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Is it you or is it me? Attrition and Non-completion in Community-Based Treatment for Harmful Sexual Behaviour: A Mixed Method Study

A thesis

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Abstract

This thesis will examine the pathways in which participants that engaged in a community based harmful sexual behaviour intervention programme dropped out of treatment; and what contributed to their decisions. A mixed-methods approach is used with two primary aims. Study one quantitatively investigated what is the extent of attrition within the service and what form do these exits pathways take. The results indicated that between 2018 and 2025, attrition accounted 22.4% of the overall data. Study two qualitatively explored the experiences of (n = 5) participants who exited their intervention early, to determine what factors contributed to early drop out. Thematic analysis identified three overarching themes that included: *Ambiguity about programme processes, imposed hardship* and *disruptions*. These results emphasise the complexity of treatment retention and highlight the role of both programme structure in conjunction with external barriers individuals face attending a community treatment programme. Future research could compare the experiences of completers with non-completers and utilise quantitative methods that incorporate data from risk assessment tools and include follow up data to report on recidivism rates. These findings highlight the importance of refining treatment delivery to support participant engagement and to enhance the effectiveness of rehabilitative efforts in sexual offender populations.

Disclaimer

In this thesis, the term ‘harmful sexual behaviour’ (HSB) is used in conjunction with the term ‘offender’ and ‘sex offender’ to describe individuals that have engaged in sexually harmful actions towards minors. At times, these terms are used interchangeably throughout this thesis which is a reflection of predominant language used within majority of the reviewed literature. It is important to recognise the growing shift towards using ‘harmful sexual behaviour’ as the preferred term in the field of sexual harm which is less stigmatizing terminology. This language seeks to emphasize the problematic behaviour rather the labelling the individual themselves and promotes a more therapeutic understanding which aligns with many codes of ethics and practice frameworks within clinical settings. This thesis aims to respect the shift in the language within the sexual harm sector particularly within forensic psychology, to pay respect to the individuals that were interviewed, while also remaining consistent with the referenced material.

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Chapter One: Literature Review

Every day we are bombarded by messages in the media circulating the horrors of sexual harm towards children. With no 'one-size-fits-all' solution across countries, the extent of the problem seems to be growing expediently with rates of sexual assault reporting in New Zealand increasing to 28,000 in 2024 compared to 5,000 in 2018 (Ministry of Justice, 2024). For those individuals who engage in sexual harm against minors, the common public perception that they are monsters and should be lock away in prison depict them as incurable predators. This attitude tends to increase fear within the public consciousness especially when the emotional and physical harm inflicted on victims and their families is considered (Arata, 2002; Hornor, 2010). Given the intense stigma and ostracism incurred by communities around the world due to the actions of those who sexually aggress against others, especially children, it is no wonder these emotionally charged responses appear quite natural (Cucolo & Perlin, 2012). Despite these entrenched attitudes, efforts to treat individuals who engage in harmful sexual behaviour (HSB) has increased alongside the justice systems emphasis on rehabilitation and prevention strategies (Porat et al., 2024).

With advances in psychological theory, treatment of sexual offenders has emerged as its own specialised clinical field that includes unique assessment tools (Hanson et al., 2009; Hanson & Thornton, 2000; Olver et al., 2011b), treatment methods (Hanson et al., 2002; Marlatt & Gordon, 1985; Marshall & Laws, 2003), and research approaches. The objective of these different components is the same; to reduce reoffending rates while supporting individuals who engage in HSB back into society safely (Beech & Hamilton-Giachritsis, 2005; Marshall & Barbaree, 1990; Polaschek, 2017).

As with any psychological intervention programme, attrition remains a significant problem with HSB rehabilitation – a concern for both the public and mental health practitioners (Barrett et al., 2003). Barriers to therapeutic engagement have typically been noted as deriving from individual offender characteristics such as personality traits, low motivation, or linked to their risk categorization (i.e. higher risk equates to higher likelihood of exiting treatment early) (Beyko & Wong 2005; Olver & Wong, 2013). However, an individual's decision to disengage from therapy is scarcely the result of one factor, but rather, it is likely shaped from the complex interaction between systemic, cultural, social, and psychological factors (Howard et al, 2019). The pressure resulting from these factors can facilitate a belief for an individual to see disengagement as their only option. Little is known from a qualitative perspective about why some individuals may decide to drop out of treatment and never to be heard from again, particularly in a New Zealand context. Therefore, this thesis aims to examine the experiences of men who exited their intervention early from a New Zealand community based harmful sexual behaviour treatment programme and examine trends of attrition rates.

The Problem of HSB in New Zealand

Harmful sexual behaviour is recognised as a serious worldwide health and social problem (Balcioglu et al, 2024). Data from a recent 2024 World Health Organisation (WHO) report, revealed that nearly one in three women and one in eight men worldwide have been subject to sexual harm, which emphasises the scale of this issue (World Health Organisation, 2024). The negative consequences of sexual harm on victims remain well established in the literature and include long-term psychological consequences such as anxiety disorders, depression disorders, and posttraumatic stress disorder (Chen et al., 2010; Dworkin et al., 2017). In addition to psychological harm, the economic cost of sexual harm impacts individuals, communities and governments greatly (Peterson et al, 2018). For instance,

Marshall and Marshall (2021) estimated that the Rockwood sexual offender treatment programme prevented 82 reoffences which based on their modelling estimates, generated a net savings of $14.663 million Canadian dollars for taxpayers. This suggests that effective treatment can more be cost efficient that relying on incarceration alone. Individuals that experience sexual harm may incur loss of income or the inability to work due to ongoing health related and psychological expenses. (Peterson et al., 2018). At the societal level, there are significant financial demands on the health system, social services, and justice systems. There are also intergenerational impacts for victims and their families which are more difficult to quantify, yet equally as important (Peterson et al., 2018). In New Zealand, a report commissioned by the Accident Compensation Corporation (ACC) revealed that sexual violence had an approximated total cost of close to 6.9 billion dollars in the year 2020 alone (Schulze & Hurren, 2021). This included costs to the crown (e.g., law enforcement, justice system), victims receiving treatment (e.g., loss of income, physical and emotional harm), and costs to wider society (e.g., reduced community wellbeing) (Schulze & Hurren, 2021). This suggests that investment in prevention, including rehabilitation of those individuals that engage in sexual harm, is the likely target of any government.

It has been suggested that recorded charges and convictions of sexual offences have increased internationally over the past two decades; however, the observed increase may be explained by greater public awareness, improvement in victim supports, and historical reporting (Borumandnia et al., 2020). Nevertheless, sentencing data from the Ministry of Justice indicates that between 2013 and 2023 in New Zealand, 56,018 charges and 7,517 convictions were reported for adult sexual offenders (Ministry of Justice, 2023). Charges that included child victims under the age of 16 years old accounted for almost 69% of the 56, 018 charges highlighting the significance of this issue with the New Zealand context. Of the 7,517 individuals that were charged and convicted, 57% received custodial sentences, 21% received

home detention, and the remainder community-based sanctions (e.g., intensive supervision by a probation officer) (Ministry of Justice, 2023). Despite incarceration remaining the most common sentencing outcome, about one in five were sentenced to community-based options, suggesting management outside of custodial contexts are a viable option (Department of Corrections, 2024). Because the need for community protection remains the primary focus throughout the justice system, rehabilitation options in the community such as psychological intervention must also be in place to provide enough evidence to a court that a community sentence in a viable option (Grossi, 2017).

Risk-Need-Responsivity (RNR) Model

In response to the 'nothing works' agenda that emerged in the 1970s and claimed that no effective interventions existed for general offending behaviour, let alone HSB, Andrews et al (1990) challenged this view with the resulting 'what works' principles of offender rehabilitation known as the Risk-Need-Responsivity (RNR) model. The RNR model has been described as a significant contribution to the assessment and treatment of offending behaviour (Seewald et al., 2018). Referred to as an 'umbrella' framework for correctional psychology (Polaschek, 2012), it has been adopted by correctional and community forensic agencies in New Zealand, Australia, Canada, USA, and the UK, and also underpins programmed intervention for sex offenders in these countries (Brogan et al., 2015; Keulen-de Vos & Schepers, 2016). As a framework, RNR identifies and addresses 'criminal conduct' by means of risk factors, criminogenic needs and addressing responsivity barriers. The RNR model has since gone on to inform policy, underpin programme development, and produce a basic design for intervention aimed at reducing recidivism (Polaschek, 2012). Briefly, the rational of the RNR model's three core principles are as follows: *Risk Principle:* align the intervention to that of the offender's risk of reoffending with preference given to treating higher risk vs lower risk. *Need Principle*: assessment of criminogenic needs (e.g., antisocial

attitude, offence related cognitive distortions), that are considered dynamic and become the target of treatment. *Responsivity Principle:* The delivery of treatment considers learning style, psychological well-being, motivational levels, cultural differences and cognitive ability to maximise treatment adherence and effectiveness (Olver & Wong 2013; Polaschek, 2012). Together, these principles provide a structured framework for organisations rehabilitative efforts in forensic settings.

Empirically, there is substantial support for the application of RNR-informed interventions to treat individuals who have committed sexual offences and meta-analyses indicate that programme adherence of RNR principles is associated with greater reduction in recidivism (Harkins & Beech, 2007; Marshall et al., 2008; Schmucker & Lösel, 2015). For example, in their meta-analysis of the RNR's utility to treat sexual offender in the community and residential settings, Hanson et al (2009) analysed 23 studies involving 3,121 offenders that were treated compared to 3,625 untreated offenders. Their findings indicated that treated individuals displayed a significantly reduced rate of sexually reoffending (10.9%), in comparison to the untreated offenders (19.2%). Furthermore, rates of general recidivism were lower for the treatment group (31.8%) compared to the non-treatment group (48.3%). Based on these and other findings, the RNR model has become highly influential in shaping sexual offender treatment programmes internationally and is frequently adopted as the organising framework for services treating people who have engaged in HSB.

Despite the RNR frameworks substantial empirical base, it is not without challenge. The main dispute by researchers revolves around the framework's narrow focus of risk management and criminogenic deficits. For instance, Ward and Gannon (2006), suggest that the adoption of the RNR model may leave individuals feeling dehumanised through what is essentially a deficit-focused perspective. This can feel impersonal and demotivating and fail to foster a sense of hope or positive identity transformation. Ward et al. (2012) note that by

narrowing treatment focus on criminogenic needs and neglecting holistic well-being, practitioners risk missing unique characteristics of human functioning such as, creativity and self-directed goals that are crucial to genuine rehabilitation and reintegration.

The Good Lives Model (GLM)

The movement towards positively oriented goals as opposed to avoidance-oriented treatment offers benefits for offenders (Whitehead et al., 2007). During the 1990's, as the popularity of positive psychology increased and the treatment for sexual offenders began to emphasise the need for a holistic approach, Ward (2002) developed the Good Lives Model (GLM) to offer a strength-based approach that could be used in conjunction with, or as an alternative to, RNR approaches to offender management.

The basic principles of GLM include 11 'primary goods' that every human needs to live a fulfilled life and that offenders, just like ordinary citizens given the opportunity, would seek these goods out (Ward & Fortune, 2013). These primary goods include: *life* (e.g., balanced lifestyle, sexual wellbeing), *knowledge*, (e.g., expanding intellectual interest), *excellence in work* (skill development and job fulfilment), *excellence in play* (engaging in enjoyable activities), *agency* (self-determination), *relatedness* (building strong and meaningful relationships), *community* (participating in community groups), *spirituality* (exploring purpose and spiritual faith), *inner peace* (the ability to cope with stress), *happiness* (experiencing joy) and *creativity (*expression through arts) (Yates et al., 2010). GLM-informed interventions involve the individual to identify each primary good and to set goals and actions to meet that need, either explicitly or implicitly is called the secondary good (Ward & Fortune, 2013). The GLM, considers criminogenic needs to reside within the way in which and individual goes about getting their primary needs meet. For example, a person who sexually offends against a child may resort to commit this behaviour if their relationship and

intimacy needs are not adequately met with an adult, and have offence supportive cognitive distortions contributing as a driver of their behaviour. In this example, a blockage of getting this primary need meet has resulted in an inappropriate alternative (sexually offending against a child), as a secondary way to meet this need (Willis et al., 2013). The framework proposes that the criminogenic needs are situated within the internal (beliefs, thoughts and emotions) and external obstacles (lack of access) that block and frustrate the individuals access to the primary goods mentioned above. Intervention is therefore premised on helping the individual with increasing internal skills (e.g., prosocial values) and identifying opportunities in their external environment (opportunities for social support) in order to meet their primary needs in a healthy way - which in turn, produces a prosocial identity and lifestyle (Ward & Gannon 2006).

In practice, the GLM provides a framework that guides interventions (good life plan), that is aligned with an individual's values and core interests, while also attempting to capitalise off their strengths. In this way, the intervention is posited that on discovering an individual's personal strengths and goals, this will reduce the potential for further offending and orientate them towards gaining the psychological and social resources required to achieve these (Serie et al., 2023). Barnett et al. (2014) investigated the effectiveness of the GLM, and strength-based approaches compared to RNR relapse prevention (RP) approaches with N = 601 individuals charged with sexual offences that were participating in community treatment programmes in the United Kingdom. Pre- and post-intervention data from risk assessment tools (e.g., Violence Risk Scale – Sexual Offence Version; VRS:SO, and the Stable-2007) were used to compare treatment change scores between the two groups. The results revealed similar outcomes for both programmes; The RP group (n = 399) decreased their sexual preoccupation scores significantly from pre- to post-treatment (mean change = 0.9), and the GLM group (n = 202) showed similar decreases (mean change = 0.8). Additionally, attrition

was low and did not differ significantly between the GLM programme (15%), and the RP programme (14%). In a similar study, Harkins et al., (2012), reviewed treatment change and attrition scores between participants attending relapse prevention programmes (n = 701) and (n = 76) individuals attending a strength-based programme based on GLM principles. The results indicated there was no significant difference in treatment change scores, or attrition rates with an attrition rate of 1% for the RP module and 2% for the GLM module. The authors then interviewed 20 participants of a relapse prevention programme, 15 that attended the good lives programmes, and (n = 11) staff members (e.g., group therapy facilitators and individual therapists). The study found that while facilitators tended to prefer the GLM and reported as being more engaging and motivational, a majority (63.7%) reported that it didn't seem suitable for high-risk and individuals low in motivation. In support of the RP approach, individuals attending the programmes also reported more understanding of their offending and had more ability to identify risk factors compared with those in the GLM programmes (80% vs 46%). Conversely, a greater proportion of GLM participants reported improved understanding of the positive aspects of themselves.

While these results have important implications for treatment programmes using these two approaches, perhaps the most serious disadvantage of these studies lies in the methodological approach of the GLM studies. Marshall et al. (2017) suggests that effective evaluation of strength based and GLM interventions for sexual offenders should involve two key methodological steps. These include rigorous pre- and post-treatment measures of criminogenic factors, engagement and skill acquisition ensuring programmes produce meaningful change on dynamic risk and protective factors. The second step involves post-treatment follow up for several years to determine whether these in-program changes translate into reduced reoffending in the community. Marshall et al. (2017) critiques much of the existing GLM and strength-based literature for failing to employ these robust

methodologies, noting that most studies report only on engagement or within-treatment gains without following up on actual recidivism rates or using standardized outcome metrics.

These debates have a direct effect on treatment delivery for HSB interventions in community settings. While the GLM may address RNR critiques by taking into account motivation, personal agency and is considered a more humanistic approach, its underdeveloped long-term research evidence stalls interest. Future studies that incorporate longitudinal designs alongside established risk principles are needed particularly when community sentences tend to prioritise public safety and rehabilitation. In addition to this, these two approaches differ in their underlying epistemological approach and dependent on practitioner preferences and training in either approach could result in a large amount of variability in treatment settings which one considered more directive towards risk and the other a movement towards more strength-based goals. These two different approaches could suggest individual experiences may vary with regard to therapeutic intervention style.

Sexual Offender Treatment Programmes

Over the past century, sexual offender treatment programmes (SOTPs) have evolved considerable with the incorporation of both RNR and GLM underpinnings. The Clearwater Sex Offender Treatment Programme in Canada that was initialled developed by Psychologist Dr Arthur Gordon, is considered internationally for its design and acts as a benchmark for treatment programmes (Marshall & Laws, 2003). Notably, Cognitive Behavioural Therapy (CBT) has been recognised by researchers and practitioners as the most effective treatment option to reduce reoffending rates (Hanson et al, 2009; Rocha & Valenca, 2023; Schmucker & Lösel, 2015). It has a well-established theoretical basis to address the cognitive characteristics consistent with sexual offenders (e.g., misreading social cues, shifting blame, maladaptive moral judgment, distorted cognitions, the minimization of harm and denial

(Marshall and Hollin, 2015). Additionally, the behavioural components include teaching about avoidance of high-risk situations, replacing maladaptive coping mechanisms with healthy alternatives, and recognizing and managing triggers that could lead to reoffending Harkins & Beech, 2007; Harrison et al., 2020).

Numerous meta-analyses have indicated that CBT on average can contribute positively to the treatment of sexual offences. For example, the effectiveness of CBT's use with treating sex offenders was explored across 43 studies comprised of 9,454 sex offenders (Hanson et al., 2002). Offenders that received treatment displayed sexual recidivism rates of (12.3%), compared to individuals with no treatment (16.8%). In addition, within the studies that had participants with sexual offences against children displayed a reduction in sexual recidivism rates from (17.9% to 9.9%). In 2009, the Safer Society North American Survey highlighted the extensive use of CBT in treatment settings across both residential and community settings in the US and Canada. In community-based programmes 92% of the US and 88.5% of the Canadian programmes all employed CBT for adult sex offender treatment programmes' - highlighting its popularity (Schaffer et al., 2010).

Treatment programmes tend to incorporate group therapy alongside individual sessions. The intervention emphasis is primarily focused on group work and individual therapy that follows modules designed to target intervention needs (e.g., emotional regulation techniques, interpersonal skills, communication skills, coping skills, how to identify social support, role playing behavioural skills and the identification of cognitive distortions with the purpose of cognitive restructuring (Marshall & Laws, 2003; La Fond, 2005). In New Zealand, Kia Mārama, and Te Piriti, are the two prison-based programmes that operate as special treatment units for male adults that have engaged in sexual harm towards a child. The programmes have modules that cover, victim impact and empathy, mood management,

understanding offence pathways, and arousal reconditioning. Treatment is delivered within a therapeutic community in a separate unit in prison from general offenders. Olver and Wong (2013) examined treatment outcomes in high-risk treatment programmes that included Kia Mārama and Clearwater. The results indicated a moderate efficacy with a reduction in sexual recidivism rates by approximately 10–27%. Specifically, offenders showing positive changes on dynamic risk factors (e.g., sexual deviance, anger, and social inadequacy) exhibited significantly lower recidivism rates. Findings from the Kia Mārama programme also revealed that CBT-based interventions targeting specific criminogenic needs reduced recidivism by between 19 - 23% (Olver & Wong 2013).

Community-Based Treatment Programmes

Community-based HSB treatment programmes, or Community Sexual Offender Programmes (CSOP) serve an important role in addressing sexual offending rates given that not every person who engages in inappropriate sexual behaviour will be sentenced to prison. This typically depends on severity of offending, charging laws and legislative constraints on imprisonment. CSOP's usually deploy structured group and individual programmes that are underpinned by the RNR model, incorporate CBT, and are similar in structure and process to that of prison-based treatment programmes (Beech et al., 2012; Hanson & Bussiere, 1998). These programmes differ from those run in prisons in that they often engage supervision from community probation services, with elements of social support (social workers and other community agencies), drawing the focus on holistic reintegration (Craissati et al., 2009; Lambie & Stewart, 2003). Empirical support exists for community formats in reducing sexual recidivism, although effect sizes vary. For instance, a meta-analytic review concluded that CSOP participation yields modest reductions in sexual reoffending compared to non-treated controls (Hanson et al., 2002; Hanson & Bussiere, 1998), with success linked to treatment

intensity and adherence to evidence-based principles (Beech et al., 2013; Lambie & Stewart, 2012). In New Zealand, CSOP's have been evaluated for adolescent and adult populations. Lambie and Stewart (2012) assessed the outcomes of the adult programmes for the three community treatment programmes (Safe Network, STOP and Well STOP). The results showed that recidivism rates were lower for treatment completers (8.1%) compared to non-treated offenders (21%), and (16%) for the comparison group. Similarly, the results from a Canadian CSOP that used a comparison group of non-treated offenders demonstrated lower rates of recidivism rates of treated offenders 1.1% (1 out of 89), compared to the comparison group 7.3% (4 out of 55). Together, these studies provide important insights that community-based treatment programmes are an effective rehabilitative option for individuals charged with sexual offences. However, despite positive treatment efficacy, studies that predominantly quantify recidivism rates tend to overlook the significant problem of attrition (Beech et al., 2013). Because maintaining long-term engagement is a key goal of practitioners working with individuals with sexual offence histories, a more comprehensive evaluation would include delving into the clients perceived experience of treatment (Levenson et al., 2010). Some researchers now argue that in order to understand barriers to engagement, it is crucial to incorporate qualitative insights to improve service delivery and ensure that culturally and individually diverse populations are incorporated alongside traditional treatment metrics (Lambie, 2012). This is essential for improving treatment success with community-based programmes particularly within culturally specific context such as New Zealand.

In summary, the progression of treatment programmes indicates that attendees who complete treatment are more likely than non-treatment completers to not re-offend. This provides evidence that treatment in prisons is effective in reducing re-offending rates particularly when the principles of the RNR model are employed. The GLM offers clinicians

a strengths-based approach to addressing criminogenic needs, however the framework lacks long term research to support its claims. When treatment programmes utilise individual and group therapy in conjunction with empirically tested treatment frameworks, the risk of sexual harm decreases.

Attrition Characteristics Among Sexual Offender Treatment Programmes

A long-standing concern for mental health professionals that provide treatment is the failure to complete psychological intervention. Attrition, or treatment dropout, refers to the premature withdrawal from treatment before reaching a planned or clinically appropriate endpoint (Harris, 1998). Attrition has been a major concern in the treatment of multiple psychiatric disorders, most notably when treating anxiety-based problems and depression (Olver et al., 2011b). It is also well documented that treatment non-completion rates are high particularly within community based domestic violence programmes (Roberston, 1999), and community drug and alcohol treatment programmes (Schroder et al, 2008). Previous research has indicated within offender programmes, elevated criminogenic risk profiles, antisocial and psychopathic personality traits, mandated participation, and responsivity mismatch (e.g., not using intervention methods appropriate for someone's learning capabilities), are all indicators of treatment dropout (Olver et al., 2001b). Across sex offender specific programmes, attrition has been linked to heightened static/dynamic risk, psychopathic traits (Olver, & Wong, 2011), denial/minimisation, motivational barriers (Beyko & Wong 2005), and programme design issues (Howard, et al., 2019). Most research has often focused on static factors (e.g., criminal history), as predictor variables of attrition. However, as Polaschek (2012) notes, the mechanisms that can influence attendance such as if the attendee was mandated and the geographical location of the treatment often go undocumented.

In their meta-analysis of treatment attrition and recidivism, Olver et al. (2011) reviewed 114 studies including over 40,000 offenders with 34 studies focusing specifically on sexual offending treatment. The reported average attrition rate across the sexual offender studies was 27.6%. Common characteristics identified from previous attrition research (e.g., low motivation, antisocial personality traits and psychopathy were also revealed as predictors of treatment dropout. Furthermore, demographic variables such as unemployment, younger age, being unmarried and having a lower educational attainment were all significant predictors. The study also noted that the community-based programmes tend to have higher attrition rates compared to institutional programmes, likely due to external distractions and weaker enforcement mechanisms (Olver et al 2011).

As outline previously, Lambie and Stewart's (2012) examination of the outcomes from the three New Zealand intervention programmes for (N = 296) adults that engaged in HSB with children under the age of 16 revealed a positive reduction in recidivism for those that completed treatment. However, attrition was a notable challenge with an overall treatment completion rate of just 45% across the three programmes. The drop-out rates varied across the programmes with Safe Network having the highest non-completion rate (66%) compared to WellStop (48%) and Stop (32%). The authors noted that longer programme duration and participants with more extensive offending histories in Auckland (Safe Networks key location) likely contributed to higher attrition rates (Lambie and Stewart, 2011). The reliability of these results is subject to certain limitations. For instance, the methods used for the exclusion and inclusion criteria of attrition were not clearly defined and it was not clear whether assessment data (e.g., did not complete assessment interview) were included in the data pool. Without providing a clear distinction with the attrition data, it could be that Lambie and Stewart (2012) included assessment drop out data which likely increased the chance of a Type I error. These discrepancies have been proved a common short falling of

previous attrition research methodologies as well (Beyko, & Wong, 2005; Marcellus, 2004). The tendency to over-report attrition data has stemmed from including those that drop out of the assessment phase of treatment, those that may have moved out of region, individuals who were sentenced to prison, or those that finished their sentencing conditions (Howard et al., 2019). In order to address these limitations within attrition research, Wormith & Olver (2002) refined attrition into three core sub categories which include: *administrative based exits* (e.g., individual is sent to prison, relocated to another town, or sentencing conditions finish before treatment completion), *agency-initiated dropout* (e.g., an individual's presentation is considered treatment interfering which includes non-attendance and the therapist initiates case closure), or *client initiated dropout* (e.g., client stops attending and breaks all contact with no reason given). Polaschek (2012) examined the attrition rates of violent high-risk offenders attending a prison-based programme in New Zealand and was able to clearly identify and categorise non-completion which enhanced the strength of the research methodology and findings. When attrition research methods are more robust, it is clear that reliable data can be extracted for research purposes which will likely inform programme delivery changes. This can enable the identification attrition risk factors and improve retention and overall treatment outcomes.

Motivation in Men who have Sexually Offended

Motivation pertains to external and internal processes that activate, guide and maintain behaviour – Influenced by emotions, beliefs, goals, relationships and the environment, motivation is considered a shifting state rather a single quality people either have or lack (Deci & Ryan, 2008). Recent theories empathise that motivation is made up of both *what* people want (goals that align with values) and *why* they want it (autonomous, verses avoiding external consequences) (Banhdu et al., 2024). From this perspective, motivation can be considered as a dynamic factor that can be moulded and shaped in

response to the environment, while also being influenced by services structured and how practitioners engaged with clients (Deci & Ryan, 2008; Ntoumanis et al., 2021).

Awareness of the dynamic nature of motivation has important implications for the planning and delivery of intervention as well as identifying contributing factors to attrition. The enhancement of behaviour change is a primary goal of programmes treating offenders; however, sex offenders are frequently cited as unmotivated especially if they present with a lack of eagerness to address their offending or to participate fully in a programme of treatment (Terry & Mitchell, 2001; Teriney & McCabe, 2002). Additionally, denial of their offence can also cause problems for the delivery of treatment. In the past, these factors have been used as exclusion criteria for sex offender treatment programmes. However, recent research suggests characteristics such as denial may not hinder treatment growth (Jung & Nunes, 2012; Marshall et al., 2001). The Transtheoretical Model of Change (TTM; Prochaska & DiClemente, 1982) is a popular framework to understand and measure motivation and has been incorporated into sex offender risk assessment tools such as the VRS:SO. The model conceptualises motivation into the following five categories: *pre-contemplative* (not open to change), *contemplation* (on the fence about change), *preparation* (intentional about plans to change), *action* (changing the undesired behaviour), and *maintenance* (preserving the progress) (Prochaska & DiClemente, 1982). The model suggests that therapy, when focused on a problematic behaviour typically involves a cyclical nature of being aware of one's problems, rather than a linear process (Prochaska & Prochaska, 2019). Therefore, because of the dynamic and temporal nature of motivation, these five stages are a way to measure and conceptualise the change process and track this as individuals pass between the different stages (Krebs et al., 2018).

One limitation of using the TMM is defining individual offender's willingness to engage in treatment without considering external barriers. *Treatment readiness* encompasses both internal and external qualities that can influence treatment participation and therapeutic engagement (McMurran & Ward, 2010; Watson et al., 2018). Readiness for treatment extends beyond motivation it encompasses cognitive, emotional, and social competencies. Furthermore, attendees in both prisons based, and community sexual offence treatment programmes often are mandated to treatment and as a result, fostering treatment readiness requires a multidimensional approach that aligns therapeutic strategies with offender's unique needs and strengths (Strugess et al., 2016). Treatment-seeking, treatment attendance, and treatment participation have all be related to the motivation for change. For instance, Harkins and Beech (2007) examined the role of motivation and recidivism rates of 180 sex offenders attending treatment programmes over the course of 10 years post treatment. The authors found that offenders with internal motivation were more inclined to exhibit changes in thinking errors, and offending attitudes, whereas those that were motivated into treatment by external sources (parole requirements), showed mixed results. While all offender groups showed increased motivation during institutional treatment, this often dropped after release into the community, suggesting a need for ongoing support to sustain motivation.

Individuals Compelled into Treatment

In order to reside in the community, individuals convicted of sexual offences are often mandated to a treatment programme either by court sentencing conditions, probation officers, or the parole board (Maruna & King, 2009; Terry & Mithcell, 2001). These conditions play a crucial role through the monitoring of sentencing conditions and rehabilitative efforts by adding a layer of accountability. However, the feeling of being monitored can also contribute to feelings of mistrust, anxiety and stress (Phelps & Ruhland, 2022). Due to the fear of

probation and court related consequences, individuals that are mandated to attend treatment likely experience indirect pressure, or explicitly informed of the attendance, lowering the sense of personal agency and in turn, lowering motivation levels (Phelps & Ruhland, 2022). Extrinsic motivation (e.g., an individual is motivated by external sources), is further complicated when the referral behaviour of discussion (harmful sexual behaviour) elicits stigma and profound shame in individuals.

Shame is a significant emotional response that can contribute to the minimisation of behaviour, avoidance of discussion and accountability, and can also lead to denial (Tewksbury, 2012). All of which are common treatment interfering behaviours, but in a similar vein, can also be treatment targets for intervention (Dearing et al, 2005). This dynamic can then translate into individuals trying to present themselves in a more favourable light to avoid negative consequences such as increased monitoring during treatment. The inability to engage authentically in treatment in noted as a barrier to progress and may also at times, undermine the development of a genuine therapeutic alliance (Taxman & Ainsworth 2009), which is a significant predictor of positive treatment outcomes (Andrews & Bonta, 2010). However, mandated individuals can also present with internal motivation and willingness to engagement in treatment. When treatment programmes recognise that stigma and shame are a common experience of individuals navigating the criminal justice system, therapy can be delivered in a more compassionate and supportive manner, fostering meaningful progress (Andrews & Bonta, 2010).

Motivation Among Self-Referred Individuals

Many sexual offender treatment programmes, particularly in the community often accept voluntary or self-referred clients. Participation is voluntary as based on this premise, they tend to present with higher levels of intrinsic motivation compared to mandated

individuals (Lampalzer et al., 2021). Personal awareness of the need for change, a commitment for improved wellbeing, or the desire to address problematic behaviour are all considered motivating factors of self-referred individuals (Miller & Rollnick, 2012). As individuals feel more empowered and accountable for their behaviour and treatment progress, higher levels of treatment engagement translate into positive treatment outcomes (Ryan & Deci, 2017). Mandated verse self-referred motivation to treatment formed the central focus of a study by Dodier-Lemay et al. (2019), in which the authors proposed that there is evidence to suggest that voluntary service users may also experience pressure similar to that of mandated clients. The mechanisms of external pressure included expectations from family members and partners that are inevitably compounded by the fear of losing these relationships or their social and community membership. The avoidance of social and legal sanctions (e.g., prison) also provides external motivation to engage in treatment (Jung et al., 2012; Levenson et al., 2017). This convoluted interaction between internal motivation and external pressure suggests that self-referral is not entirely free from coercive forces and may impact treatment engagement and outcomes (Jones & Thornton, 2008). Furthermore, as noted earlier, shame and stigma associated engaging in harmful sexualised behaviour are noted as barriers to engagement; something that self-referred clients are not immune to (Levenson & Macgowan, 2004).

In short, while self-referred individuals typically present with higher levels of intrinsic motivation compared to mandated individuals, it is essential to acknowledge that they are not exempt from external pressures such as the threat of legal consequences or the loss of connection from family members and friends. Effective treatment programmes should place an emphasis on tailoring interventions in conjunction with an individual's readiness for change and understand the complex interplay of social and psychological factors in community-based rehabilitation (Hanson & Morton-Bourgon, 2009). Treatment approaches

such as motivational interviewing, foster a supportive and non-judgemental environment which are essential for helping individuals overcome resistance and internal conflicts (McMurran & Theodosi, 2007).

Therapist Relationship

Widely recognised as crucial for effective sex offender treatment, therapist qualities are considered a major research topic. With empirical agreement across all disciplines of mental health, relational and interpersonal skills are emphasised as being as important as technical intervention skills at shaping outcomes (De Salve et al., 2024; Meier, 2023). Previous research on offender interventions has reported that therapists who adopted a warm, empathetic, and non-confrontational style created a more supportive therapeutic environment, fostering better individual engagement and positive behavioural change (Ackerman & Hilsenroth, 2003; Beech & Hamilton-Giachritsis, 2005). Specific therapist attributes, such as open-ended questioning, appropriate levels of directive feedback, and the ability to instil hope are also positively associated with treatment outcomes (Hersoug et al., 2009). Harsh or confrontational styles, on the other hand, have been linked to higher dropout rates, oppositional behaviour, a lack of cooperation, denial of behaviour and adopting the therapist's views in an insincere manner (Tieney & McCabe 2002). It has been suggested that over time, therapists with more experience working with sexual offenders develop a more positive attitude towards their clients - increasing therapeutic alliance and overall programme success (Walji et al., 2014). In their literature review, Sandhu and Rose (2012) explored the therapist's part in enhancing behaviour change with sex offender in treatment. The results indicated that therapist characteristics, relational dynamics, and techniques contribute to treatment outcomes. The reduction of offence minimisation and increased accountability were strongly associated with empathy, warmth, sincerity, and respect. Additionally, the presence of female therapists in particular, was noted to positively impact offender's

perceptions of women and their interpersonal relationships (Sandhu & Rose, 2012). There would therefore seem to be a definite need to consider therapist qualities as not only predictors of treatment success but also key moderators of attrition.

Cultural Competency

Cultural context shapes how individuals experience, understand and communicate life experiences and phenomena (Fisher, 2022). Cultural attitudes, beliefs and customs are transmitted generationally and may influence what is deemed appropriate or scared topics of discussion such as sensitive topics like sexuality (Fisher, 2022). This has important implications for therapists to consider particularly with sex offender treatment programmes. Given that sex offender treatment programmes were primarily developed in Western countries, culturally sacred meanings to sex may be overlooked and create a barrier to engagement if misunderstood, or leave clients feeling uncomfortable (Butler & Byrne, 2009). A lack of awareness of traditional customs such as greetings and relational customs may also impede the establishment of rapport and interfere with treatment progress (Tamatea, 2024). Anderson et al. (2019) conducted a study exploring predictors of premature termination in psychotherapy, with a focus on the role of culture and client-therapist dynamics. Their findings emphasize that cultural competence significantly influences therapy retention. Clients who perceived their therapists as culturally competent demonstrating respect for their beliefs, customs, and family dynamic were more likely to complete therapy. This aligns with previous research that proposes therapeutic alliance and treatment satisfaction have been liked to therapist cultural competency (Constantine, 2002; Fuertes et al., 2006). This suggests that in order to provide a therapeutic experience of cultural safety, practitioners must be aware of cultural differences attached to meanings of sex, relationships and roles within families in order to provide appropriate intervention for harmful sexual behaviour.

It has been demonstrated that culturally informed HSB treatment programmes that are responsive to participants cultural backgrounds, in particular indigenous peoples, are associated with positive treatment satisfaction. Recently, Gutierrez et al. (2018) conducted a meta-analysis of treatment sex offender programmes across Canada, New Zealand and Australia. Their results indicated that treatment engagement and satisfaction can increase as well as an observed reduction in recidivism rates when culturally important factors, such as the use indigenous language and spiritual teachings, were included into programmes (Gutierrez et al., 2018). Across the seven studies that were included in the meta-analysis, the average recidivism rate dropped from 48.4% to 39.1% when culturally relevant factors were included as intervention components.

These results draw including cultural customs and values may play a key role in psychological intervention and this also provides evidence that cultural competency is a key factor of treatment success. Moreover, treatment programmes need to be responsive to the needs of the cultural groups they will likely come into contact with, and this will be dependent on the context. The need to consider unique cultural differences and remain culturally sensitive to prevent potential treatment attrition.

Understanding the Participant's Perspective

People that engage in HSB are not a heterogenous group. Understanding the experiences of individuals undergoing treatment is crucial for developing and adapting effective rehabilitation programmes. Research suggests that including consumers in the decision-making process can create opportunities that empower them while also providing services with real life accounts that they can be more responsive to (Hibbard et al., 1997). Because participants attending sex offender treatment programmes can be mandated into treatment, it has been suggested that implicitly, therapists can be more likely to expect resistance and low motivation which can result in negative perceptions or them taking a

confrontational approach (Hachtel et al., 2019; Von Franqué et al., 2021). The power imbalance within the therapeutic setting, fear of judgement and a lack of platforms to express themselves have been cited as reasons for clients not providing feedback to programmes and staff (Guilfoyle, 2005).

In one of the largest studies conducted of the self-reported perceptions of (N = 291) individuals on the sex offender register in the US, Levenson et al. (2024) used open-ended questions through an online survey to explore the positives and negative experiences of their rehabilitative treatment. Three broad theme's major themes emerge from the analysis and included *positive experiences, negative experiences and interconnections between community corrections and mandated clients.* Learning new skills, being a part of the group therapy and learning about self were all subthemes that comprised the positive experiences for (n = 66) of the sample. The theme that participants responded highly to was *Negative experiences* with (n = 125) respondents, which was made up of the following subthemes: abusive and demanding therapists, coercive treatment, inadequate experience of therapist and structural programme barriers. Another study by Collins et al. (2010), qualitatively explored the experiences of eight participants that attended a community sexual treatment programme in Sydney and found that non-completers of the programme cited emotional distress, misaligned treatment goals, hopelessness, and discomfort with programme structure as key reasons for dropping out. Offense-related discussions and struggling with the structured format and disclosure requirements of the programme were contributing factors to some of the participants dropping out of treatment.

These results provide insight into treatment barriers and highlight several important implications for service providers working in the sexual harm sector. Firstly, if critical responsivity factors (e.g., individual cognitive and emotional challenges or learning difficulties), are not considered when developing a treatment plan then issues such as

difficulty with absorbing programme and treatment concepts can create a negative experience for service users. Secondly, the results indicated that therapist communication styles and intervention techniques need adjusting. This has been identified as a major contributing factor to treatment users often reporting feeling overwhelmed by the volume of content, and that concepts were delivered quickly often without explanation (Olver et al., 2011). These findings highlight the need for personalized treatment approaches, motivational support, therapist reflexivity, and enhanced therapeutic engagement to improve retention rates and treatment effectiveness.

HSB Community Programme

During the 1980's, global awareness of child sexual abuse began to grow, and professionals began to seek guidance on protocols and treatment (Goodyear Smith, 1994). Specialised counselling services were established to treat victims and with an increase of allegations made against adults, public anxiety began to manifest. In New Zealand during the early 1990's allegations of child sexual abuse were made against intentional communities such as Centre Point Community in Auckland. The media attention of the police investigation and subsequent sentencing of several members including the founder, Bert Potter, followed by similar allegations and sentencing of child sex offenders, Neville Cooper and Peter Ellis, prompted widespread policy and professional prevention changes. One of these being the establishment of Safe Network and other agencies set up to treat those individuals who did not receive a custodial sentence and required intervention to reduce their likelihood of reoffending - aligning with global efforts to reduce child sexual abuse rates. Safe Network is one of three community-based treatment programmes in New Zealand that provide services to adults (males, females and non-binary 18 years and over) and adolescents (girls, boys and non-binary 13 to 17 years old) to address their harmful sexual behaviour. They also provide

support for children (aged between 5-12 years old), that may present with problematic or concerning sexual behaviour and offers services to individuals with intellectual disabilities.

Safe Network provides service delivery from its offices in Auckland, Bay of Plenty, Northland, Waikato and online. The clinical staff consist of psychologists, psychotherapists, counsellors and clinicians who are working towards registration in their respective disciplines. All staff undergo specialised training to use structured clinical judgement tools that assess the extent of the harmful sexual behaviour (e.g., VRS:SO, Stable-2007, Structures Assessment of Protective Factors against Sexual Offending; SAPROF-SO, Assessment, Intervention and Moving On; AIM and AIM3). The adult service provides support to individuals presenting with harmful and concerning sexual behaviours towards minors (under the age of 16 years old). Typical referral behaviour may include sexual contact with a child or young person, non-contact sexual behaviour (e.g., grooming a child or young person with the intention of engaging in sexual conduct, voyeurism and exhibitionism) and technology assisted sexual behaviour (e.g., accessing, producing or distributing sexual content involving animals or children). Safe Network also offers a service for individuals with concerning sexual ideation who have not engaged in any contact or non-contact sexual behaviour but are having sexual thoughts towards a minor that is causing them distress. Safe Network referrals are funded through Oranga Tamariki/Ministry for Children, The Department of Corrections and the Ministry of Social Development with a self-funded option also available. Adult referrals are accepted from the Department of Corrections (mandated), self-referral through the Ministry of Social Development (Non-mandated adults; Adults presenting with concerning sexual ideation), a fee for service pathway, and through community agencies and court referrals through the Ministry of Disabilities

The core adult service programme, Waka Waiora/Journey to Wellbeing, is a specialised programme that was developed by experts in the field of harmful sexual

behaviour including a forensic psychologist with a history of offender programme development, and a clinical psychologist who specialised in this field. The programme is written into a manual that acts as a guide for clinicians which has undergone reviews by clinical psychologists and researchers working in the field of offender rehabilitation (e.g., Armon Tamatea and Bill Marshall). The programme is underpinned by the RNR model and Good Lives Model and consists of a range of topics and components pertaining to the treatment of harmful sexual behaviour which include some of the following components: healthy coping responses and emotional regulation, addressing unhelpful beliefs about the self and others, problem solving and communication skills, managing sexual arousal patterns, and healthy sexual expression. Typically, an individual attends two or three assessment appointments which are semi-structured interviews guided by risk and protective factor tools that have been validated for the use with sexual offenders. After assessment information is collected, a detailed report is produced that outline the relevant findings and confirming whether Safe Network's service is suitable. During the assessment process the length of time on someone's sentencing conditions if they are referred by The Department of Corrections, is also considered when projecting their intervention time frame, as well as any other responsivity issues (e.g., cultural considerations and learning styles).

Interventions are tailored and based on the responsivity factor of the RNR model and will consist of an evaluation of individual needs against service delivery. Interventions consist of a combination of one-to-one and group therapy sessions. Based on group numbers and whether the person is fit to attend group (must not have a diagnosed intellectual disability), individuals can attend group therapy for a time period lasting up to 12 months. Individual sessions are meant to complement group therapy with attention focused on elaborating on topics covered in group sessions or to cover the full intervention when group therapy cannot be delivered. Cognitive behavioural therapy, psychosexual education and the

Good Lives Model are all incorporated into the adult programme that focuses on a strengths-based approach and underpin the delivery of both individual and group therapy.

This Study

This thesis aims to investigate treatment attrition among men who were engaged with the Safe Network, an alliance/association/collective of community-based HSB intervention programmes in New Zealand. Specifically, the experiences of men who self-initiated their exit from intervention and the demographic and referral/data is examined to identify potential trends associated with treatment dropout. This thesis has two key objectives: (1) to quantitatively describe the attrition rate and compare characteristics between those who complete the programme and those who dropped out, and (2) to examine the qualitative experiences of men who participated in the programme and discontinued treatment prematurely. This research seeks to answer the following research questions among individuals who attended the programme between January 2018 and May 2025:

- What is the extent of attrition in community-based sexual harm treatment programme and what form do these exit pathways take?
- What experiences and factors contribute to early drop out for former service users?

A mixed-method approach (Quan-QUAL) is used in this thesis to analysis data on men exited treatment alongside in-depth qualitative interviews which can offer a nuanced understanding of the factors that shape men's decisions to leave treatment and highlights opportunities to enhance programme engagement and retention through service user led feedback.

Chapter Two: Method

This thesis aims to understand both the characteristics associated with attrition from a community-based HSB treatment programme and the subjective experiences of men who disengaged from the programme before completion. As outlined in the literature review section, previous studies seldom combine quantitative characteristics with the qualitative accounts of participants, limiting the results that can be drawn from programme level patterns and the personal insight of service users. To address this knowledge gap, the present study utilises two connected studies. Study One draws on administrative (quantitative) data to identify patterns between completion and non-completion samples as well as a closer examination of the non-completion subsample. Study 2 used in-depth interviews to explore participant experience within the programme and their lives prior and after exiting the programme. The latter study was informed by the former. This chapter outlines the design, participants, and analytical techniques used for Study 1 followed by the recruitment process, procedures, qualitative analysis and ethics for Study 2.

Study One: Characteristics of Completers and Non-Completers

Participants

This study involved the analysis of administrative data. The following inclusion criteria were used to narrow the group of interest and to excise variables that would clutter the purity of the sample.

Inclusion criteria:

- Identify as male on file information
- Have previously attended Safe Network and completed the assessment phase
- Moved into the intervention phase after accepting the assessment outcome

- Recorded as completed or not completed intervention
- Assigned to one of Safe Network's adult contracts (i.e., The Department of Corrections, Non-Mandated Adults (NMA), Concerning Sexual Ideation (CSI), Fee for Service (FFS) and The Ministry of Disabilities.
- Over 18 years old at the of engagement with Safe Network

Exclusion criteria:

- Adult Psychosocial Contract (social work contract)

During initial assessment interviews, Safe Network service users are invited to provide written consent to the use of their anonymised information for research purposes which also includes data-analysis and contact details for follow-up interviews. Individuals were informed that no identifiable information would be used nor published in any research or journal. The sample for Study One was comprised of 554 individuals that were divided into treatment completers (n = 431) and those who had not completed treatment (n = 123) between January 2018 and May 2025.

Participants were initially identified through Safe Network's centralised client data base. Filters were applied to screen for clients in the "intervention incomplete" category and three categories were revealed from the list and are as follows: administrative dropout (e.g., due to relocation, incarceration, or changes in contractual status such as sentencing conditions ending), therapist initiated dropout (e.g., client being discharged from the service due to the inability to maintain commitment to intervention, not making enough progress, or mental health and substance issues interfering with treatment), and client initiated dropout (the individual had stopped attending intervention appointments, and did not make contact or give

a reason for their exit from the service). Filters were then also applied to identify participants who had completed intervention, and both data sets were downloaded into an Excel file.

Procedure

Material and analytical strategy

- Given the descriptive analyses, Microsoft Excel was used to organise raw data, create descriptive summary tables of participant characteristics (e.g., demographics, treatment hours), and quantify key variables such as attrition rates and completion status across subgroups. This study was included to provide insights in what is the extent of attrition in community-based sexual harm treatment programme and what form do these exit pathways take?

Study Two: Understanding Attrition and Non-Completion

Participant Recruitment

Inclusion and exclusion criteria that are carefully defined help ensure the resulting sample provide a fair and accurate representation of the target population which strengthens external validity and the potential to generalise findings (Findley et al., 2021). Internal validity is enhanced by controlling for confounding variables and only targeting the necessary factors to answer the research question (Andrade, 2018). The following inclusion and exclusion criteria were used to strengthen the quantitative component of this research and to control for unrelated variables.

Inclusion criteria:

- Male only participants

- Individuals who have previously attended Safe Network and completed the assessment phase
- Individuals that were moved into the intervention phase after accepting the assessment outcome
- Individuals who disengaged from the service without providing further communication

Exclusion criteria:

- Therapist-initiated dropout
- Administrative dropout
- Being under the Ministry of Health contract, (having an intellectual disability) or CSI contract.

Study Two employed purposive sampling to recruit participants with direct experience of dropping out of a community-based treatment programme for individuals who had engaged in harmful sexual behaviour. Purposive sampling is particularly appropriate in qualitative research when the aim is to obtain in-depth insights from individuals most knowledgeable about the phenomenon of interest (Palinkas et al., 2015; Tajik et al., 2025). Participants were intentionally selected for their ability to provide relevant information to their unique experience of dropping out, and also of their experience of engaging with safe Network key intervention programme, meaning, participants were either from the self-referral or court mandated referral pathway.

The sample consisted of five individuals recruited from the 'self-initiated dropout' sub-sample from the non-completion sample (n = 47). Eligible participants were identified, and each case was verified through reviewing final case notes on files to reference check that the clients did in fact self-initiate their exit from the programme. Only individuals in the

client-initiated dropout category were included as this sub population aligned with the research question and aims. In addition, this reasoning aligns with the attrition framework used in previous research (e.g., Wormith & Olver, 2002), strengthening the research projects methodology. After potential participants were identified, they were categorized in alphabetical order by surname with every fifth participant on the list being contacted by the researcher. This was to reduce biased selection and to provide a more impartial sample. Initial contact was made through email (Appendix A) with the information sheet (Appendix B) attached and then via follow up phone calls a week later to provide the study information and formally invite participation at a convenient time. If participants did not respond to the initial email invitation or phone call, the next person on the list was contacted until the list of potential participants was exhausted.

Participants

Five previous service users of Safe Network responded and agreed to be interviewed during the recruitment phase. These participants ranged in age from 18 to 50+ years old at the time of interviews. All five participants were male and four were New Zealand European, and one was recorded as falling in the "other" ethnicity. Their length of engagement in intervention ranged from 2 weeks to 6 months prior to exiting the service. Participant location varied and to protect their identities, formal information of their location and office they attended for therapy was removed from the demographic reporting. Additionally, I have chosen to not present one participant's ethnicity as it may identify them, so they were classed in the "other" category. This was due to staff members at Safe Network having access to the "intervention complete" data which through filtering categories, may have identified participants and protecting their identities was paramount and considered at every stage of the research process. Another critical reason was that participants may be re-referred or potentially self-refer to the service in the future and therefore, protecting their identities and

information about them was crucial. Three participants were referred by the Department of Corrections (mandated) and two were self-referrals (non-mandated).

Procedure

Location

All participants were given the options of being interviewed over Zoom, Microsoft Teams, in person if based in the Waikato or Bay of Plenty region (due to researchers travel limitations), or over the phone. All participants chose to be interviewed over the phone and all agreed to be in a private location for the duration of the call.

Material

The interviews were all recorded using a digital device for ease of transcription, then the files were uploaded to a secure work-supplied laptop that uses a third-party provider (DTSL) to manage security and antivirus software. REANNZ, a secure New Zealand research service was used to transcribe the interviews. The terms and conditions of REANNZ stipulate that files are available for up to 15 days after transcription has occurred and are then automatically deleted from their cloud storage service. NVivo, a computer programme used to produce codes and qualitative themes was also used through the researcher's secure student account with password protection and user access controls held by the researcher. All participants read the information sheet (see Appendix C), prior to their interviews, and were then emailed the consent form (see Appendix D), that were reviewed before the interviews commenced. Four of the five participants were unable to sign the consent form online and gave verbal consent which was recorded during the interview. This was only after they were read out the consent forms and agreed they understood the research project and any limitations. The researcher notified the participants before the recording began, and when it ended.

Interviews

Study two of this research comprised semi-structured interviews (n = 5) with former service users of Safe Network who were all living in New Zealand at the time of the interviews. A semi-structured interview procedure was used to allow for participants to access their personalised experiences, and also to provide the researcher access to these individuals perspectives that contributed to their lived experience of the Safe Network programme. The interviews were conducted between March and May 2025 and each interview lasted approximately 30 minutes. An interview schedule pertaining to this study's aims was used (see Appendix D). The major topics of the interview schedule were as follows: the initial contact process (e.g., referral process, assessment interviews, beginning of intervention, information sharing), external barriers and supports (e.g., employment, finances, housing and personal relationships), did the programme align with personal goals (e.g., timing of referral, programme goals vs personal goals), and personal experiences (e.g., relationship with therapist, feelings after exiting from the programme). A sample of interview questions are as follows: "Could you describe to me how the initial intake and assessment process was for you?

All five participants received the information sheet and consent forms prior to the interview via email. Every participant was thanked for participating in the interviews, and a final statement of the purpose of the interview was shared, before offering interviewees the opportunity to ask any questions prior to the interview commencing. It was reiterated that they could request to pause or stop at any time during the interviews. I conducted all the interviews in a private and quite office space. The participants were informed of the recording beginning followed using the semi-structured interview sheet which allowed for further follow up questions when necessary. After the questions were all answered, the researcher asked participants if there was anything else they would like to add relating to

their experience of the Safe Network programme that had not been discussed or asked throughout the interview. The interviews were ended followed by the offering of a debrief, which all five participants agreed to. This enabled a smoother closing of the interview and the offer of any extra support.

To ensure that the participants were supported both prior to and after the interview; the researcher conducted a debriefing session with the participants after the interview recording had concluded to answer any questions and to ascertain whether the participants required any extra support. Furthermore, with my therapeutic training and experience, I was equipped and prepared to address any immediate emotional responses. If necessary, they were offered the phone numbers of free counselling agencies listed on the information sheet for support. The interview question guide and process were not designed to elicit an emotional response that would warrant triggering intervention (i.e., not enquiring about trauma or abuse or even what brought them to treatment).

Analysis

In keeping with the study's central aim, a qualitative design was considered the most appropriate methodological choice that would capture the personal experiences of participants and allow the emergence of themes in the data to occur naturally. On paper, the research participants dropped out of their intervention due to a lack of engagement or attendance, yet neglecting the stories and voices of service users can tend to perpetuate stereotypical narratives particularly in criminal justice rehabilitation that they simply were unmotivated or presented with an antisocial attitude. In addition to this, recidivism rates tend to be used as the metric of success and failures in criminal rehabilitation (Levenson et al., 2024). Therefore, the application of a qualitative approach would capture a deeper understanding of their decision-making processes related to exiting the programme early.

The value of qualitative research is increasingly recognised for informing and improving intervention design across the criminal justice system, yet despite this, a review of Copes et al (2020), suggested that between 2010 and 2019, about 10% of criminology articles that were published employed qualitative methods. This highlights the need for more research using qualitative methods to create meaningful change and the underappreciated value of personal narrative which can extend beyond stereotypes and stigma particularly ethnographic methods. Although surveys have the ability to measure a range of attitude, beliefs and perceptions across multiple people at once, due to small number of eligible participants for the qualitative interviewing, they were not considered a viable option for gathering data. Furthermore, due to the limitations of research participant attrition and the potential to oversimplify participants experiences, they were not considered a useful data collection approach to answer the research aims.

The benefits and limitations of numerous qualitative analyses were considered to address the central research question. Grounded Theory was considered during the research design phase; however, it was viewed as nonpractical due to its epistemological underpinnings that would not completely address the research aims. Because Grounded Theory is fundamentally interested in building theory from understanding phenomena and creating new theoretical frameworks from the data (Charmaz, 2006), this approach did not align with the purpose of this research. To understand the experiences of previous service users of Safe Network, particularly non-mandated vs mandated treatment, the meaning and patterns related to clients' experiences was central rather than to contrast a new explanatory theory of attrition. In addition to this, Grounded Theory places emphasis on data saturation in order to develop a substantial theory. This was not the objective of this research project, rather to interpret the nuanced subjective experiences linked to accessing therapy for harmful sexual behaviour. Given that the research question was not aimed a theorising a process or

psychological mechanism, but rather at describing the interpreting how participants experienced motivation, pressure, coercion and change in the treatment context, Grounded Theory procedures and theoretical underpinnings were less appliable (Birks & Mills, 2015).

In contrast, Thematic Analysis was better suited as a qualitative method of inquiry that allowed participants experiences to generate themes without the requirement to produce an explanatory model or theory. Thematic Analysis can explore individuals lived experiences by identifying patterns across data, and interpreting key, but not necessarily all, components of the data. It can be used to analysis the perceived benefits of a treatment programme (Nielsen et al, 2018), the perceived barriers (Richie, 2001) and can be adapted to accommodate various sample sizes and research questions. For instance, it can used to analysis small data sets with 1-2 participants to large studies with 60 or more participants (Smith & Davies, 2010). Thematic Analysis also enables the researcher to conduct analysis of qualitative data (themes), while simultaneously holding the data grounded in the participants own account of events (Braun & Clark, 2006). Moreover, Thematic Analysis allows the construction of meaning attached to the participants therapeutic experiences and wider socio-legal contexts. Thematic Analysis is also well-matched for use in applied psychology research including forensic and clinical contexts where the aim is often to inform practice and improve service responsiveness (Clarke & Braun, 2018).

To gain an understanding of the participants own perspectives, an inductive approach was taking to the analysis to enable a more natural manifestation of potential causes for attrition, rather than being guided by previous theories (Braun & Clark, 2006). The design of this research was based on a critical realist epistemological approach which acknowledges the existence of an objective reality that emphasises human knowledge, and the influential nature of social and cultural contexts (Hastings, 2021). Critical realism positions itself between

positivism and constructivism, granting researchers the ability to explore how participants lived experiences reflect real phenomena, while at the same time, deciphering this information through a subjective lens (Fletcher, 2017).

Analysis Procedure

After the interviews were recorded, the files were transferred to a laptop and sent through a secure and confidential file transfer system (REANNZ). Once processed, transcripts were forwarded to participants who requested to review their interview. Each participant was given three weeks to amend, remove, or add content before the transcript was finalized. Following this, NVivo, a widely used computer programme in qualitative research (Wong, 2008), was used to organise the data and produce codes. The analysis of the transcripts was prepared according to Braun and Clark's (2006) six-phase thematic analysis approach. This procedure includes becoming familiar with the data (e.g., re-reading the transcripts multiple times), developing initial codes (e.g., highlighting significant statements without applying predefined groups), searching for themes, reviewing themes, defining and naming themes. To determine the names of themes, the unique experiences of participants and their association with theoretical constructs were developed. Throughout this process, Braun and Clarke (2006) highlight the iterative and repeated engagement required to refine themes, which is a part of the reflective nature of qualitative research, and to account for possibly researcher bias.

Ethical Approval

Confidentiality

To protect participant confidentiality and privacy, all identifying information was removed from the transcripts. This included: names, geographical location and any comments

that may reveal their identities such as them naming Safe Network staff members they may have interacted with. Because of the delicate and complex nature of the research participants referral behaviour to Safe Network, I used a staged approach for contact whereby an email was sent out through the recruitment stage follow by a phone call one week later. This was to allow participants the time to consider the research aims and read relevant information without the pressure of an initial phone call. Based on these processes that were in place, the risks for harm were assessed as low by the researcher during the ethics application. However, the human and ethics committee identified the potential harm to prospective participants that could be caused by them being contacted out of the blue by an unknown researcher due to the personal and sensitive nature of the topic. In response to this, I provided more relevant information about my professional background and clinical experience in the field of harmful sexual behaviour. As the researcher it was crucial to approach participants in a trauma-informed way, as well as utilize relevant training and experience to work safely and ethically with people that have engaged in harmful sexual behaviour. During the phone call interviews, these skills were drawn upon to establish rapport, and a sense of therapeutic safety for participants.

Cultural Safety

This research project received ethical approval from the Human Research Ethics Committee (Health) at the University of Waikato; project number 2024#14. Prior to the research design phase, I identified issues and concerns related to cultural safety, participant distress and confidentiality. To mitigate these issues, I sought consultation from Safe Network's Māori and Pasifika Cultural supervisors and took on board feedback to reflect on the importance of creating a culturally informed space during the participant recruitment, and interview process. This included the use of basic te reo when deemed appropriate with

potential participants, and fostering partnership throughout the research interviews which including an inquiry if there were any meaningful or important ways in which the interview was to be started or ended. To mitigate the potential distress of participants during the after the interviews, a debrief was held and provided in the information sheet were a selection of phone numbers to nationwide free counselling services.

Service Provider Consent

During the initial planning stages of this project, I undertook consultation with Safe Networks Clinical Director, Clinical Research Advisor, CEO and Cultural Supervisor. Based on Safe Network's research policy, the research procedures were evaluated before the project was signed off. The research must not cause undue harm to clients, and the research topic must align with Safe Networks research visons and goals (increase client satisfaction and inform service delivery changes). Following this internal review process the CEO confirmed his support the research project. All participants were provided with written informed consent, and the potential risks were outlined prior to the beginning of interviews. Participants were reminded they could end the interview at any time and of their right to withdraw within three weeks of receiving their transcripts for reviewing. Audio recordings and data were secured on a password-protected devices accessible only to the researcher and academic supervisor who will retain this information for five years in accordance with the University of Waikato's research ethics policy. To mitigate any potential bias, given the researcher's dual role as researcher and clinical staff member, no recruitment of participants whom I had interacted with through the processes of assessments, interventions and group therapy facilitation were contacted for this research project.

Positionality

During the initial stages of this research project, my awareness of the position I held as both researcher, and clinician in the workplace where the participants would be recruited required critical reflection. This was mainly due to understanding the power that comes from this dual role, as well the harm that could be caused with this inherent power. I have relevant experience in the clinical and administrative processes involved in both individual and group therapy components. This, I considered valuable insight that increased my ability to recruit participants and build rapport, while simultaneously giving me a nuanced understanding of some of their experiences. However, I also noted this as a potential hindrance with recruitment when sharing my positionality as researcher and clinician at Safe Network. I drew on my professional experience working at Safe Network and strongly considered how it could feel, as someone who exited the programme prematurely, to be contacted out of the blue by a researcher and clinician. It was critical that I explained the process of the research and its aims in an easy-to-understand manner, while also making it very clear that the research was not aimed at any discussion of their referral HSB. In this way I was able to appease concerns and mitigate potential stressors. My position as a colleague to clinicians that may have worked with research participants produced an internal dilemma, wherein I needed to carefully consider how I would share the findings from the research without unintentionally revealing any of the identities of the participants or the clinicians they worked with.

My decisions on the recruitment processes and data analysis were all informed by these inherent dilemmas. I remained reflective and took active steps by being vocal with these concerns with my research supervisor. As an ongoing process of reflective practice, prior to interviews I reminded myself of the importance of maintaining cultural safety and

staying open-minded and curious. I became consciously aware after conducting my first interview to consider the interaction between other systems that participants were engaging with at the same time (probation officers, court system), and how my own understanding of these systems and services could shape my interpretations of participant experiences.

While considering the impacts of my professional identity, my personal identity including my Pākehā cultural background needs to be acknowledged in my role as researcher. This is because I may not hold the same worldviews and beliefs as some of Safe Network's service users, many of which are of Māori and Pasifika descent. Due to this, I was intentional with maintaining an element of partnership throughout the interview process which included acknowledging my own cultural background during my introduction and acknowledging limitations in my understanding of culturally important components that may arise during interviews.

Chapter Three: Results

The results of this study are presented in two sections. The first section reports on the quantitative findings from the demographic characteristics, attrition pathways, and treatment engagement of participants. The second section details qualitative insights, summarizing key themes and subthemes identified through interview analysis with data from analysed transcripts provided thereafter.

Study One: Characteristics of Completers and Non-Completers

Demographic Characteristics

Demographic characteristics for both completers (n = 431), and non-completers (n = 123) of the treatment programme are displayed in Table 1. Of the total sample (N = 560), completers made up 77.7% and non-completers comprised 22.3% respectively. The breakdown of participants age groups was split up across six groups. Of those, the 25–34-year-old age group had the largest number of participants (n = 141; 32.7%) with 44 non-completers (35.7%). The mean age of the completers sample was 42.9 years (SD = 15.3), and the mean age of non-completers was 40.5 years (SD = 14.9).

It can be seen from the data in Table 1 that the largest ethnic group was New Zealand European, which comprised 159 participants completing (36.9%) and 50 (40.7%) not completing the programme. There were 86 (20%) Māori completers, with 31 (25.2%) not completing, followed by 51 (11.8%) Pasifika completing the programme, and 12 (9.7%) not completing the programme. Participants from ‘other’ ethnicities totalled 55 (12.8%), with 12 (9.7%) non-completers. Lastly, 8 completers (1.9%) did not state ethnicity and 4 (3.3%) non-completers. The ethnicity distributions across completers and non-completers were yielded similar results with New Zealand European participants comprising the largest proportion of

both completers (36.9%) and non-completers (40.7%), followed by Māori, Pasifika, and other ethnicities in smaller proportions.

Table 1

Demographic Characteristics of Completers and Non-Completers

	n (%)	
Demographic	Completers (*n* = 431)	Non-Completers (*n* = 123)
Age Group		
18-24	18 (4.2%)	11 (8.9%)
25-34	141 (32.7 %)	44 (35.7%)
35-44	98 (22.7%)	29 (23.6%)
45-54	67 (15.5%)	13 (10.6%)
55-64	57 (13.2%)	15 (12.2%)
65+	50 (11.6%)	11 (8.9%)
M (SD)	42.9 (15.3)	40.5 (14.9)
Ethnicity		
New Zealand European	159 (36.9%)	50 (40.7%)
European nfd	72 (16.7%)	10 (8.1%)
Māori	86 (20%)	31 (25.2%)
Pasifika	51 (11.8%)	16 (13.0%)
Other	55 (12.8%)	12 (9.7%)
Not Stated	8 (1.9%)	4 (3.3%)
Contract Type		
CSI	10 (2.3%)	6 (4.8%)
Corrections	202 (46.9%)	52 (42.2%)
Fee for Service	7 (1.6%)	0 (0%)
Non-Mandated Adults	170 (39.4%)	58 (47.1%)
Ministry of Health	42 (9.7%)	7 (5.6%)

Note: European nfd = European not further defined

Pathway Characteristics

The sample included participants from five referral sources. Ten participants (2.3%) referred through the CSI pathway, of whom 6 (4.7%) did not complete their interventions. The largest group came from Corrections, with 202 participants (46.9%), of which 52 (42.2%) did not complete their interventions. Non-Mandated Adults numbered 170 (39.4%),

with 58 (47.1%) not completing. Lastly, there were 42 participants (9.7%) from the Ministry of Health, with 7 (5.6%) non-completers.

Table 2 outlines attrition pathways among participants. The predominant reason for program exit was non-attendance or client refusal, accounting for 47 (38.2%) of dropouts, with an average of 18.08 treatment hours completed prior to dropout. The next most frequent attrition category was "Other" reasons with 20 (15.5%) participants completing an average of 21.21 hours, followed by mental or medical health incapacitation (19.47%) and 22.92 average hours of completion prior to drop out. Additional dropout reasons included custody or remand (8.5%), relocation or being uncontactable (6.2%), and unsatisfactory progress, which had the lowest average completed hours (6.06 hours). The variability in average treatment hours completed before dropout indicates differing levels of participant engagement based on attrition reasons.

Table 2

Intervention Exit Categories and Therapy Hours

Exit reason	*n*	%	*M* (hrs completed)
Non-Attendance/Refusal - Client	47	38.2	18.08
Incapacitating Mental Health/Medical Issues	19	15.4	22.92
End of Supervision Order/Sentence Conditions	17	13.8	15.72
Custody/Police Custody/Remand/Prison	11	8.9	23.04
Moved out of Region or Uncontactable	8	6.5	29.12
Unsatisfactory Progress	4	3.2	6.06
Lack of Funding Pathway	1	0.8	0
Non-Attendance/Refusal - Family	1	0.8	53
Referral to Non-HSB Service Prior to Completion	1	0.8	16
Other	14	11.8	24.21

Note: Other refers to participants transferring to another contract (e.g., participant transfers from a Non-Mandated Adult contract to a Department of Corrections referral after they have been sentenced with probation and corrections care as the outcome).

Table 3 reports average and median intervention hours completed prior to dropout, organised by ethnicity. Indian participants (*n* = 3) averaged the highest completion hours (*M* = 37.75) followed by European (not further defined) participants (*n* = 11) with averaged completion hours (M = 29.40), and New Zealand European participants (*n* = 54) (mean = 23.27). Māori participants (*n* = 35) averaged 15.18 hours, Pasifika participants (*n* = 12) averaged 17.7 completed hours, and other ethnic groupings reported lower average hours. Median values were generally lower than means, reflecting skewed distributions possibly due to some participants with very high engagement hours.

Table 3

Completed Intervention Hours of Non-completers by Ethnicity

Ethnicity	N	Average Hours	Median Hours
New Zealand European	50	23.27	14.00
Māori	31	15.18	8.62
Pasifika	16	16.28	7.00
European	11	18.70	12.70
Indian	3	37.75	9.00
African	2	1.00	1.00
Asian	3	23.60	23.60
Latin American	2	12.00	12.00
Other	5	10.31	10.25

This study examined the demographic variables and both, referral and exit pathways for men that were engaged in intervention at the Safe Network programme. The data identified that middle age New Zealand European participants comprised the largest demographic group in the sample. Compared to other ethnic groups in the sample, they were more likely to exit treatment prematurely particularly within the 25-34 and 35-44-year-old groups. The most prevalent non-completion referral pathway was those from the Department of Corrections and the Non-Mandated adult pathways. The most common attrition exit reason was refusal/non-attendance from a client, with a smaller number exiting due to health

reasons, custodial sentencing, relocation and unsatisfactory progress. Participants showed varying levels of engagement across attrition pathways with average hours ranging from around six hours for unsatisfactory progress to over 22 hours for health-related issues and those men in the *Client Refusal* category on average, completed 18 hours before dropping out.

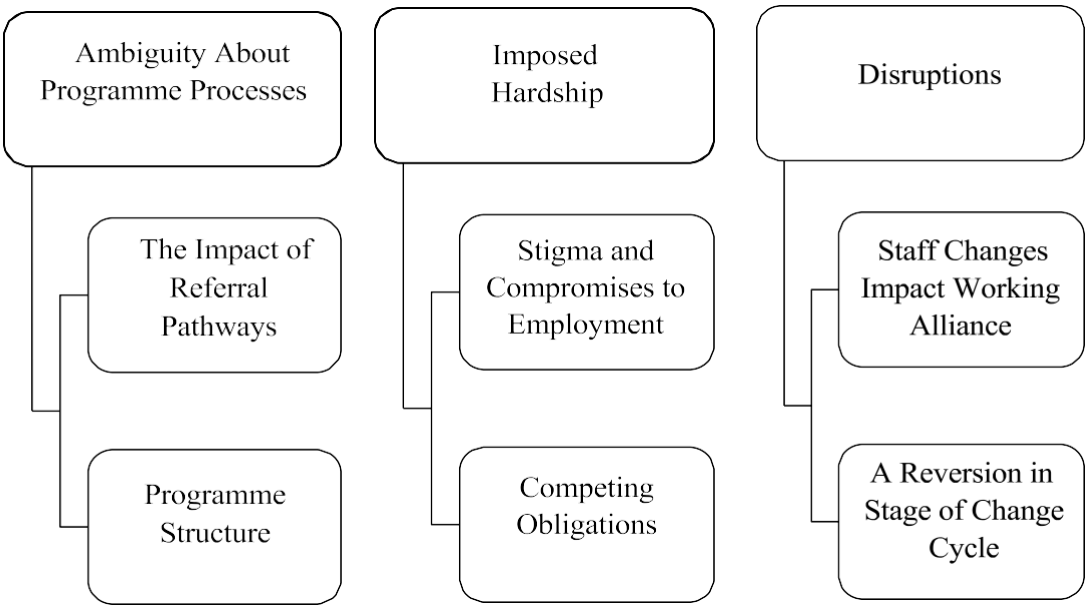
To further examine what has contributed to the high volume of participants exiting that refused to engage with their intervention, research is yet to examine the qualitative experience of individuals that have dropped out of a New Zealand treatment programme for harmful sexual behaviour. With no feedback provided from these individuals before their exit, this will be the focus for study two of this thesis; examining the qualitative experiences of some of these men.

Study Two: Understanding Attrition and Non-Completion

After reviewing the interview transcripts, three themes emerged from the participants' experiences at Safe Network. The themes were, *ambiguity about programme processes,* which related to participants experiencing confusion and anxiety about referral pathways, and also the programme requirements, goals and methods. The second theme was *imposed hardship,* which came from both managing work, lifestyle commitments while balancing programme demands and also compliance pressure from referrers such as the department of corrections, over treatment readiness. A third theme emerged which was *disruptions* which related to participants' experiences of safety within their therapeutic relationships and emotional response after exiting the programme. These themes emerged in relation to different components of the participant's experiences as illustrated in the diagram below (see figure 1).

Figure 1

Attrition and Non-completion Themes and Subthemes



Ambiguity About Programme Processes

A persistent theme for most participants was confusion regarding the programme's structure, the process of admission, and the requirements expected of them, which combined, contributed to an underlying experience of anxiety and uncertainty. This sense of ambiguity extended from initial approaches to the service, through assessment, and into the intervention phases, making it a consistent barrier throughout various stages of their therapeutic engagement.

Participants described lacking clear information about programme content, the distinction between individual and group therapy, and the criteria that determined the duration of their treatment. The process was particularly unclear for those referred via the Department of Corrections as they often felt unaware about what to expect during their referral and about the subsequent steps in the programme. For these men, ambiguity about

procedural details contributed directly to feelings of anxiety and apprehension and often shaped their initial attitudes and motivation to participation.

Two subthemes captured the nuances within this overarching uncertainty. First, the experience of ambiguity differed between mandated and non-mandated clients, with the former group reporting less clarity, and heightened distress regarding treatment expectations and potential consequences. Second, this persistent lack of transparency was recognized as more than situational; rather, it appeared embedded within the overall service experience, hindering engagement, motivation, and ultimately participant retention.

Overall, ambiguity about processes not only generated confusion and anxiety but also served as a significant barrier to effective engagement, illustrating the importance of clear, consistent communication in forensic therapeutic settings.

The Impact of Referral Pathway. All of the participants that were referred through the Department of Corrections described not being provided any information by their probation officers about Safe Network and what the programme involved. Additionally, the lateness of referrals and processing time combined with uncertainty created a sense of anxiety which impacting their level of motivation to attend.

> *"No, because corrections were pretty much like, 'We have to put you onto this. You're going to go to this place. It's Safe Network and they deal with this type of thing,' and that was pretty much it."* - P3.

> *"Well, I thought I didn't know much about the Safe programme... I thought I was going to go to some ward... get pills and stuff. Corrections were pretty much just like, 'Here, you go to this address, it's court mandatory.' And I'm like, 'What am I doing?'"* - P1

The men also described being unaware of the timing for referrals, which were competing with their sentencing condition timeframes, and as a result for one of the men, this meant his intervention was premised on the lack of time to complete the required intervention causing confusion and anxiety. By the time some of men were seen for initial assessments and began intervention, they were roughly than halfway through their sentencing conditions.

> *"I was on probation for a while before I got told to go. And then I remember distinctively, this just triggered a memory in my head, that my Safe therapist said, "We've got to play catch-up because you've been admitted too late, I was thinking wait, catch up on what"?* - P1

> *"Corrections took nearly eight months before they even took me into the programme. So, by then I'd done six months of therapy on my own, and they wouldn't even recognize that ... everything had settled down. My life was going really well, and then I had to go rehash it all so much later on"* - P2

In contrast to this, the other men who self-referred described a more self-directed experienced due to the necessity of referring themselves through the website, or with the support of administrative staff. Due to needing to find out information about the correct pathway of referral, the participants would likely have been required to digest the information and may have been followed up by a staff member through the triaging process, whereas the mandated participants referral information is all attached to the referral. This appeared to create a difference in how they experienced the referral pathway.

"Yeah, I was given a card and.....said, 'Look, go and check this out. I think it'll be helpful.' Then I went on the website to see....and then I went from there I could see all the referral pathways." - P4

"Yeah. I believe I met with a girl there in the start of all of it. I think she was in admin. And yeah, she just enrolled me through the whole process really. So, yeah, I guess it was all right." - P5

This subtheme highlights the discrepancy of information provided to mandated participants which appeared to impact the participants willingness to engage in the programme. Also, wider structural issues were identified as pivotal particularly the information sharing and communication process between Safe Network and the Department of Corrections, one of their key stakeholders. While contrast to this, non-mandated participants reportedly felt somewhat supported and clear about the programme based on the information they found through self-referring, or with the support of administrative staff. This suggests that individual agency and access to information may reduce initial anxiety.

Programme Structure. The programme's structure was another area where participants described experiencing uncertainty. During the sharing of intervention and programme information such as timeframes, group therapy processes and topics, participants reported that a lack of information created confusion, frustration, pressure and a sense of animosity indicating a reduced sense of motivation to continue, and a disconnect from the treatment process.

"No. It was just a blank; it's going to be 12 months. That was it....but the fact that their assessment recommended 12 months, was a bit over the top…. I've been through

therapy that I paid for and done. I knew what expectations I was expecting from this lot, but it never happened." - P2

"I don't know how many weeks I was there, but before I dropped out, [therapist] said, 'We haven't actually started therapy yet. I was like, Oh, what are we doing then? I've been here for a long few weeks now and I haven't really done therapy. So yeah, I was a bit confused." - P5

"There wasn't really enough given back about the group session. It was not really explained to me what the content in the group sessions was, how it was structured, or what that was all about ...Basically, they said it was a group of people getting together... like a big discussion group…but it sounded like an AA meeting…. It didn't really explain to me what the topics were" - P4

The lack of information provided about programme processes may reflect communication gaps between individual clinicians and the wider structural processes. The lack of information given to participants prevented them from being able to understand and track their progress. For participant P1 and P4, who both had group therapy included in their treatment plan, they were faced with an extra level of uncertainty specifically about content of the group, and group processes including confidentiality.

"Yeah, that would've been the main thing. Who are the other people that are attending and just making it a safe space, because I'm coming from having to join, go to Safe and do all that was never something that I ever anticipated in my life I'd have to do.

There's a little bit of shame and embarrassment in that, that comes with it as well. Taking that with you into the group, that's a bit tough as well"- P4.

For one of the men, the risk of confidently was a major concern that increased anxiety levels:

"*Because also in the back of my mind was like, "What if I bump into one of these guys?" the whole time doing it, I was sweating bullets Maybe if I had a couple more sessions with [Therapist] and talked a bit more and opened up a bit more, I would've probably been a bit more ready to go into a group setting because I've opened up that a little bit more"* - P1.

It was apparent participants were seeking reassurance and understanding. Some of the men offered solutions to address the lack of information given prior to the referral, with one offering an idea for participants referred through the Department of Corrections:

"Yeah. Like when you go into Corrections and they tell you, "Watch this short little film here and this is where you're going to go, blah, blah, blah, and this is what they do," then you have more of a, I reckon, understanding of the place in what is needed of you here" - P1.

Similarly, another participant provided a suggestion about how information about group therapy could be provided to client's particularly after the initial assessment interview:

> *"Probably just a simple explanation of what the structure was for the session and what's covered, who's there, what the expectations were to be, stuff like that. Probably just in a brochure would've been helpful or on the website or even a personal letter once you'd gone through the referral process and that said, "Yes, you've been accepted to this. These are what we offer, and this is what happens."* - P4.

Imposed Hardship

This theme reflected the men's experiences of ongoing pressure which impacted their ability to engage with the Safe Network programme. This included the need to hide their attendance at Safe Network to protect their identity. For one, after their identity was exposed in the newspaper, they ended up losing their job creating financial insecurity and this contributed to their decision to leave the programme prematurely. Work obligations competing with the office hours of Safe Network often meant participants were unable to balance work commitments with the demands of attending regular individual and group therapy sessions. For some of the mandated participants, the pressure from the criminal justice system, particularly their perceived fear or support from their probation officer created extra pressure; but also acted as a catalyst to exiting the programme early.

Stigma and Compromises to Employment. Employment was identified by most of the participants as a consistent barrier to attending the programme. For example, men reported that the timing of appointments clashed with work obligations and childcare arrangements which created pressure both to keep their attendance up at Safe Network and also balance working.

"*It was basically the timing, the timing didn't work... the boss would come in and cover me... but I think the Safe Network was only available in the afternoon around lunchtime, and that was just not a possibility*." - P4. "*Because I would have to lie to my*

employer that I need to go away twice a week and all that, so finish work early, it's not really something you want to discuss with your employer." – P5

The men described feeling like there were no other options available to them and that this contributed to their decision to disengage. Difficulty balancing work obligations while trying to adhere to programme structures and led some of the participants to feeling disempowered, reinforcing the perception that treatment expectations were misaligned with the realities of their daily responsibilities.

> "*A little bit, yes. Yeah, it was like, well, this is what we do in a box, and if you're outside the box, well tough luck…. I didn't want to leave, but I felt like I had to because there wasn't that option to accommodate me with the scheduling and that. That was my main reason for pulling out because even the one-on-one sessions were in the afternoon while I was working, so it just felt like there were no other options available, so I had to just withdraw basically*." - P4

Some also identified having to conceal their attendance at Safe Network due to the nature of their referral behaviour, and for one participant, disclosure of his offence to an employer resulted in job loss. Others described lying to employers about session attendance or missing treatment to avoid exposure. For many, balancing work commitments, parenting responsibilities, and the secrecy and shame surrounding their offending created a constant source of stress.

> "*Because the times I had to go to Safe, on those days that I had to go to pick up [my children] from school... and I think I just got there as the bell rang on two*

occasions…… my mum and my dad left me in school countless times really, really late. No, yeah, I'm not going to do that to my [children].” - P1.

These challenges that participants described highlight how competing external pressures can undermine motivation and capacity to engage, even when internal willingness to change exists. Additionally, the emotional strain linked to concealing attendance at a sex offender treatment service reinforced feelings of isolation and shame. Attending therapy during standard business hours thus created dual pressures, logistical and emotional, making treatment feel unachievable with everyday life demands. Some of the participants suggested that offering after-hours or flexible sessions would have reduced these conflicts and maintained their participation

“*It would just be accommodating the timing sessions maybe, working around that*.” - P4.

In sum, this theme illustrates how seemingly overlooked aspects of programme structure such as session timings, and the perceived inflexibility to accommodate this, can contribute to participants experiencing a block in access to treatment – further impacting programme retention.

Competing Obligations. Some participants described experiencing pressure from both the programme structure and the criminal justice system, particularly regarding readiness for group participation without adequate preparation and support. For many, the seemingly fast progression and expectations set by programme staff and probation officers created an environment that prioritised compliance with referral conditions over therapeutic readiness. Men spoke of the tension between programme requirements and personal

emotional capacity, describing a lack of flexibility that left them feeling powerless in determining the pace or content of their treatment.

> "*Yeah. I wasn't ready... Yes. It was too early for me to do group. I was very hesitant on it. I told my therapist that I'm not too keen on it. It's too early. but I was still fresh into it and coming in, opening up to [therapist], and then all of a sudden, 'Oh yeah, you've got to open up towards a group.' It's like, 'Hang on, settle down now…. The whole time doing it, I was sweating bullets…. Maybe if I had a couple more sessions with [therapist] and talked a bit more and opened up a bit more, I would've probably been a bit more ready*.'" - P1

> "*Yeah. I was realising that early on… The whole Safe Network is just not working, it's actually going backwards but corrections were saying, no, I had to stick with it…. I think at that stage I was over it, get it over with, I had moved on*." - P2

This theme illustrates that participants perceived the treatment process as one in which external compliance took precedence over internal readiness, contributing to disengagement and emotional withdrawal. For several, probation-mandated attendance and perceived programme inflexibility reinforced a sense of coercion rather than collaborative rehabilitation. When readiness is misjudged, early or forced exposure to individual and group processes can heighten anxiety and shame rather than foster engagement. Interestingly, P1 and P2 illustrated that probation officers played a double-edged role in this process; sometimes intensifying feelings of a lack of control but in other instances, offering understanding that restored agency.

"*Also, on the side note, the probation officer I had, not [name], [name], I had first. [name] was good. I had another [person]…. [they] were very vague, and [they] made my life a living hell through my six months of home detention…. [they] pretty much said, 'You have to go to do Safe. You have to go to Safe because it's mandatory by the court.' And if you don't go, I think [they] said, yeah, if I don't go, I end up back at court and I have to explain why…" I was having difficulties with that one probation officer, and yeah I changed probation officer back to the one I originally seen, the nicer one that really understood…. I said to [person], 'I can't do this.' And [they] said, 'Leave it with me…. Everything that you said to me, I typed it up in the email and I sent it through with all my work and it's fine*.'" - P1

"*And then I changed corrections officer. And the corrections officer, [they] were good. The [person] had this idea that this is what you've got to do, and you've got to just do it. Whereas the corrections officer said to me, [they] said, 'If this is not working for you, you don't have to continue it.' And that was also a contributing factor to me pulling out of it*." - P2.

These accounts reveal that the relational stance of probation officers whether rigid or supportive shaped participants' sense of agency and their willingness to persist with treatment.

Disruptions to Treatment

This theme examined participants therapeutic relationship, the relational safety that was established and for some, the disconnection that came from disruptions to the therapy such as being transferred to another therapist. Secondly, participants initial emotional responses after disengaging from the Safe Network Programme were also encapsulated into

this theme. Participants mostly responded with experiencing a sense of relief from leaving while one experienced a sense of disappointment and unresolved feelings about unfinished goals. Some appeared relieved that they would not need to attempt to negotiate difficult scheduling particularly with work and the emotional strain of having to revisit their referral behaviour. These themes highlight the accumulation of emotions for participants when navigating the criminal justice system and attempting to fit in personal therapy for harmful sexual behaviour in the community. For the majority of participants, a sense of relief came from leaving the programme reducing financial, work and logistical constraints. A release from a strain and pressure suggests these participants may have likely made the decision to leave long before they did. For others, P1 experienced a sense of relief from pressure of attending while acknowledging a desire to complete the programme suggesting programme drop out may be experienced as release from pressure and simultaneously a loss of opportunity. These findings highlight the importance of improving exit processes particularly for those who disengage for reasons outside of their control. Moreover, clients that exit may need the space to process this closure.

Staff Changes Impacts Working Alliance. All participants described the therapeutic relationship as a central factor influencing their emotional engagement and motivation to continue treatment. For many, the quality of the relationship with their therapist shaped not only the degree of trust and openness they could achieve but also their overall commitment to the Safe Network process. Those who experienced emotional safety, relational consistency, and empathy within therapy often viewed the programme as a supportive space for reflection and behavioural change. In contrast, others described their experiences as somewhat directive, or disrupted by staff changes, which diminished their sense of connection and undermined their participation.

"*Yeah, I really enjoyed the first clinician I was assigned to, but [they] didn't see me through the whole process, I was transferred to someone else, then the new therapist was always a bit, not aggressive, but trying to... Don't know, it's hard to explain. But yeah, I feel [therapist] maybe just was a bit hard on me saying, 'This is wrong. Don't do that*.'" - P5

"Yeah, I think I was seeing [therapist] to start with, and then after a while I got transferred to someone else, and then I was like, "Hey, what the hell?" That fucked everything up, being transferred to someone else……and I'm like, "fine, I'm going to try and explain to them, even though they'll probably have it on record." - P3

"*The counsellor was fantastic, don't get me wrong. [they] were absolutely amazing, but it felt a little bit impersonal, but at the same time I know that as coming from a counsellor's perspective, you can't invest yourself too much in each patient that you see. It did just feel like numbers, you're another person they have to see*." - P4

"*Good. [Therapist] was great. I enjoyed it… When I did open up a bit to [therapist] and [they] fully understood what I was talking about and things I needed to do mentally to either stop what I'm about to do or think about my actions*." - P1

A Reversion in Stage of Change Cycle. For most participants, the process of leaving produced immediate relief from the accumulated strain of financial insecurity, disrupted employment, and emotional stress tied to programme mandates. Several men acknowledged that they had contemplated disengagement long before formally exiting, viewing departure as inevitable given the competing pressures of real life.

"*I think a bit of a relief, really. Because I would have to lie to my employer that I need*

to go away twice a week and all that, so finish work early." - P5

"*Good. I thought I don't have to go down the same track every week, relive what was going on at the time when I end up with corrections, and I can get on with my life. Yeah, it was a lot of relief and it was a lot easier*." — P2.

However, some of the men articulated a noticeably different experience, expressing disappointment and emotional fatigue at having invested substantial preparation and effort, only to have external circumstances, such as scheduling and work conflict, force withdrawal.

"*I was disappointed. I had psyched myself up to be able to do all of the work and having the backwards and forwards conversations with the Safe people and the boss at work and going through all of that stress and then having at the end just go, oh, well, it's not going to work. Yeah, disappointed*." - P4

"*I was relieved in a way that I don't have to try and scrimmage around to try and get money to go to the meetings… In a way, I was disappointed that I couldn't finish because I did want to*…" - P1

The findings from the interviews depict attrition as an outcome from multiple sources including systemic structures, service processes and participant personal circumstances, rather than individual motivation and readiness alone. The men reported ambiguity around programme processes, imposed hardships and disruptions to treatment from staff changes as key factors that impacted their sese of safety and fit within the programme. Uncertainty about the programme structure created confusion and anxiety for most men. This was further exacerbated for some who were mandated to treatment from the Department of Corrections

who enter treatment with minimal information and felt their referral was driven by system requirements rather than their own needs.

Competing obligations such as parenting responsibilities, employment demands, and financial security further constrained participant engagement. Additionally, staff transfers created disruptions which undermined the therapeutic stability required for harmful sexual behaviour treatment. The pressure from attempting to keep their engagement with Safe Network a secret and the potential stigma from their behaviour which included the risk of losing employment if their identities were revealed, created emotional hardship for the men. Over time, treatment dropout was often a response to the anxiety from these circumstances which began to undermine therapeutic engagement even when men expressed a desire to change.

Chapter 4: Discussion

This thesis utilised a mixed methods approach to examine the pathways and characteristics associated with attrition for men that attended a community-based HSB programme across two separate studies. The first study utilised quantitative data to explore trends in demographic variables (e.g., age, ethnicity) and organised theses by ethnicity, contract type, and hours of intervention completed before participants exited the programme. The results indicated that between 2018 and 2025, self-referred men exited the service at higher rates (48.1%), than mandated participants (41.7%). Furthermore, it was revealed that New Zealand European recorded the highest rate of attendance, and disengagement with the programme followed by Māori participants. The attrition rate for the men attending the programme between January 2018 to May 2025 was 22.4%. The second study then examined the qualitative accounts of men that dropped out of the programme after either self-referring or who were mandated to attend as an outcome of being involved in the justice system between January 2018 and May 2025. This present study sought to identify and understand factors associated with attrition in the treatment of adults who have engaged in HSB towards minors. Specifically, it is the first of its kind to explore this in a New Zealand context.

Analysis of trends identified three themes *ambiguity with programme processes, imposed hardship* and *disruptions*. To date, Lambie and Stewart (2012), are the only authors to have presented quantitative attrition data from this service in New Zealand, however their results may have been skewed due to including data from individuals that did not complete the referral or assessment interviews. Furthermore, while previous research has focused on static predictors such as risk levels (Beyko & Wong, 2005; Olver et al., 2011), this study adds valuable qualitative data insights into attrition. The findings in this discussion section are generally linked to international studies as there are no qualitative studies in New Zealand

that have specifically explored men's dropout experiences from a harmful sexual behaviour programme.

The Extent of Attrition in Community-based HSB Treatment Programme

The aim of Study One was to classify attrition data from January 2018 to May 2025. The results highlighted multiple pathways and individual characteristics linked to treatment dropout. Firstly, of the overall sample ($N = 560$), attrition accounted for 22.4% of the sample which was similar to results found in other studies. For example, Olver et al. (2011) reported an average attrition rate of 27.6% after reviewing 34 studies reviewing sex offender treatment for (n =12878) individuals. However, rates of attrition varied from 11% to 54 % within the studies reviewed and the authors suggested several factors including treatment setting (e.g., prison or community programmes) could account for the difference in dropout rates. The findings observed in this study mirror those of the previous studies that have examined attrition and support the common finding that roughly one quarter of participants in sexual offender treatment programmes may be vulnerable to treatment drop out for a multitude of reasons.

Non-attendance/client refusal was the primary reason for dropout and accounted for roughly one third of exits from the programme. This reflects a well-documented pattern in the literature where treatment dropout is frequently linked to disengagement behaviours such as skipped appointments or refusal to continue (Olver et al., 2011). Additionally, a range of attrition pathways including completion of sentencing conditions, health incapacitation, or relocation highlight the complex, multifactorial nature of dropout. Such findings are consistent with meta-analytic evidence showing that attrition is not typically attributable to a single factor, but rather shaped by interactions between individual characteristics, systemic factors, and external life circumstances (Olver et al., 2011; Carl & Lösel, 2021).

The ethnic breakdown of treatment engagement further underscores the significance of cultural and contextual factors in dropout. The data indicated variation in average hours of treatment completed by ethnic group, with Māori and Pasifika participants, who are over-represented in New Zealand's criminal justice system though less than their pakehā counterparts for sexual offences, averaged fewer hours than New Zealand European participants. While it is well documented that western frameworks and knowledge may not accommodate cultural differences in understanding sexuality, identity, belief systems, and sexual offender treatment (Beyko & Wong, 2005), further research is required to determine why Māori and Pasifika completed less therapy hours on average, before they exited the programme. Based on sampling methods, there were no respondents in the qualitative study that identified as Māori or Pasifika; so no meaningful inferences can be made here but signals an important direction for future research. However, emphasis should be placed on using qualitative methods to ensure the voices of Māori and Pasifika service users are the substance of programme changes that may increase their treatment retention and engagement hours.

Ambiguity About Programme Processes

Two subthemes that contributed to the theme of ambiguity about the programme processes were *the experience of referral pathways and the perception of programme structure.* Considering whether the men were mandated to attend or self-referred, it was clear that both these pathways come with very different experiences with the mandated individuals having no agency in the decision-making, or with receiving enough information to feel comfortable and understand what the service was about. Thus, emotions such as anxiety were present before their initial contact with the service staff which also appeared to impact levels of motivation. This supports research that outlines that within the criminal justice system, individuals may experience mistrust and fear due to sentencing conditions and being

monitored by probation and court conditions (Maruna & King, 2009). A notable experience for the men who were mandated to attend counselling was the lack of agency they felt in the referral process. For some of the men, their referral almost came as a surprise which appeared to indicate to them to that their freedom of choice had been removed that ultimately lead to a sense of resentment and reluctance to engage with the therapeutic process before it began. This hesitation by individuals to engage in therapy is familiar in other literature on mandated treatment particularly with substance abuse and domestic violence programmes (Hatchel et al., 2019). One unanticipated finding was that for the mandated individuals, they reported a receiving minimal information about the programme or processes involved from their probation officers which caused nervousness and reluctance to engage in treatment. Studies report that anxiety increases for service users when poor information sharing creates uncertainty and a lack of effective information sharing before or during treatment, as well as about treatment processes and what to expect (Olver et al., 2011). These factors also work to undermine motivation for people to participate in treatment. Similarly, Wong et al. (2024), emphasized that if clear communication, prior contact before the initial appointment, and reoccurring appointments with the same clinician were had, the individuals in their study were three times more likely to attend the following appointments. Research also suggests that when patients have concerns about data sharing or privacy, their motivation to attend mental health services reduces (Shen et al., 2019). When information is provided or consumed for example, for the men who self-referred, they reported finding enough information about their pathway for referral and also receiving support from admin staff at times. For the men that were mandated to attend treatment in this study, it could be seen that their initial thoughts about Safe Network after receiving limited information meant that they were nervous which may have impacted their capacity to build trust within the therapeutic

context - underscores the importance of information sharing to reduce anxiety about treatment.

Considering the subtheme of programme structure creating confusion and increasing levels of anxiety at times, some of the men described how a lack of understanding of programme duration and content impacted their level of engagement. This finding supports previous research exploring treatment experiences of sex offenders in the U.S with a reoccurring theme related to programme confusion and frustration. Levenson et al., (2024) found that many participants described the programmes they attended as “rudderless” and lacking explicit goals tailored to their individual needs. Without appropriate benchmarks articulated, participants in this study reported a perceived absence of any formal curriculum which left them feeling helpless and stagnant in their progress. Indeed, some participants in this study stated a lack of clear structure created confusion and ultimately for some, left them feeling hesitant to join the group therapy component. When this information was not made available to them, this contributed to their overall sense of disengagement and hampered motivation. Beyko and Wong (2005), found that unclear information and lack of motivation as significant predictor of sex offender attrition. In particular, they reported that insufficient understanding of the treatment programme’s purpose and structure contributed to disengagement. They suggested that motivation could be supported through clarity about treatment goals and advocated for robust client education about programme structures, and intervention planning as key factors to reduce attrition and strengthen therapeutic alliance through collaboration. Without this clarity, individuals may be unable to internalise treatment content. In this study, two participants offered suggestions on how to fix communication gaps with one offering a suggestion for mandated participants that included viewing a video that could give an overview of the programme and service expectations. Secondly, another participant recommended providing a brochure to participants that outlined programme

concepts and expectations. These findings highlight the utility of qualitative investigations as a key method to reduce attrition by gaining valuable insight into where the breakdown of communication occurs from the participants perspective that was also found in previous studies (Collins, et al., 2010; Lindegren et al., 2025; Sturgess, 2010; Levenson et al., 2024).

Imposed Hardship

This theme was comprised of two subtheme, *stigma and compromises to employment,* and *competing obligations.* In regard to stigma and compromises to employment, almost all of the men indicated that needing to work fulltime for financial reasons including to support themselves and family members, was a constant source of pressure. For example, some of the men discussed needing to lie to their employers as about needing time off for therapy appointments due to shame, stigma, and need to conceal their offence. Practical and structural barriers, particularly around transport, childcare and work are often cited as barriers to attending therapy appointments, with previous research identifying inflexible scheduling and daytime only appointments as barriers for working class men or those needing to attend to caregiving responsibilities (Sweetman, 2021; Tuschick 2024). While two of the men acknowledged after hours group therapy sessions were offered to them, it appeared that social stigma, fear and shame contributed to their reluctance to engage in this, meaning, the emotional strain, driven by fear of being identified, may have outweighed this opportunity to accommodate one of their barriers to treatment. This is consistent with research from Lindegren (2025), who interviewed incarcerated sex offenders and found participants described a strong need to conceal their identity because of the intense shame and the fear of social dismissal. The reality of trying to conceal one's identity can become a significant emotional burden and impact the treatment process. For men in this study, the need to conceal their identities meant that exposure of their offence would likely threaten their ability

to retain their job in some instances with one reporting he lost his job after his identity was revealed in the newspaper. The fear of being "outed" in the community, particularly through news outlets and social media can also undermine the trust within treatment settings (Lindegren, 2025). Furthermore, it well documented that individuals engaging in forensic services experience social stigma and shame in relation to attending treatment which is widely recognised as a significant barrier to treatment success (Beech et al., 2013; Tewksbury, 2012). Other outcomes of social stigma include what McAlinden (2006) describes as the tension for offenders to need to constantly manage or conceal their "offending identity" during treatment and as a result, could impact their ability to construct a prosocial identity.

Another important finding was the second subtheme, *competing obligations* which highlighted both the pace of therapy as too quick for some men, and the need to comply with court and probation conditions due to fear of the legal consequences. It is common for many mandated clients to perceive therapy as a punitive measure imposed by the legal system. Furthermore, mental health professional working with mandated clients often report that individuals view them as a part of the justice system, which can create hostility towards the therapist and therapeutic process that enviable interferes with treatment engagement, and rapport building (Levenson et al., 2024). For some of the men, the pervasive tension between compliance with the criminal justice system impacted genuine therapeutic readiness. As one participant noted, the pressure to progress through treatment components without adequate emotional preparation reinforced a sense of powerlessness and ultimately lead to their disengagement which aligns with motivational literature that readiness to advance to another stage of change (e.g., moving from individual therapy to group therapy) is individualised and requires attuning to the individuals emotional and cognitive preparedness (Prochaska & DiClemente, 1982). When the pace is externally driven, as this participant described,

therapeutic work can be compromised (Maruna & King, 2009; Tangney & Dearing, 2002). External pressure to comply with treatment requirements with the goal to satisfy legal obligations may lead some participants to engage on a superficial level. In this study, some of the men's treatment readiness may not have sufficiently been assessed, instead often assumed to occur once programme entry criteria were meet.

It is noteworthy to consider the influence of probation officers emerged as a critical component for either exacerbating or mitigating some of the men's anxiety and ultimately, their decision to exit the programme earlier than recommended. The men that reported experiencing rigid probation officers tended to reinforce external controls and impact motivation which is consistent with findings that extrinsic motivators like mandated treatment compliance may lead to mixed engagement outcomes (Harkins & Beech, 2007). Conversely, when some of the men reported a change in probation officers either back to a familiar one or a new officer, they described feeling supported and safe enough to explain their reasons why they could not continue with the programme. This appeared to restore agency and highlighted the collaborative approach which is encouraged and recommended to foster motivation and treatment readiness (Andrews & Bonta, 2010; Strugess et al., 2016).

A Reversion in Stage of Change Cycle

This theme ultimately encapsulated both the positive and negative experiences of the therapeutic alliance and the unresolved emotional closure experienced by the men after they exited the programme. Turning to the first subtheme, the therapeutic relationship was described by participants as a crucial element that supported both their emotional and motivational engagement. This aligns with established research that demonstrates therapist's that display warmth and empathy create a trusted and supportive therapeutic environment (Ackerman & Hilsenroth, 2003; Beech & Hamilton-Giachritsis, 2005). In contrast, disruptions such as therapist transfers ruptured the participants sense of safety and therapeutic

security that was not re-established with the new clinician who they perceived as directive and had a less empathic style than that of the first clinician they were assigned to echoing findings that confrontational approaches are linked to higher dropout rates and oppositional behaviours (Tieney & McCabe, 2002). Recent literature supports these conclusions and also draws our attention towards therapists with more experience working with individual's that have engaged in harmful sexual behaviour tend to develop more acceptance towards these individual's that can enhance therapeutic alliance (Walji et al., 2014). An experience highlighted by some of the men was the experience of being transferred to other clinicians that disrupted consistency which contributed to undermine their therapeutic process. This has been empathised in previous research of sex offender treatment by Daly (2008), who stressed that continuity in therapeutic relationships as crucial for sustained engagement and that case management should provide attentive transitional support when necessary.

Turning to the final subtheme, it was clear that accumulation of contributing barriers as well as the emotional experience of the men created a multifaceted disengagement experience. While most reported a sense of relief due to escaping the need to try balance programme demands with competing external factors (e.g., working schedules and family commitments), others expressed a sense of disappointment about not completing goals. Emotionally, the relief of disengagement appeared to provide an escape from the challenges these men faced from a systemic level and highlights that the emotional complexity of disengagement may be undervalued and suggests that treatment exit processes may not adequately address participant's need for closure and meaning making. For some of the men treatment exit was experienced as both feelings of relief and disappointment, which is consistent with broader literature of the ambivalence of withdrawing from intervention too early (O'Keeffe et al., 2019). This has been often overlooked in rehabilitative research in particular with men that attend sex offender programmes, with the experiences of these men

illustrating that disconnection or withdrawal in a psychological defence mechanism but is emotionally costly. This suggests that treatment attrition should not solely be seen as behavioural outcome but rather as an affective process that reveals participants require a delicate process to ensure closure, that includes validation and recognition of time spent attending therapy. Importantly, these findings highlight a potential gap in the way service providers support those that disengage and may require a more formal process for closure. Such processes could support the resolution of unresolved feelings while reinforcing the progress made prior to disengagement. Given the social stigma experienced by the individuals in this sample, it could be hypothesised that with a more relational disengagement process, if future self-referral was required they may be more likely to seek support.

Practical Implication for Policy and Practice

These findings suggest several courses of action for Safe Network and other community service providers addressing harmful sexual behaviour to enhance client engagement and retention. Firstly, improving communication is critical. Collaborative, clear, and tailored information sharing has been consistently shown to improve client outcomes and increase satisfaction (Danaher et al., 2023). Given that a dominant theme for participants was a lack of understanding about the programme structure, employing multiple forms of communication such as therapeutic letters, informational pamphlets, and multimedia videos could effectively reduce anxiety and enhance clarity. Deliberate, systematized communication channels should be embedded into policy and practice frameworks, particularly for interfacing with key external agencies before referrals commence. Furthermore, the referral process for mandated clients would benefit from enabling greater client agency and clarity during the referral period which would likely require Safe Network to produce something probation officers could share when the conversation about referrals arouse. Engaging clients actively in the referral and treatment planning process boosts

treatment readiness, autonomous motivation, and reduces early dropout (Bosma et al., 2017; Polaschek, 2012). Safe Network and other community agencies providers could also consider flexible service delivery options to accommodate clients' competing pressures, such as employment and childcare. Scheduling alternatives including after-hours groups and after-hours therapy sessions either in person or through virtual participation may decrease barriers to consistent attendance (McMurran & Theodosi, 2007; Olver & Wormith, 2011). Considering flexible hours and after-hours appointments where possible, is already an option for men attending Safe Network's programme, it may be that it was simple impossible for clinicians to offer times outside of office hours given they have families and responsibilities of their own to attend too.

Because ambivalence and anxiety were reported by participants regarding group and individual therapy readiness, incorporating motivational interviewing (MI) as part of preparatory engagement and early treatment is strongly recommended. MI techniques, which emphasize empathetic, supportive, and directive communication, have demonstrated efficacy in enhancing motivation to change and reducing attrition among offender populations (Pinto et al., 2025; Prescott, 2020). Training staff in MI could help them better address client ambivalence, strengthen therapeutic alliance, and facilitate smoother transitions into group work. Lastly, improving therapeutic alliance stability by minimizing clinician turnover and fostering empathetic therapist-client relationships may enhance motivation and reduce dropout. If staff members are able to pinpoint when someone might be close to dropping out of intervention strategies could be implemented to attempt to keep them engaged. Finally, attention to the closure process for clients even if they have disengaged from treatment is warranted. Considering the men reported an emotional response to disengagement, a therapeutic letter may provide closure and mitigate any negative outcomes for the clients.

Research suggests that therapeutic letters have relational benefits when implemented intentionally (Pyle, 2009).

Limitations and Future Directions

The major limitation in this study in the small sample size of interviewees. While this may be considered somewhat common within qualitative research, interviewing more men would have likely expanded the potential of more themes to emerge, and made these results more generalisable. However, it is necessary here to highlight that the majority of individuals who disengage from services on their own accord, do not usually want to receive any further contact (Marziliano et al., 2021). A proportion of participants within this study who were contacted declined to participate in this study. As a result, this research sample could be considered skewed in that those who volunteered to participate may not fully represent the views and experiences of the entire population of potential participants. It is possible that other participants had positive and negative experiences but were not captured – potentially excluding conflicting accounts. Although the study has successfully demonstrated that the treatment experience of individuals produced common themes, the period of time when participants engaged with the service varied meaning that the potential for programme drift occurred overtime. Although Safe Network uses a manualised intervention programme, the delivery of this may have varied over the years. Because of this, it cannot be determined whether the participants of this study received similar treatment. It would be interesting to compare experiences of individuals who completed intervention with those that did not who encountered similar barriers (e.g., work and family commitments, nerves about entering group therapy, hostile probation officers) and examine what external and internal factors kept them in the programme.

One source of weakness in this study which could have affected the measurements of attrition rates is the quantitative data. Firstly, the exclusive reliance of demographic data can

oversimplify the complexities of participants experiences by grouping individuals into categories such as age, gender or ethnicity. This approach can mask within group differences and fail to capture psychological and cultural factors that influence outcomes (Sharghi et al., 2024). Furthermore, in relation to forensic attrition research, relying on demographic data can also overlook important responsivity factors and as a result, limit the explanatory usefulness of the findings (Polaschek, 2012). The quantitative data that was used in this study was partially reliant on clinicians entering information manually into a data base. This introduced a concern about reliability due to the potential for inconsistencies with documentation and inputting client information, specifically related to attrition data. Different levels of expertise, time constraints, and improper training can result in errors in data entry which cannot be ruled out as a potential disruptor to the validity and generalisation of the research findings (Connolly et al., 2024). While I was unable to fully control for this when I conducted the quantitative element of this study due to the number of cases and limited project time, I reviewed the final two-three cases notes of interview participants before contacting them to ensure they were indeed a part of the cohort of intervention incomplete individuals. This created more robust reliability and also served to protect any previous service users who had completed the programme being contacted unintentionally. Further research that utilizes information from the risk assessment tools as a part of a quantitative analysis that aimed to predict recidivism rates would be a more ideal method to strengthen similar studies to consider whether these factors also contribute to attrition.

While the voices of participants were heard in this study, another limitation of this study was not hearing the experiences of staff members who interact with them. It is well documented that the experiences of staff working with adults that have engaged in sexual offences towards children experience higher rates of emotional stress, difficulty sleeping (Bach 2018), burnout, emotional distancing, and compassion fatigue (Mivshek & Schriver

2024; Shrim & Baum., 2022). Therefore, understanding the experience of staff members would be beneficial to explore whether any therapist attitudes or beliefs may impact their relational style with clients. As noted earlier in the literature review, Harkins et al. (2012) reported staff members and previous participants of treatment programmes identified notable differences in experiences dependent on whether the RNR or GLM approach were utilised. Given the particular relevance that in the literature the RNR framework is considered to focus on risk reduction through targeting criminogenic needs, while the GLM proposes it can address these through emphasizing a goal-oriented approach focusing on improving quality of life and wellbeing, there may have been variations in treatment content and approaches by staff members; thus, potentially influencing the client's experience of treatment. These theoretical underpinnings and divergent philosophies may have impacted service delivery across individual clinicians.

Finally, given my role as researcher and clinician at Safe Network, it is possible that subjective bias could have occurred when interpreting results. For instance, personal interpretation may further amplify narratives, especially if the researchers' own beliefs or emotional responses unconsciously shape data interpretation. To minimise the impact of this, I followed Braun and Clarke's (2006) qualitative data analysis methodology and stayed reflective throughout the process. Future research could look into interviewing participants that have exited early from the other two community based harmful sexual behaviour agencies in New Zealand. This may support the generalisability of the results and also determine whether similar trends are experienced by service users as a national level.

Conclusion

The findings from this study have provided insight into what may contribute to attrition in a community-based treatment programmes for adult males that have engaged sexual offences. This novel research was the first of its kind in New Zealand to employ a mixed method approach to investigate attrition to address unknown barriers to treatment. An attrition rate of 22.4% was found, and the second aspect of this research provided valuable information on what contributes to men leaving the programme before their intervention are complete. This is a useful approach as it allows for a deeper understanding from the client's perspective, rather than simply relying on file information, or ideas based on assumptions. Interviewing men that did not complete the programme meant that several important insights were revealed. Firstly, it was learned that a lack of clarity of the purpose of intervention and limited information related to the programme were both issues. Furthermore, pressure from external sources including work, family and at times, probation requirements meant that participants were experiencing anxiety that appeared to impact their ability to engage during their intervention. Finally, therapist relational styles were also highlighted as key feature of their experience. Treatment programmes should identify ways of increasing a more salient transition into programmes with clearly outlined information and have strong communication channels with participants. This, in turn, may have positive consequences for programme retention and with participant well-being. With more engagement in intervention, the likelihood of sexual recidivism decreases. The current findings add to a growing body of literature on the evaluation of treatment programmes, programme delivery design, and the experience of service users. A future study could explore the factors from risk and protective factor tools to gain further insight into these referral related items. Also, follow up investigations that included access to correctional data would shed light on recidivism outcomes for attrition populations. Furthermore, future research could assess the experiences

of Māori programme participants to understand their experience of the intervention programme, specifically engagement retention and either the early phases of the intervention or initial assessment process, and the way information is shared both within services and with external agencies.

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Appendix A: Interview Recruitment Email

Kia ora/Hello,

My name is Brendan Cowles, and I am a psychology master's student at the University of Waikato. I'm reaching out to invite you to participate in my research project, which seeks to explore why some individuals have chosen to exit the Safe Network programme early. As someone who has previously used Safe Network services, your experiences are invaluable to understanding how the programme can be improved for future participants.

We are looking for people in Aotearoa New Zealand who are 18 years or older to share their personal experiences in a one-on-one interview. The interview can take place online, over the phone, or in person, and will take approximately 20 to 40 minutes. This research is focused on your experience of the programme, not your personal details or history, and all information you provide will be anonymized to protect your privacy.

As a token of appreciation for your time and contribution, you will receive a grocery voucher after completing the interview.

I've attached an information sheet with more details about the project. If you're interested in participating or would like to learn more, please don't hesitate to reach out to me via email, phone, or text. I'm happy to answer any questions you may have.

Thank you for considering this opportunity to share your story. I look forward to hearing from you.

Ngā mihi nui,

Brendan Cowles

Ph: 021 245 1458

Email: bc132@students.waikato.ac.nz

Appendix B: Information Sheet

As a previous service user of Safe Network, you have been invited to share your experience as part of a research project aimed at understanding why some individuals choose to exit the Safe Network programme early. Your insights are valuable in helping us better understand the journey and personal experiences of those in the programme. This research is conducted by Master's student Brendan Cowles, under the supervision of Dr Armon Tamatea at the University of Waikato.

Purpose of the Research

The goal of this study is to explore how your sense of self and your experiences during the Safe Network programme may have contributed to your decision to exit early. This research is not about assessing you, but rather about learning from your story to improve the programme for future participants. I'm interested in your personal experience, and your voice will help guide future developments in the programme.

What Your Participation Involves

You are invited to participate in a one-on-one interview, which can take place online, over the phone, or in person within the Bay of Plenty or Hamilton region, whatever suits you best. The interview will focus on your experience of the Safe Network programme and is estimated to take between 20 to 40 minutes, though this may vary depending on what you'd like to share.

Confidentiality and Your Rights

Your privacy is a top priority. All the data collected will be anonymised, meaning no one will be able to link your identity to the information you provide. You are free to withdraw from the study at any time without giving a reason.

Potential Risks

There are no anticipated risks involved with participating in this research. You are encouraged to take part only if you feel comfortable.

Ethical Approval

This research has been approved by the Human Research Ethics Committee of the Division of Arts, Law, Psychology, and Social Sciences. If you have any questions regarding the ethical aspects of this study, you can contact the committee at alpss-ethics@waikato.ac.nz.

Data Storage

All data will be stored securely for a minimum of 5 years after the research project is completed. The data will be stored by Dr. Armon Tamatea and only the research team will have access to it. If required for publication, anonymised data may be shared in public repositories.

Funding

As a token of appreciation for your time and contribution, you will receive a grocery voucher upon completing the interview. This research is self-funded and forms part of a Master's thesis.

Contact Information

If you have any questions or would like more information about the research, please feel free to reach out to:

Brendan Cowles Email: Phone/Text: 021 245 1458 bc132@students.waikato.ac.nz or,

Dr Armon Tamatea Email: armon.tamatea@waikato.ac.nz

Appendix C: Consent Form

UNIVERSITY OF WAIKATO
DIVISION of ARTS, LAW, PSYCHOLOGY & SOCIAL SCIENCES

PARTICIPANT CONSENT FORM

Name of person interviewed: _____

I have received a copy of the Information Sheet describing the research project. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation, and that I can withdraw my participation at any time before or during the interview, with the final date of withdrawal being *up to three weeks* after I have received my interview transcript.

During the interview, I understand that I do not have to answer questions unless I am happy to talk about the topic. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet.
I understand that my identity will remain confidential in the presentation of the research findings

Please complete the following checklist. Tick [✓] the appropriate box for each point.	**YES**	**NO**
I wish to view the transcript of the interview.		
I wish to receive a copy of the findings.		
Other?		

Participant :		Researcher :	
Signature :		Signature :	
Date :		Date :	
Contact Details :		Contact Details :	

Appendix D: Interview Question Guide

1. Can you tell me about the nature of your motivation and expectations of the programme?

Prompts: Can you describe a moment or event that caused your expectations of the programme to shift?

How did your motivations for joining the programme evolve as you progressed through it?

2. Were there any barriers or challenges you can recall at time in your life?

Prompts: Were there any specific moments or experiences that particularly made you question continuing with the programme?

How did you try to overcome the challenges or obstacles you encountered, and what was the outcome?

3. Can you tell me how you generally experienced the intervention programme?

Prompts: Can you share an example of a positive or negative interaction with the staff that stood out to you?

How did the structure of the programme meet or fail to meet your expectations and needs?

4. What did your support system look like at the time of your intervention at Safe Network?

Prompts: How did the attitudes or actions of your family or friends influence your participation in the programme?

Were there any points where your support system encouraged or discouraged you from continuing the programme?

5. Can you share some reflections on whether the programme aligned with your personal goals and needs?

Prompts: In what ways did the programme help or hinder your ability to achieve your personal goals?

Can you explain how your needs changed over time and whether the programme adapted to those changes?

6. How did your cultural background influence your experience with the treatment program, and did it play a role in your decision to drop out?

Prompts: Were there aspects of your culture that you felt were not acknowledged or understood by the clinicians?

Did you feel that your cultural identity was respected throughout the programme? If so, how?