be assigned to him in order for him to effectively engage with them. The acute environmental protective factor present in the pre-treatment assessment was the positive shift in Participant 2's monitoring whereby he was granted leave for ground walks.

Tables 12 and 13 show a comparison of the pre and post-treatment ratings for Participant 2 on the acute client and environmental sections respectively. In the post-treatment interview, Participant 2 was more open and the interview was conducted in one session. On the acute client items, Participant 2 presented with a greater number of risk factors, and an increase in protective factors. A major contributor to the increased risk resulted from a complete lack of contact from Participant 2's family; the affect this had on him was shown through an increase in sexual thoughts and thoughts related to his offending, and periods where he did not want to attend the SAFE-ID group. A unique consideration that arose from information obtained from staff was Participant 2's obsession with violence and guns; whilst there was not a lot know about this issue and there was not an opportunity to discuss it with Participant 2, it presented as a potential risk factor for him. Protective factor changes included a further extension of his leave and positive responses to and behaviour in treatment. He developed a greater

understanding of his offending pattern and made effective use of coping strategies to deal with anger and sexual preoccupation.

On the acute environmental factors, Participant 2 again presented with an increased number of risk factors from pre-treatment but only a small increase in protective factor ratings. The lack of contact with his family is shown through the increase in risk related to social relationships. He experienced change in his primary nurse which affected his general behaviour on the ward and participation in treatment. He had more exposure to potential victims; however he coped well with this and responded well to direction regarding appropriate behaviour towards women. He further increased his time out of the facility with leave granted for daily ground walks and weekly trips to a nearby shopping centre.

Table 11

Participant 2's pre-treatment factor ratings on the ARMIDILO-S.

	Risk	Protective
Stable Client Items		
1. Supervision compliance	1	2
2. Treatment compliance	1	2
3. Sexual deviance	2	0
4. Sexual preoccupation/hypersexuality	2	1
5. Offence pathways	2	0
6. Emotional coping ability	2	1
7. Self-efficacy	1	1
8. Relationships	1	1
9. Substance abuse	1	1
10. Impulsivity	2	0
11. Mental Health	1	0
12. Unique Considerations	0	0
Stable Client Items Sub-total	16	9
Acute Client Items		
1. Changes in compliance with supervision/treatment	0	2
2. Changes in sexual preoccupation/hypersexuality	0	0
3. Changes in victim-related behaviours	0	1
4. Changes in emotional coping	1	1
5. Changes in use of coping strategies	0	0
6. Changes to unique considerations	0	0
Acute Client Items Sub-total	1	4
Stable Environmental Items		
1. Attitude towards ID individuals	0	2
2. Communication among supervisory staff	2	1
3. Client specific knowledge by supervisory staff	0	2
4. Consistency of supervision	1	2
5. Situational consistency	0	2
6. Unique considerations	1	0
Stable Environmental Items Sub-total	4	9
Acute Environmental Items		
1. Changes in social relationships	1	0
2. Changes in monitoring	1	2
3. Situational changes	0	0
4. Changes in victim access	0	0
5. Changes in access to intoxicants	0	0
6. Unique considerations	0	0
Acute Environmental Items sub-total	2	2

Table 12

Pre-treatment and post-treatment acute client item ratings from the ARMIDILO-S for Participant 2.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute client items				
1. Changes in compliance with supervision or treatment	0	1	2	2
2. Changes in sexual preoccupation/hypersexuality	0	2	0	0
3. Changes in victim-related behaviours	0	1	1	2
4. Changes in emotional coping	1	1	1	2
5. Changes in use of coping strategies	0	0	0	2
6. Changes to unique considerations	0	1	0	0
Acute Client Items Sub-total	1	6	4	8

Table 13

Pre-treatment and post-treatment acute environmental item ratings from the ARMIDILO-S for Participant 2.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute environmental items				
1. Changes in social relationships	1	2	0	0
2. Changes in monitoring	1	2	2	2
3. Situational changes	0	1	0	0
4. Changes in victim access	0	1	0	1
5. Changes in access to intoxicants	0	0	0	0
6. Unique considerations	0	0	0	0
Acute Environmental Items Sub-total	2	6	2	3

Participant 3: The staff member interviewed as part of the ARMIDILO-S was a care manager for Participant 3's residential provider; she oversaw his management and care for his residence and daily activities.

Table 14 shows the pre-treatment factor ratings for Participant 3 on the ARMIDILO-S. Although he had risk ratings on all stable client items but mental health, noteworthy items were offence pathways, self-efficacy, and relationships. Participant 3 demonstrated a pattern of denial and minimisation of his offences, and had a tendency to shift blame to his victims. In the interview, he presented with a negative outlook, and frustration that he was still under the IDCC&R Act when he did not think he should be. He felt this limited his ability to engage in society (e.g. in paid employment). Feelings of loneliness were reported by Participant 3, and this was confirmed by staff. He was described to fall into the wrong relationships whereby he would gravitate towards those who would accept him; this included forming relationships with people much younger than himself because he described feeling more comfortable with them. Participant 3 had previously engaged in individual treatment and learned coping strategies (e.g. 'wise mind') which were viewed as a protective factor, however this also meant that he was able to "talk the talk" without necessarily following through with appropriate actions. His relationship with his partner and children provided motivation for him; therefore these relationships were viewed as a protective factor. Participant 3 had no history of mental illness.

Protective ratings for the acute client factors were slightly higher than risk ratings. Risk ratings were related to inappropriate behaviour towards a female staff member and self-reported difficulty in coping with stress, frustration and

loneliness. Protective factors included a decrease in supervision and changes in his partner and family that he reported as having a positive effect on him.

The risk ratings for the stable environmental items were low, and the protective ratings were high. There was some doubt about the consistency of supervision received from family and residential staff with preferential treatment and ineffective supervision being concerns. The staff member interviewed expressed some scepticism about Participant 3's relationship with his partner and the support offered by his family. Protective factors in Participant 3's environment included sound communication between staff and awareness of risk and management plans. The staff member interviewed had a good knowledge of his risk factors and behavioural patterns, and had previous experience with the SOTSEC-ID program (on which the SAFE-ID program was based).

Risk ratings for the acute environmental items were slightly higher than protective ratings. A key change was an extension of his informal care order, meaning he would remain under the IDCC&R Act for longer; this caused difficulty between Participant 3 and his care manager. The extension of his order also created some difficulties in his relationship with his partner. Changes to his environmental protective factors included the reduction in supervision levels and the absence of any desire to access or use intoxicants.

Tables 15 and 16 show a comparison of the pre and post-treatment ratings for Participant 3 on the acute client and acute environmental sections respectively. The increase in acute client risk factors related to compliance with supervision and treatment, victim-related behaviours, and sexual preoccupation was due to an incident whereby Participant 3 used a cell phone to store inappropriate messages and photographs of females. Following the discovery of this incident, Participant

3 disengaged with the staff member interviewed for several weeks. Whilst no charges were laid, it was considered a serious incident and lapse in his progress. In the post-treatment interview, Participant 3 demonstrated a lack of insight into his behaviour through his minimisation of the seriousness of the incident, and expressed the opinion that he had received enough treatment after completing individual therapy and the SAFE-ID group. Despite the above concerns, Participant 3 showed an increase in his protective factors related to an increased awareness of the type of victim he targets (and the reasons why he targets this type of victim), and awareness of his triggers for offending. In addition, he also reported using coping strategies learned from the SAFE-ID group (thus showing some mitigation of risk), for example removing himself from inappropriate discussions and situations.

In the acute environmental ratings, the risk ratings increased whilst the protective factors remained neutral with some changes between items. A change in victim access related to the incident with the cell phone as he accessed victims present in his everyday environment. This also meant his supervision was increased and he was unable to participate in some recreational activities. Participant 3 presented to staff as though he was learning skills from the SAFE-ID group, however his inappropriate actions with the cell phone demonstrated that he still had some behavioural problems. Change in the post-treatment protective factors was due to the increased monitoring (therefore it was no longer a protective factor) and Participant 3 responding well to the prospect of his parents being unable to offer support for several months due to being overseas.

Table 14

Participant 3's pre-treatment factor ratings on the ARMIDILO-S.

	Risk	Protective
Stable Client Items		
1. Supervision compliance	1	1
2. Treatment compliance	1	1
3. Sexual deviance	2	0
4. Sexual preoccupation/hypersexuality	1	1
5. Offence pathways	2	1
6. Emotional coping ability	1	0
7. Self-efficacy	2	1
8. Relationships	2	2
9. Substance abuse	1	1
10. Impulsivity	1	1
11. Mental Health	0	2
12. Unique Considerations	1	0
Stable Client Items Sub-total	15	11
Acute Client Items		
1. Changes in compliance with supervision/treatment	0	1
2. Changes in sexual preoccupation/hypersexuality	0	0
3. Changes in victim-related behaviours	1	0
4. Changes in emotional coping	1	1
5. Changes in use of coping strategies	0	1
6. Changes to unique considerations	0	0
Acute Client Items Sub-total	2	3
Stable Environmental Items		
1. Attitude towards ID individuals	0	1
2. Communication among supervisory staff	0	2
3. Client specific knowledge by supervisory staff	0	2
4. Consistency of supervision	1	1
5. Situational consistency	1	2
6. Unique considerations	1	0
Stable Environmental Items Sub-total	3	8
Acute Environmental Items		
1. Changes in social relationships	1	0
2. Changes in monitoring	2	1
3. Situational changes	1	0
4. Changes in victim access	0	0
5. Changes in access to intoxicants	0	2
6. Unique considerations	0	0
Acute Environmental Items Sub-total	4	3

Table 15

Pre-treatment and post-treatment acute client item ratings from the ARMIDILO-S for Participant 3.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute client items				
1. Changes in compliance with supervision or treatment	0	2	1	1
2. Changes in sexual preoccupation/hypersexuality	0	1	0	1
3. Changes in victim-related behaviours	1	2	0	2
4. Changes in emotional coping	1	1	1	1
5. Changes in use of coping strategies	0	1	1	1
6. Changes to unique considerations	0	1	0	0
Acute Client Items Sub-total	2	8	3	6

Table 16

Pre-treatment and post-treatment acute environmental item ratings from the ARMIDILO-S for Participant 3.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute environmental items				
1. Changes in social relationships	1	1	0	1
2. Changes in monitoring	2	2	1	0
3. Situational changes	1	0	0	0
4. Changes in victim access	0	2	0	0
5. Changes in access to intoxicants	0	1	2	2
6. Unique considerations	0	2	0	0
Acute Environmental Items Sub-total	4	8	3	3

Participant 4: Two staff members were interviewed for the pre-treatment assessment of the ARMIDILO-S. The first was the care manager for Participant 4's residential provider and oversaw the management and care for his residence and daily activities; he was interviewed following Participant 4's completion of the SAFE-ID group. The second person interviewed was a staff member from a vocational service attended by Participant 4, who had regular interactions with him. This person was unavailable for a post-treatment interview.

Table 17 shows the pre-treatment factor ratings for Participant 4 on the ARMIDILO-S. In the stable client items, significant risk factors were Participant 4's sexual deviance and lack of knowledge of appropriate sexual relationships, lack of understanding of intimate relationships, and tendency to make friends with antisocial peers. Impulsivity was important as this was related to his offending and previous use of violence. A unique consideration for Participant 4 was that he was easily influenced by others and this had proved to cause problems for him in the past. Important protective factors for him were his compliance with supervision and treatment; he followed staff direction and generally attended groups and daily activities without difficulty. He would seek staff assistance if he was having difficulty coping with any problems. He did not have a history of substance abuse or problems related to his substance use.

The acute client items for Participant 4 showed slightly higher protective factors than risk factors. Acute risk at this time related to staff concern about a potential victim at one of his day activities and difficulties he was experiencing emotionally where he reported feeling lonely. With respect to protective factors, Participant 4 was demonstrating a positive attitude towards attending the SAFE-ID group and had been given permission to go for walks without supervision.

Stable environmental items showed high risk factors and protective factors. Situational consistency was important to Participant 4 as he was easily upset by changes to his routine and he would present with either anxious or disruptive behaviour. He was dependent on staff for support; however some staff did not appear to have a thorough understanding the factors that placed him at risk of sexual offending. Protective factors in Participant 4's environment included open communication between his residential and day placement setting and consistent monitoring.

Acute environmental items also showed low risk and protective factors. Risk factors included concern with attention he paid to a specific staff member and a reduction in supervision when he was allowed out for independent walks. Protective factors included the continued monitoring of Participant 4 despite his increased independence and his continued resistance of substance use.

Tables 18 and 19 show a comparison of the pre and post-treatment ratings for Participant 4 on the acute client and acute environmental sections respectively. In the acute client items, his risk factors increased in the post administration. This related to an incident where he established a cell phone account and made a large number of calls to a phone sex line. It was noted by one of the staff interviewed that there are periods where Participant 4 has a greater sexual preoccupation and is more focussed on females; the incident occurred during one of these periods. There was also some concern regarding whether Participant 4 understood the material covered in the SAFE-ID group. There were occasions where he gave the impression to staff that he understood discussions but would leave group sessions or team review meetings with questions that he would ask staff later.

Protective factors in the acute client section did increase from pre to post-treatment. Whilst his compliance with supervision decreased (as a result of the incident) he demonstrated improved mood and increased use of coping strategies, for example talking with staff more. He also continued to show no interest in gaining access to or using substances therefore this was viewed as a definite protective factor for him.

In the acute environmental section, risk factor ratings increased and protective factor ratings remained the same. Increased risk was largely related to changes in staff whereby Participant 4 was assigned a new care manager and key worker. The loss of his previous care manager was important as Participant 4 had developed a good relationship with him and relied on him frequently for support. He reported that these new staff were not as strict, but also stated that he was not getting on with female staff. A protective factor that changed slightly yet still held the same rating was related to his monitoring. Participant 4 had his care order under the IDCC&R Act extended therefore his monitoring was increased in order to ensure a gradual progression to being unsupervised in the community.

Table 17

Participant 4's pre-treatment factor ratings on ARMIDILO-S.

	Risk	Protective
Stable Client Items		
1. Supervision compliance	1	2
2. Treatment compliance	0	1
3. Sexual deviance	2	0
4. Sexual preoccupation/hypersexuality	2	0
5. Offence pathways	1	0
6. Emotional coping ability	1	1
7. Self-efficacy	1	1
8. Relationships	2	1
9. Substance abuse	0	2
10. Impulsivity	2	1
11. Mental Health	1	0
12. Unique Considerations	1	0
Stable Client Items Sub-total	14	9
Acute Client Items		
1. Changes in compliance with supervision/treatment	0	2
2. Changes in sexual preoccupation/hypersexuality	0	0
3. Changes in victim-related behaviours	1	0
4. Changes in emotional coping	1	0
5. Changes in use of coping strategies	0	1
6. Changes to unique considerations	0	1
Acute Client Items Sub-total	2	3
Stable Environmental Items		
1. Attitude towards ID individuals	0	2
2. Communication among supervisory staff	0	2
3. Client specific knowledge by supervisory staff	1	2
4. Consistency of supervision	1	1
5. Situational consistency	2	1
6. Unique considerations	1	0
Stable Environmental Items Sub-total	5	8
Acute Environmental Items		
1. Changes in social relationships	0	0
2. Changes in monitoring	1	1
3. Situational changes	0	0
4. Changes in victim access	1	0
5. Changes in access to intoxicants	0	2
6. Unique considerations	0	0
Acute Environmental Items Sub-total	2	3

Table 18

Pre-treatment and post-treatment acute client item ratings from the ARMIDILO-S for Participant 4.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute client items				
1. Changes in compliance with supervision or treatment	0	2	2	1
2. Changes in sexual preoccupation/hypersexuality	0	2	0	0
3. Changes in victim-related behaviours	1	1	0	0
4. Changes in emotional coping	1	1	0	1
5. Changes in use of coping strategies	0	1	1	2
6. Changes to unique considerations	0	0	1	2
Acute Client Items Sub-total	2	6	3	6

Table 19

Pre-treatment and post-treatment acute environmental item ratings from the ARMIDILO-S for Participant 4.

	Risk		Protective	
	Pre	Post	Pre	Post
Acute environmental items				
1. Changes in social relationships	0	1	0	0
2. Changes in monitoring	1	1	1	1
3. Situational changes	0	2	0	0
4. Changes in victim access	1	1	0	0
5. Changes in access to intoxicants	0	0	2	2
6. Unique considerations	0	0	0	0
Acute Environmental Items Sub-total	2	5	3	3

Inter-rater reliability

Inter-rater reliability was calculated for the RRASOR, STATIC-99 and SVR-20. Pearson's correlation coefficients were computed using the ratings of each rater on the individual items as data. Results from the analysis, as shown in Table 20, indicate that inter-rater reliability was very high for all measures: RRASOR (M = 1.000), STATIC-99 (M = 0.995), and SVR-20 (M = 0.991).

Table 20

Individual and mean inter-rater reliability for the RRASOR, STATIC-99 and SVR-20

	Participant				Mean
	1	2	3	4	
Measure					
RRASOR	1.000	1.000	1.000	1.000	1.000
STATIC-99	1.000	1.000	0.980[a]	1.000	0.995
SVR-20	0.994[a]	0.993[a]	0.990[a]	0.987[a]	0.991

[a] correlation is significant at the 0.01 level (2-tailed)

Discussion

Research in the field of intellectually disabled sex offender assessment is deficient, in the sense that there is no proven test methodology that can has been evaluated to assess pre-post risk-relevant changes over a course of sex offender treatment. The present study was designed to examine a set of measures that could be used to thoroughly assess risk and treatment needs. The measures were selected on the basis that they may show change to risk relevant factors following the completion of a group treatment program.

Although the research was limited due to the small sample size, there were still some statistically and clinically significant results found that demonstrated change post treatment in the expected direction. However, some measures used did not show change as expected and possible reasons for these findings are discussed at the end of this section.

Expected changes

The results for the pre-post analysis of the SVR-20 were as expected with decreased total scores, indicating a decreased in the participants' level of risk. These results demonstrate change that was clinically significant for the participants; however the change was not statistically significant. Dynamic items that showed change for some participants included minimisation and denial of sex offences, attitudes that support or condone sex offences, future planning (lacks realistic plans), and (negative) attitude towards intervention. Previous research utilising the SVR-20 (Sjostedt & Langstrom, 2001; de Vogel et al, 2004) examined the predictive validity of the SVR-20 in relation to other risk measures.

To date, no studies have used the SVR-20 to examine change post treatment with IDSOs or non-IDSOs.

The lack of statistical significance obtained in the analysis of the SVR-20 scores may have been a result of the small sample size. It may also have been caused by the limited number of dynamic factors included in the SVR-20, as the majority of factors are static and will only change as an offender gets older or commits a new offence. It may be that the SVR-20 is not sensitive enough as a measure to detect change in dynamic factors, and that in order for the measure to show statistically significant change in a pre-post comparison there would need to be a greater proportion of dynamic factors included in the measure (or the dynamic aspects of some of the apparently stable factors more clearly explicated, such as could be done in the substance abuse item for example).

The results for the pre-post analysis of the ASK were as expected with generally increased total scores, indicating an increase in participants knowledge of, and attitudes towards sexuality. Statistically significant improvements were found for Participants 1, 2 and 3; the results for Participant 4 were not statistically significant. Pre and post-treatment administrations of the ASK demonstrated that Sexual health and Menopause were areas where participants did not improve. In comparison, knowledge of Parts of the body, Sexuality, and Contraception were areas that participants generally improved on.

Previous research by Galea et al. (2004) found that participants had poor knowledge of sexually transmitted infections, sexual health, safer sex practices, legal issues regarding sexuality (rights), and contraception. Participants in their study were not specifically identified as IDSOs, but a small percentage had participated in unspecified offender treatment programs or had displayed

problematic socio-sexual behaviour. Whilst Galea and colleagues did not examine pre-post change in ASK scores, a comparison of the mean section scores from their study with the individual results for participants in the present study showed that participants in the present study generally demonstrated greater knowledge on all sections of the ASK. Thus, it would appear that this is in line with the findings of Michie and colleagues (2006) whereby IDSOs demonstrated a greater level of sexual knowledge than control participants.

Results for the pre-post analysis of the acute items in the ARMIDILO-S generally showed an increase in participants' client and environmental protective factors. Whilst this was an expected result, the results for the acute client and environmental risk factors was unexpected and is discussed below.

The results of the RRASOR and STATIC-99 were not assessed post-treatment as these measures are actuarial measures based on static factors that do not change over time (Lambrick, 2003). The exclusive use of actuarial measures in assessing risk has been criticised for the limited view of risk it produces, and the inability to assess change following treatment (Keeling et al., 2007). However, in the present study, the RRASOR and STATIC-99 were utilised in order to provide an estimate of baseline risk. The results of these assessments were relatively consistent with the legal status of the participants including in the present research. For example, Participant 2 was rated as the highest risk of the four participants with a moderate to high risk rating on the RRASOR and high risk rating on the STATIC-99. These risk ratings are consistent with his current requirement for inpatient care on a Secure Care order under the IDCC&R Act 2003 (Ministry of Health, 2003).

The use of actuarial measures with the IDSO population does lend its hand to under-representations of risk as often sexual offending by IDSOs is merely considered challenging behaviour and not brought before the judicial system where charges would be made (Beech, Fisher, & Thornton, 2003; Keeling et al., 2007). This limitation of actuarial measures was highlighted in the present research in the RRASOR and STATIC-99 assessments for Participant 1. Whilst Participant 1was technically not eligible for assessment with the RRASOR and STATIC-99, his hypothetical ratings on these measures placed him at moderate to high and high risk, yet he was a voluntary participant of the SAFE-ID group and not on a formal order under the IDCC&R Act 2003.

Unexpected changes

The results for the pre-post analysis of the QACSO were not as expected; the post-treatment scores were consistently lower than the pre-treatment scores which would have indicated a decrease in socially unacceptable responses. However, analyses of the results from the QACSO did not find any statistically significant change between the pre and post administrations. This lack of significant change may be due to a floor effect, given that participants' pre-treatment scores were already relatively low.

These results are comparable to previous research which utilised the QACSO with similar populations and treatment conditions. Murphy, Powell, Guzman and Hays (2007) and Rose, Jenkins, O'Connor and Jones (2002) both found that whilst total scores on the QACSO decreased, results were not statistically significant. Lindsay and Smith (1998) found significant results that demonstrated that 2 years of probationary treatment was superior to 1 year of

probationary treatment; however their study only employed the Exhibitionism and Offences against children scales.

The lack of significant results in the present (and previous) research demonstrates that whilst treatment may be effective with risk relevant factors like sexual knowledge, it is not effective in changing cognitive distortions. Maruna and Mann (2006) suggested that minimisation and denial are normal human processes and focusing on eliminating them through treatment may not be an effective goal. Further, the authors stated that the explanations that include cognitive distortions, like minimisation and denial, may actually provide links to specific dynamic factors for an offender that could be targeted in treatment.

Results for the ARMIDILO-S risk ratings for acute items were not as expected; generally participants' risk levels increased on client and environmental items over treatment. Whilst Participants 3 and 4 had incidents of inappropriate behaviour and it would make sense for their risk to increase, Participants 1 and 2 were not reported to have reoffended and yet their risk factor ratings increased. It appears that through the treatment process, rapport developed between the participants' and SAFE-ID treatment team which helped to facilitate a greater knowledge of the participants' thinking and behaviour patterns and resulted in more thorough ARMIDILO-S assessment post-treatment (compared to the pre-treatment assessments). For example, the author noted that in the post-treatment interviews for the acute items of the ARMIDILO-S, participants were more at ease in discussing topics of a sexual nature.

Further, it is possible that environmental factors would not always be expected to decrease following treatment as these are factors that are generally outside an offender's control and treatment is focused on working with the

offender, not their environment. For example, some participants had changes in staff which affected their risk, however changes to staff are outside their control. Such changes may or may not be related to actual offending and there was no analysis of the relationship of such changes in risk measures to actual re-offending in this study. Thus, some changes in environmental risk factors may be spurious or prognostic - these possibilities need to be examined in future research utilizing a larger sample over a longer follow-up period.

Limitations and Future Directions

The present research had several limitations which will be discussed in the following paragraphs.

Firstly, the small sample size was a key limitation in terms of gaining statistically significant results and because of this, the results must be interpreted with caution. Many studies in the area of IDSO assessment and treatment have utilized small samples and have acknowledged this as a limitation (e.g. Murphy et al., 2007) inherent to the area given the limited numbers of such offenders in the sex offender population in general.

Another limitation was that the present research did not use a no-treatment comparison group, therefore it is not possible to state whether attending the SAFE-ID treatment group was a factor that contributed to increased sexual knowledge on the ASK, decreased risk on the SVR-20, or the increases in the acute protective factor ratings on the ARMIDILO-S.

Because of the nature of the ARMIDILO-S, whereby staff were evaluated on their knowledge of participants' behaviour, their interactions with participants, and their perspectives on the participants' care and management, it is possible that

responses to questions were affected by impression management or other common sources of bias (e.g., dishonesty, incompleteness, or trying to please the interviewer), even though anonymity was assured by the author. At times, staff interviewed appeared to demonstrate restraint and apprehension in discussing areas of concern or areas where they felt a participant's care may have been managed better.

Further, the decision by staff involved the participants' care not to take part in the research meant that the information gathered by the ARMIDILO-S was limited. More complete assessment with key staff may have led to greater information regarding strengths, weaknesses, and areas of recent change.

The use of self-report scales has been noted to lead to dishonest reporting that may not present a true picture of risk (Williams, Wakeling & Webster, 2007); this may have affected the results in the present research. The discussion of sexual behaviours with a stranger can be uncomfortable and may have lead to some impression management on the part of the participants. However, the use of actuarial measures (like the RRASOR and STATIC-99), file information, and interviews with staff in the present study, helped to develop a more accurate picture of risk and is hoped counteracted potential bias.

The present research has shown some evidence of logically consistent risk-relevant changes that occurred over the course of treatment, supporting the use of some of the measures employed in this study. Further research examining risk relevant changes over the course of treatment with a larger sample would be beneficial and may lead to more logically consistent results. The use of a no-treatment comparison group would also provide useful information on changes

that occur as a result of the treatment and those which may occur naturally over time.

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Appendix A

Participant information sheet and consent form.

Research into the Effectiveness of Assessment Instruments in Measuring Change in Persons with Intellectual Disabilities who have Sexually Abusive Behaviours and/or who have Sexually Offended.

My name is Vanessa Burrett and I am a student from the University of Waikato who is doing some research as part of my studies. I would like to tell you about my research project, and then ask you if you would be interested in being involved.

My research involves looking at the use of assessment instruments to measure change in persons with intellectual disabilities who have engaged in sexually abusive behaviours or who have sexually offended. I want to assess your progress by attending a programme (either a group or individual work with a SAFE therapist). The research will look at how useful these instruments are and if they predict how well you will do in treatment.

As part of this research, I would like to meet with you and ask you some questions. I would also like to ask your key worker and your care manager some questions. Everyone who agrees to be part of the research project will get asked the same questions. I will talk to you and your key worker before you start the group and after you have been in the group for 7 months.

Any information you or your key worker tells me will be kept private except where you have provided me with some information which raises some concern about your safety and risks to other people. In this case, it is my responsibility to inform the clinical team and/or your care manager about these concerns. When I write about the research work I will not include any names, addresses or other details that could identify you. If you tell me something that makes me think that you or someone else is in danger, I will have to tell someone that is responsible for making sure you, and others around you, are safe. If this happens I will try to tell you first.
If you say YES, but change your mind later, you can say NO and stop being involved in the research. All you have to do is tell one of the staff, and any information I have will be taken out of the research and destroyed.

The SAFE therapist will always be available to talk about the research with you and answer any questions you have.

If you want to contact the person who is running the whole research project, you can speak with Dr Joseph Allan Sakdalan, my clinical supervisor from the Regional Forensic Psychiatry Services. His telephone number is xxxxxx, and his email address is xxxxxxxxxxxx. If you agree for me to ask your key worker some questions, please tick this box. ☐

If you would like to say YES and be part of my research please sign the bottom of this form. This means you agree that you understand the information I have given you about the research I am doing and that you are willing to take part in it.

Name: ____

Date: ____

Signature: ____

Witness: ____

Date: ____

Signature: ____

Appendix B

Staff information sheet and consent form

Dear ______________________

My name is Vanessa Burrett and I am completing a Masters of Social Sciences in Psychology at The University of Waikato.

The research is part of my Masters thesis, working in collaboration with SAFE Network in Auckland. The research considers the effectiveness of a series of psychometric tests in measuring risk, level of sexual knowledge, and belief systems about sexual offending in intellectually disabled sex offenders. The study will also consider the effectiveness of these tests in measuring change in the participants after treatment.

Information about the client's past and present behaviour is necessary to complete some of the psychometric tests included in the research. This information will assist in determining if the psychometric tests are giving an effective picture of participants' risk level and their response to treatment interventions.

As a researcher, I hold a strong personal commitment to maintaining confidentiality with respect to any information obtained in the research process. The following are some key points that highlight my commitment in the research to maintaining the dignity and respect of yourself and the participants.

1. The research project has received approval from the University of Waikato Department Of Psychology Human Ethics Committee (available on request).
2. All information gathered as part of the research is anonymised through each participant being allocated an identifier.
3. There will be no use of staff names in the recording of information.
4. I am bound by the confidentiality rules like any clinical staff member from SAFE Network in that I cannot disclose any information about the client(s) unless I have major concerns about safety of the client or safety of a potential victim. In this case, I will discuss my concerns immediately with the manager of the house where the client resides and the group facilitators from the SOTSEC-ID group.

If you have any further questions please do not hesitate to contact myself or my clinical supervisor, Dr Joseph Allan Sakdalan, on the details provided below.

Vanessa Burrett

Phone:

Email:

Joseph Sakdalan

Phone:

Email:

If you understand the above information and agree to participate in the research, please print and sign your name below.

Name: ____________________________________Date: __________________

Signature: ____

Appendix C

SAFE-ID group treatment information sheet

Waitemata District Health Board
Te Wai Awhina

ID OFFENDER SERVICE
REGIONAL FORENSIC PSYCHIATRY SERVICES
Pohutakawa Unit, Private Bag 19986, Avondale, Auckland 7
Ph: 09 845 7538 ext 5508 Fax: 09 845 7536

SAFE
stoppingsexualabuse

SAFE Programme
PO Box 8726
Symonds Street
Auckland

P: +64 9 377 9898 ext 732
F: +64 9 377 9229
www.safenetwork.org.nz

Does the Safe-ID Group really help men?

It is great that you want to be part of the Safe-ID Group. We want to find out if the Safe-ID Group really helps men to stop sexual offending. This is research work. We are inviting you to take part in this work. Please read this information before you decide. You can talk to someone (like your carer or an advocate) to help you decide.

Why are we asking you?
We are asking you because you have said "YES" to joining the Safe-ID Group.

Do you have to take part in finding out if the Safe-ID Group really works?

- No, you do not have to take part in this research work.
- If you say "YES", it is still OK to change your mind later and say "NO." You do not have to give a reason.
- You will still be able to go to the Safe-ID Group even if you say "NO"

What do you have to do, if you say "YES" to this?
As you know, the Safe-ID Group lasts about six month.

(Names of the staff removed in thesis) who run the Safe-ID Group will talk to you and ask you some questions:

- before the first day of the group,
- halfway through the group and
- after the last day of the group
- and 6 months after the end of the group.

You need to answer the questions as honestly as you can. There might be some questions that you do not want to answer. That is OK. You do not have to give a reason.
The questions will take about two or three visits to talk through.

What do we want to know?

- We want to know whether the Safe-ID Group helps men, by looking at your answers to the questions.

Is there anything bad about this research?

- Sometimes the questions may make you feel sad or upset. You can tell the person asking you the questions if you feel upset.
- Being part of this research may not help you.

Is there anything good about this research?

- The group and the research may help you to feel safer around other people.
- By saying "YES" to taking part, you will help other men because we will find out whether the Safe-ID Group really works.

What if you don't like the way this work is done?

- You can make a complaint to Mason Clinic, Regional Forensic Psychiatry Services or to SAFE Network.
- We will give you information about how to complain
- You may want to ask a friend or staff member to help you to make a complaint.

Will information kept about you be private?

- Yes. We will only tell someone else if we think that you or someone else is in danger, or if you tell us about a new offence.
- We will ask you if it is OK to tell your doctor about you being part of the research.
- We may need to look at your medical records and we will ask you if this is OK
- All of the results of this work will be kept locked away and only the research workers will be able to look at the files.
- If you pull out of the research, the information about you will be destroyed.

What happens at the end?

- We will tell you how well you have done
- We will tell you whether the Safe-ID Group helps men
- If you need more help (treatment or counselling) you can ask for some.
- The researchers will write about the work. No names or addresses will be given.

Who are the research workers and treatment team?

IDOLS team: (names of the staff removed in thesis)
SAFE team: (names of the staff removed in thesis)

Has the work been checked?

- People have looked at the work to check that it is safe.
- People have also checked that everyone gets good information before they start.

Further information:

- Thank you for reading the information about this work.
- You will be given a copy of the information sheet and consent form.
- You can talk to Dr Sakdalan (XX-XXX-XXXX Ext. XXXX) or (name of staff removed in thesis) (XX- XXX XXXX Ext. XXX) if you want more information.

Appendix D

SAFE-ID group treatment consent form

ID OFFENDER SERVICE
REGIONAL FORENSIC PSYCHIATRY SERVICES
Pohutakawa Unit, Private Bag 19986, Avondale, Auckland 7
Ph: 09 845 7538 ext 5508 Fax: 09 845 7536

SAFE Programme
PO Box 8726
Symonds Street
Auckland

P: +64 9 377 9898 ext 732
F: +64 9 377 9229
www.safenetwork.org.nz

CONSENT FORM FOR TREATMENT

Safe-ID Group

Name of Group Facilitators:
IDOLS team: (names of the staff removed in thesis)
SAFE team: (names of the staff removed in thesis)

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

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

I agree to join the Safe-ID Group ☐

My name: ___________________________
Date: _________
Signature: ___________________

Group leader: ________________________
Date: _________
Signature: __________________

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

Name: ___________________________________
Who is my: ___________________________________(keyworker etc)
Telephone Number: _________________

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Safe-ID Group

Some men with learning disabilities are being asked to join a Safe-ID Group. The Safe-ID Group is to help them stop sexually offending. You are being invited to join the Safe-ID Group.

Background:
Some men with learning disabilities commit sexual offences like:
- Touching a child on the 'private parts' (genitals)
- Showing other people their 'private parts' in public.
- Forcing someone to have sex with them.

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

The Safe-ID Group
We are starting a group to help men stop doing these sexual offences. The group will teach men about:
- Their bodies
- Who it is OK to touch and who it is not OK to touch
- What can get you into trouble
- Feelings
- How to stop sexual offending

Joining the Safe-ID Group
- The Safe-ID Group is every week at Whanau Room, Pohutakawa Unit at the Mason Clinic for 2 hours.
- The group lasts for about 6 month.
- There will be 5 – 10 men in the group.

Do I have to join the Safe-ID Group?
No, you do not have to join the Safe-ID Group.

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

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

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

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

What if I don't like what happens in the Safe-ID group?
- You can make a complaint to Mason Clinic, Regional Forensic Psychiatry Services or to SAFE Network.
- You will be given information about how to complain.
- You may want to ask a friend or staff member to help you make a complaint.

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

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

Contact name for further information:
You can talk to Dr Sakdalan (Phone (XX) XXX-XXXX Ext. XXXX) or (name of the staff removed in thesis) (Phone (XX) XXX XXXX Ext. XXX) if you want more information.

My Name: ____________________________________
Date: _________
Signature: _______________________________

Group Facilitator: _______________________
Date: _________
Signature: _________________

Appendix E

SAFE-ID group treatment information sheet for parents/caregivers

ID OFFENDER SERVICE
REGIONAL FORENSIC PSYCHIATRY SERVICES
Pohutakawa Unit, Private Bag 19986, Avondale, Auckland 7
Ph: 09 845 7538 ext 5508 Fax: 09 845 7536

SAFE Programme
PO Box 8726
Symonds Street
Auckland

P: +64 9 377 9898 ext 732
F: +64 9 377 9229
www.safenetwork.org.nz

[Insert date], 2009

Dear [insert name]

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

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

The group will be held at Whanau Room, Pohutakawa Unit at the Mason Clinic for 2 hours on Wednesday at 10-12pm for six month. It is important that ______ attends all sessions of the group.

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

Please do not hesitate to contact Dr Sakdalan (XX- XXX-XXXX Ext. XXXX) or Stefan Nagler (XX-XXX XXXX Ext. XXX) if you want more information if you have any questions or concerns about the treatment, or if there are any difficulties with transport for ______ to the group.

Yours sincerely

ID OFFENDER SERVICE
REGIONAL FORENSIC PSYCHIATRY SERVICES
Pohutakawa Unit, Private Bag 19986, Avondale, Auckland 7
Ph: 09 845 7538 ext 5508 Fax: 09 845 7536

SAFE Programme
PO Box 8726
Symonds Street
Auckland

P: +64 9 377 9898 ext 732
F: +64 9 377 9229
www.safenetwork.org.nz

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

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

What does the treatment involve?

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

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

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

Does it cost anything to receive the treatment?

The treatment will not cost anything to the individual or family.

How long is the treatment?

The treatment will last for about half a year. There will be one sessions per week each session lasting for 2 hours.

Does the individual have to take part?

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

For some men, the court legally requires their attendance at the group. Refusal or absence from the group may have legal consequences (e.g. breaching a probation order/return to court).

What happens if the individual does not like the treatment?

All men are able to withdraw from the treatment at any stage. However, for those men who are legally required to attend treatment, there may be legal consequences from withdrawing from the treatment.

What are the benefits of receiving treatment?

Research with non-disabled populations has suggested that this type of group treatment is successful in preventing re-offending. Individual progress in treatment may result in changes in legal status or the level of security required by the individual.

What are the risks of receiving treatment?

The treatment groups will address sensitive issues such as attitudes to potential victims of abuse. This may create mild psychological distress or embarrassment. Levels of distress will be monitored constantly during the group by clinicians that are experienced in responding to distressed individuals.

The level of risk that the individual poses to others will be monitored carefully by the group facilitators. Facilitators will maintain active links with parents/carers/ probation officers and doctors etc. to discuss perceived increases or decreases in risk.

What happens at the end of the treatment?

There are a range of options which may be offered to the individual following treatment, such as:

- individual therapy
- another full group therapy programme
- a maintenance group which reviews content of the first group, but meets less regularly (e.g. once per month).

All men will be staying in touch with learning disability services after the end of the group. Further treatment and/or counselling will be available.

What happens if the individual or I want to complain?

- You can make a complaint to Mason Clinic, Regional Forensic Psychiatry Services or to SAFE Network.
- You will be given information about how to complain.
- You may want to ask a friend or staff member to help you make a complaint.

Will the content of treatment be kept private?

Yes, however there may be times when an individual has given information which the group facilitators believe someone else needs to know (for example if the individual or someone else is in danger). The individual is aware of this limit to confidentiality. The individual is also aware that if disclosures of offences that have been previously unknown are made then the appropriate authorities will be contacted if the victim can be identified.

Will the individual get feedback at the end of the treatment?

The individual will be told about their progress in treatment. Feedback will also be given to the referring agent and other people involved in the individual's risk management.

What do I need to do?

You need to let us know if you have any concerns about ________ taking part in the treatment.

Contact name for further information:
You can talk to Dr Sakdalan (XX- XXX-XXXX Ext. XXXX) or (name of the staff removed in thesis) (XX-XXX XXXX Ext. XXX) if you want more information.

Appendix F

RRASOR and STATIC-99 Scoring

Scoring of the RRASOR and Static-99

Risk Factor	Codes		Score Options	Subject's Score
Prior Sex Offences (Same rules as in RRASOR)	Charges	Convictions		
	None	None	0	
	1-2	1	1	
	3-5	2-3	2	
	6+	4+	3	
Prior sentencing dates (excluding index offense)	3 or less 4 or more		0 1	
Any convictions for non-contact sex offences	No Yes		0 1	
Index non-sexual violence	No Yes		0 1	
Prior non-sexual violence	No Yes		0 1	
Any unrelated victims	No Yes		0 1	
Any stranger victims	No Yes		0 1	
Any male victims	No Yes		0 1	
Young	Aged 25 or older Aged 18-24.99		0 1	
Single? Ever lived with lover for at least two years?	Yes No		0 1	

Actuarial Method	Raw Score	Percentile Rank	Probability of Reoffense 7/10/15Years
RRASOR			
Static-99			

Appendix G

List of SVR-20 items

Sexual Violence Risk – 20 (SVR-20) items

Psychosocial Adjustment

1. Sexual deviation
2. Victim of child abuse
3. Psychopathy
4. Major mental illness
5. Substance use problems
6. Suicidal homicidal ideation
7. Relationship problems
8. Employment problems
9. Past nonsexual violent offences
10. Past nonviolent offences
11. Past supervision failure

Sexual Offences

12. High density of sex offences
13. Multiple sex offence types
14. Physical harm to victim(s) in sex offences
15. Uses weapons or threats of death in sex offences
16. Escalation in frequency or severity of sex offences
17. Extreme minimization or denial of sex offences
18. Attitudes that support or condone sex offences

Future Plans

19. Lacks realistic plans
20. Negative attitude toward intervention

Note: Adopted from Boer, Hart, Kropp, & Webster, 1997

Appendix H

ARMIDILO-S Client interview schedule

CLIENT INTERVIEW[1,2]

C. Stable Client Factors

1. Attitude Towards and Compliance with Supervision

1. Let's get started then – do you know why you have to live here? Would you rather be living somewhere else? Like where? Do you think you could live on your own? W/WN?[3]

____

____

____

2. What do you think about the rules? Do you think you need the rules? W/WN?

____

____

____

3. What would you like to be different with the rules?

____

____

____

4. Do you like your support worker (or equivalent term: support, key, case worker)?

____

____

____

[1] This interview is given after informed consent has been achieved – therefore, questions regarding consent and other introductory questions are not in the interview schedule.
[2] These questions need not be followed exactly – the interviewer is expected to modify the phrasing and content as per the understanding level of the client. Ensure the client feels you are trying your best to help them – it is better to over-simplify than assume the client understands you.
[3] W/WN is simply a short form for "why or why not"?

5. What does your care worker help you with?

____

____

____

____

2. Attitude Towards & Compliance with Treatment

1. Who are the people trying to help you keep safe? (e.g., key worker, probation officer)

____

____

____

2. How are they trying to help you? (e.g., programmes, medication, training programmes)

____

____

____

3. Do you think it (treatment, medication, training programmes) is helping you? W/WN?

____

____

____

4. What have you learnt in the programmes you have to go to? What, for example?

5. How much longer do you think you need to take these sorts of programmes?

6. How will you know when you're ready to stop taking treatment?

3. Sexual Behaviour

1. Have you ever had sex with someone? What did you do? Did you like it, or did someone force you do to something sexual with them?

2. What do you like sexually (or what sorts of things turn you on)?

____

____

3. Have you ever got in trouble because of doing something sexual? What happened?

____

____

____

____

4. Do you like magazines or catalogues with sexy pictures in them? Like what?

____

____

____

____

5. When is sex good or OK? When is it not OK? (Check for deviant interests or abuse history)

____

____

____

____

6. Is it OK to play with yourself/masturbate? Has this ever got you into trouble?

____

____

____

____

4. Inappropriate Preoccupation[4]

1. How often would you like to do [________________] (if you could get away with it)?

____

____

____

____

2. Why do you [____]?

____

____

____

____

3. Do you feel that doing [________________] is a problem for you? Could you stop if you wanted to? W/WN?

____

____

____

5. Victim Selection and Acquisition/Grooming

1. If you wanted to have sex with someone, how would you go about doing that?

____

____

____

____

[4] For this item the assessor should know from the staff member whether there is an inappropriate preoccupation of some concern and insert for the blank spaces indicated. A client may have a sexual preoccupation, or (or addition) a preoccupation with fire-setting, stealing, shoplifting, amongst others.

2. Are you allowed to have sex with other guys in the residence? Have you been able to have sex even if it's not allowed? How did you manage that?

___

___

___

3. Do you pick on other guys in the residence? How do you do that? Why do pick on some guys and not others? How about some staff – do you pick on some staff? Why?

___

___

___

___

4. (If the client has other negative or challenging behaviours that are problematic) how do you decide who to beat up (or which houses to burn, or whatever the behaviour is)?

___

___

___

___

6. Emotional Coping Ability

1. What sorts of things make you angry?

___

___

___

___

2. Do people tell you that you have a bad temper? Do you lose it easily?

____

____

____

____

3. (Ask the client about his visitors and staff members in order to find out how he/she reacted last time someone didn't show up when they were supposed to; or, how he/she reacted when a bus or ride or someone didn't show up as scheduled). For example, "how did you feel when your Mom didn't show up to visit yesterday? Or, "what would you do if the bus was late?"

____

____

____

____

7. Self-Efficacy

1. Do you like living in this place? Where would you like to live someday? What would you like to do some day for a living?

____

____

____

____

2. Do you have plans for the future? What are they?

____

____

3. What is the biggest problem you have at the moment? How can you solve that?

8. Relationship Skills[5]

1. How easy is it for you to make friends? Tell me about your best friend.

2. Do you ever feel lonely? How do you cope with that?

3. Have you ever had a girlfriend/boyfriend? Tell me about the relationship. How about now? What is special about a girlfriend or boyfriend)?

[5] Relationship skills in this context have to do with intimate relationships and friendships, as well as familial relationships.

4.Have you ever been married (if not, ask “do you think you’d like to get married someday?”)? W/WN?

5. Do you have children? How do you get along with them? (If the client does not have children, “would you like to have kids some day?”)

6. How do you get along with your Mom and Dad (assuming the client’s are alive and involved with his/her care)? Do you have brothers and sisters that are supportive?

9. Substance Abuse

1. Do you drink alcohol? (If yes: how much do you drink at a time?)

2. Do you smoke dope or use drugs? (If yes: how often/much?)

3. Have drugs or drinking caused any problems for you? W/WN?

10. Impulsivity

1. Do you sometimes act before thinking? Can you give me an example?

2. What's the silliest thing you've ever done on the spur-of-the-moment? Why did you do it? What happened after that?

3. Have you done risky things on a dare? Like what? Did you ever feel others sort made fun of you because you did something stupid? Like what? How did you feel afterwards?

____

____

____

____

____

4. Do you get bored easily? What do you do when you get bored?

____

____

____

____

11. Use of Violence or Threats towards Self or Others

1. Do you ever feel like you're going to lose your temper? When does that happen? How do people know when you're about to lose it?

____

____

____

____

2. Have you ever been so upset that you wanted to hurt yourself? Have you? When?

____

____

3. Have you ever been so upset you wanted to hurt someone else? What is the worst you've ever hurt someone?

12. Mental Health and Other Unique Considerations

1. Have you ever seen a doctor for any mental health problems? Like what?

2. Do you take any medications for your moods or anything like that? How does it help? How do you know if you are getting unwell? What do you do when that happens?

D. Acute Client Factors

1. Changes in Attitude or Behaviour toward Supervision or Treatment

1. (If the client has been moved to a new residence and especially if newly imprisoned) how are feeling about your move from your old residence to here? Do you know why you had to move? What do you think about your new place? Have you had any major problems here since you arrived? Like what? Anything I can do to help?

____

____

____

____

2. (If there any new personnel) How do you like your new support worker? Is she/he strict? Can you get away with stuff that you couldn’t with your last worker?

____

____

____

____

3. (If his/her monitoring levels have been changed and if the client is aware of the change) why did the staff change your level? How do you feel about that?

____

____

____

____

4. Do you attend the programmes you are supposed to? Are they helpful? Which ones are helpful and which ones are not? Can you think of any programmes that you might need?

____

____

____

____

____

2. Changes in Inappropriate Preoccupation[6]

1. How much have you been thinking about [_________________] – the same/more/less?

____

____

____

2. Have you had any thoughts or feelings about [___________] that have been building up? How do you handle it when that happens? How do you stop yourself from doing [__________]? (try really hard to get some detail – this is question is getting at the client's appreciation of their offensive behaviour pattern – and it also will provide the assessor and the treatment personnel with intervention ideas).

____

____

____

____

[6] For this item the assessor should know from the staff member whether there is an inappropriate preoccupation of some concern. A client may have a sexual preoccupation, but they may also have a preoccupation with bullying, fire-setting, stealing, shoplifting, amongst others.

3. Changes in Victim-Related Behaviours[7]

1. Do you like to hang out and wait for anyone from work or school because you find them sexy or cute? Have you tried to have sex with them? Have you ever been caught by the police or anybody when you're doing something like that? What happened?

___

___

___

___

___

2. Do you pick on anyone in particular? Why do you do that? (Again, this type of question is based on a reasonable history of victimizing others).

___

___

___

___

4. Changes in Emotional State or Regulation

1. Have there been any big changes with the important people in your life in the last few months (family and staff/professionals)? What has that been like for you?

___

___

___

___

[7] The questions asked for this item are predicated on the knowledge that the client has been (or has tried to be) involved in behaviours that victimize someone else. The nature of the questions would vary according to type of victimization and the above questions are illustrative for clients whose victim-related behaviours are sexual in nature.

2. How have you been feeling lately? (If up and down, or mostly down, why?)

____

____

____

3. Have things ever got so bad that you've thought about ending it all? (What caused that situation? When was the last time you felt like that? What stopped you?).

____

____

____

____

5. Changes in Ability to use Coping Strategies

1. Are you on any medication prescribed by a doctor? What and how much?

____

____

____

2. Have you been using alcohol or drugs in the last 3 months? How much?

____

____

____

3. Has your drinking/using drugs caused any problems for you in the past few months?

____

____

____

6. Changes to Mental Health Status and Other Unique Considerations (e.g., access to intoxicants)

1. Have you been using alcohol or drugs recently? (If yes, “how did you get the alcohol or drugs?”)

___

___

___

2. Is alcohol or drugs easier or harder to get here lately than before? Why/why not?

___

___

___

3. If you really wanted to, how could get your hands on alcohol or drugs? If yes, “how?”

___

___

___

4. Have you had any changes in your living arrangements recently that upset you? How about any new residents or anything else that you are having problems with?

___

___

___

5. Do you have anything you want to tell me that I haven't asked you? Do you have any questions for me? Thanks for your time!

Appendix I

ARMIDILO-S Staff interview schedule

STAFF INTERVIEW[8]

A. Stable Dynamic Environmental Factors

1. Attitude towards Intellectually Disabled Individuals

1. Tell me a bit about your client (____________)[9] (assuming the interviewee is a key worker; if the interviewee is a parent, then use “son” or “daughter” in place of client). How do you like working with him/her?

____

____

____

____

____

____

2. How would you define your role in relation to (__________); what are the important outcomes you are trying to achieve with (__________)?

____

____

____

____

____

____

3. Do you like this work? How long have you been doing this sort of work?

[8] This interview is for the staff member, parent, or support worker who is the primary worker or caregiver for the client being assessed.

[9] Whenever an underlined space (__________) is provided, please use the first name of the client being assessed.

____

____

4. What do you like best/worst about your clients?

____

____

____

____

5. Do any of your clients present special challenges for you? How about (__________)?

____

____

____

6. Why do you think your clients behave the way they do? More specifically, why do you think (__________) does some of the behaviours people seem concerned about?

____

____

____

____

____

____

7. Do you think you need any extra training to do your work more effectively?

____

____

2. Communication among Supervisory Staff

1. In your opinion, are there gaps in the information sharing process regarding (_________)'s care that need fixing?

____

____

____

____

2. Have there been times when critical information was not communicated to you? Has this impacted your ability to do your job effectively? How could this be fixed?

____

____

____

____

3. What information (if any) is kept confidential? What information is shared among staff and under what circumstances does this occur?

____

____

____

____

4. How do you share critical information about a client with staff members who need to know? For example, if (__________) did something violent to another person, how and when would you let other staff members know? Would you ever involve the police? How would you do that?

3. Client-Specific Knowledge by Supervisory Staff

1. What are the challenging (or offensive, or violent) behaviours that your client has problems with and when do they occur?

2. When or how do you know a challenging behaviour is likely to happen; what are his/her triggers for these behaviours?

3. What maintains the challenging behaviour?

4. What do you think works best to control (_________)'s challenging behaviour?

____

____

____

____

5. What do you think needs to be done to help (__________) decrease his/her behaviour? Is this feasible in this setting? What would be ideal to help manage his/her challenging behaviour?

____

____

____

____

____

____

6. How might the client behave away from this service/setting?

____

____

____

____

4. Consistency of Supervision

1. Does (__________) try to manipulate other staff members or residents? How?

____

____

____

____

2. Does (__________) manage to get preferential treatment from any of the other staff? Has he/she tried to manipulate you into getting preferential treatment?

____

____

____

____

3. Do you find that (__________)'s parents (or other supportive people external to the residential setting) reinforce negative behaviour patterns? Like what?

____

____

____

____

4. Do you have any suggestions for more effective management of your client?

____

____

____

____

5. Do you feel that your client is not being supervised effectively by some staff members? How is this affecting your client's well-being?

____

____

____

____

5. Situational Consistency

1. How dependent on consistency is your client? How do changes in consistency affect your client?

____

____

____

____

____

____

____

2. How does your client adjust to changes in routine, staffing or cancelled visits? Can you provide an example?

____

____

____

____

____

3. Does your client react badly to changes, or does he/she manage changes pretty well? Can you give an example?

____

____

____

____

____

6. Unique Considerations (include environmental suitability, access to general health care, mental health care, whatever appears to be important considerations for risk management)

1. Do you feel that (_____________)'s needs are well met in his/her current living situation? Why/why not?

____

____

____

____

____

____

2. What needs are not being met well in your opinion? How could this be done more effectively? How could that benefit (_____________)?

____

____

____

____

____

3. Does your client have any unique needs or risk factors that complicate how well his/her risk can be managed? Can you describe (an) example(s)?

____

____

____

____

____

4. Are there any interactional difficulties with other clients that occur routinely? What happens and how does (___________) react?

____

____

____

____

____

____

B. <u>Acute Dynamic Environmental Factors (within the past 3 months)</u>

1. Changes in Social Relationships

1. Has anything changed in terms of (__________)'s relationship with his/her family or friends that may have upset him/her? What happened? How did he/she react?

____

____

____

____

2. Have any of (____________)'s friends or family members moved recently? How did that affect him/her? How long did it take him/her to get over it?

____

____

____

____

2. Personnel or monitoring changes

1. (If there any new personnel) How does (___________) adjust to new support workers? Does he/she try to get away with things he/she couldn't with the regular staff? Can you give me an example?

____

____

____

____

2. (If his/her monitoring levels have been changed and if the client is aware of the change) why were his/her monitoring levels changed? How did (___________) react to that?

____

____

____

____

3. Situational changes

1. (If the client was moved within the past 3 months) how is (___________) coping with the move? Do you think he/she understands why they had to move?

____

____

____

____

____

2. What do you think your client thinks about the new place? Do you think they miss their old place? Have any odd behaviours started up because of the move? Like what?

____

____

____

____

4. Changes in victim access

1. Who has (__________) been spending time with lately? Does he/she spend time with new residents in a manner that suggests he/she is grooming them for sex or perhaps taking advantage of them in some other way?

____

____

____

____

2. Do you think that there are any new opportunities for (_________) to get into problems here, such as offending in any way? For example, does (___________) like to hang out and wait for anyone from work or school because he/she seems to find them sexy or cute?

____

____

____

____

____

____

3. Do you have any concerns about him/her offending or hurting anyone (or him/herself)?

____

____

____

____

5. Changes in access to intoxicants

1. Does (____________) have any history of using alcohol or drugs? (If yes, "how did he/she get the alcohol or drugs?")

____

____

____

____

2. Do you have any concerns about (____________) in terms of him/her trying to use alcohol or drugs?

____

____

____

6. Unique considerations

1. Have you noticed any changes in (____________)'s living arrangements that he/she is having problems with?

____

____

____

2. Are there any residents or staff members or anything that might be problematic for (_____________) that we haven't discussed yet?

____

____

____

____

3. Are there any recent social, family, or anything else that has happened that we haven't discussed and which may affect (____________)'s ability to manage his/her behaviour effectively?

____

____

____

____

____

4. Is there anything I haven't asked you and you feel is relevant to helping me understand (____________)'s risks or needs?

____

____

____

____

____

____

____

Thank-you very much for your patience and input – it's very much appreciated.

Appendix J

Table 5: SVR-20 individual item scores.

Table 5

Participants' pre and post-treatment scores on the SVR-20 individual items. Changes in scores are marked with an asterisk (*).

	Participants							
	1		2		3		4	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Psychosocial Adjustment								
Sexual deviation	2	2	2	2	2	2	0	0
Victim of child abuse	2	2	0	2*	1	1	1	1
Major mental illness	2	2	2	2	2	2	2	2
Substance use problems	0	0	0	0	2	2	0	0
Suicidal or homicidal ideation	1	1	0	0	0	0	1	1
Relationship problems	2	2	2	2	1	1	2	2
Employment problems	2	2	2	2	1	1	2	2
Past nonsexual violent offences	2	2	2	2	0	0	2	2
Past non-violent offences	1	1	2	2	2	2	2	2
Past supervision failure	1	1	2	2	0	0	0	0
Section sub-total (20)	15	15	14	16	11	11	12	12
Sexual Offences								
High density of sex offences	0	0	1	1	2	2	0	0
Multiple sex offence types	1	1	1	1	0	0	1	1
Physical harm to victim(s) in sex offences	0	0	0	0	0	0	2	2
Uses weapons or threats of death in sex offences	0	0	0	0	0	0	0	0
Escalation in frequency or severity of sex offences	0	0	1	0*	1	0*	1	0*
Extreme minimization or denial of sex offences	1	1	0	0*	1	1	1	1
Attitudes that support or condone sex offences	2	1*	2	1*	2	1*	1	1
Section sub-total (14)	4	3	5	3	6	4	6	5
Future Plans								
Lacks realistic plans	2	1*	1	0*	1	1	2	2
Negative attitude towards intervention	1	0*	1	0*	1	1	1	1
Section sub-total (4)	3	1	2	0	2	2	3	2
TOTAL SCORE (38)	22	19	21	19	19	17	21	19