PART ONE

Introduction

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Overview and Structure of the Book

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INTRODUCTION

The relationship between behavioural disturbance and forensic problems in people with intellectual disability (ID) is subtle. There is no doubt that many behaviour problems in people with severe and profound ID would be construed as offences in more able individuals. One of the determining characteristics of an 'offence' is that the perpetrator is aware of behaviour that is socially sanctioned or censured. Even when someone with mild ID may understand the nature of the offence, the criminal justice response and the response of carers is diverse across cases and situations (Clare & Murphy, 1998; Swanson & Garwick, 1990).

A problem encountered in researching the topic of sex offenders with ID is the range and interchange of terms used to describe individuals or groups of individuals with intellectual disabilities. Some authors use the term 'learning disability', 'learning impairment', 'learning disorders', 'learning difficulties', 'intellectual disabilities' and 'developmentally delayed'. This confuses and blurs the applicability of the research findings as sample sources vary, even though the aim is to encapsulate the same group. For the purpose of this chapter the term 'intellectual disability' will be used, which can be defined as:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence). A reduced ability to cope independently (impaired social functioning);
- Arising before adulthood (under 18 years of age) and having a lasting effect on development.

(Department of Health, 2001, p.14).

The Department of Health (2001) note that this encompasses a large range of disabilities, with a basic categorisation into four groups, based on IQ scores; which is the method most

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studies utilise: 50–70 – mild; 35–50 – moderate; 20–35 – severe; < 20 - profound. Assessments are usually conducted using the Wechsler Intelligence Scale for Children – Third Edition (WISC-III: Wechsler, 1991) or the Wechsler Adult Intelligence Scale – Third Edition (WAIS-III: Wechsler, 1999) with less than 70 indicating a level of intellectual disability. The assessment of social functioning causes more difficulty for research because of varying assessments and the inconsistent use of the term (O'Callaghan, 1999). Highlighting methodological problems with studies, Murphy, Harnett & Holland (1995) found none of the prison sample of sex offenders investigated had an IQ assessed under 70 but 21 percent had been referred to special schools, which may be an indication for some authors to classify these individuals as intellectually disabled.

General methodological difficulties with work in this area are that offenders with ID are only mentioned as part of larger offender cohorts. Where studies are specifically directed towards offenders with ID many studies are small in subject numbers (Johnston & Halstead, 2000). This is particularly true for sexual offenders with ID (Courtney, Rose & Mason, 2006; Craig, Stringer & Moss, 2006; Lindsay, Olley, Baillie & Smith, 1999). Under the auspices of The Prison Reform Trust (PRT), Loucks (2007) examined the attitudes and resources for people with ID within the criminal justice system in England and Wales. From this review it was estimated that 20–30 per cent of offenders have ID that interfere with their ability to cope within the criminal justice system. The Mottram (2007) research estimates that approximately 30 per cent of offenders within the prison system have an IQ less than 80. It is generally considered that the prevalence rates for offenders within the population of individuals with ID may be higher than those in the general population.

In his report, *The Incidence of Hidden Disabilities in the Prison Population*, Rack (2005) suggests that 20 per cent of the prison population has some form of hidden disability. Further research reported in the July 2006 edition of Community Care suggests that up to 7 per cent of the prison population is learning disabled and a further 23 per cent of prisoners are 'borderline' (PRT, 2006). On the other hand, Holland and Persson (in press) studied the prison population in Victoria, Australia and found a prevalence rate of around 1 per cent which is consistent with the prevalence of people with ID in the general population.

Many of the characteristics that are attributed to sexual offenders often overlap with those individuals categorised with ID. For example, research highlights the impulsive actions of individuals with ID, and this may increase the chances of them being involved in sex offences. However, these factors may also increase the likelihood of detection and give a biased picture of the relative prevalence of individuals with ID involved in sex offences.

The need for competent assessment and treatment of sexual offenders with ID has never been greater. The population in custody in England and Wales on 31 May 2008 was 82,822 (2 per cent more than a year earlier), with 82,372 in prison. In May 2009 this figure rose to 83,300 in custody, of which, 82,900 were in prison. Among the sentenced prison population, sexual offences saw an increase by 4 per cent from May 2007, rising to 7,573 sexual offenders (Ministry of Justice, 2008). In May 2009 this rose to 7, 907 sexual offenders (Ministry of Justice, 2009) a further increase of 4 per cent on the previous year. However, of these figures, it is not clear how many sexual offenders with ID are currently held in prison. While initial screening of prisoners at reception into prison or during induction may highlight problems, such testing is not systematic (Murphy, Harrold, Carey & Mulrooney, 2000) nor are these tools specific enough to identify intellectual disabilities (Williams & Atthill, 2005). The true estimate of the number of people with ID in prison remains unknown. Assuming an equal distribution in IQ

scores across the prison sex offender sample, based on Mottram (2007) estimations, there could be as many as 2,271 sexual offenders with ID currently in prisons in England and Wales. Even taking the lower figures reported by Holland and Persson (in press) the estimate would be around 800, which remains a significant number of individuals requiring special procedures for assessment and treatment. If one includes those on probation and community orders (see Lindsay, Michie and Lambrick, Chapter 15), the figures rise considerably.

Since the 1980s there has been a growing interest in the assessment and treatment of sexual offenders with ID, and researchers and practitioners have developed a range of assessment protocols and treatment interventions for this client group. Specifically in relation to assessing sexual offenders with ID a range of psychometric measures have now been developed and standardised (Lindsay, Michie, Whitefield, Martin, Grieve & Carson, 2006; Murphy, Powell, Guzman & Hays, 2007) allowing for a more accurate assessment of risk and treatment need (Lindsay & Taylor, 2009). Similarly, clinicians and researchers have begun to address the problem of treatment for men with ID who have offended sexually. Without necessarily admitting clients for in-patient treatment, several reports have suggested the feasibility of such treatment (Craig, Stringer & Moss, 2006; Lindsay, Neilson, Morrison & Smith, 1998; Lindsay, Olley, Baillie & Smith, 1999; Murphy, 2007).

Clearly, this is rapidly developing area of interest where clinicians are experimenting intellectually and conceptually with how best to assess and improve treatment services for this client group. The PRT (2006) recently made a number of recommendations regarding the diagnostic assessment and management of offenders with ID. It is hope that this volume goes some way to addressing the assessment and treatment needs in sexual offenders with ID.

STRUCTURE OF THE BOOK

The book itself is divided into a number of sections as follows:

Introduction

The second chapter in the introductory section of the book is by Leam Craig and William Lindsay who explore the characteristics, prevalence, and assessment issues for sexual offenders with ID. It is important first of all to describe in detail the client group this book focuses on and aetiological theories of sexual offending by men with ID. They provide an up-to-date review of the theories of sexual offending by men with ID and argue that such behaviour is unlikely to be comprehensively described by a single theory but by a combination of several theories including tendencies toward sexual offending, personality traits and impulsiveness can be considered alongside the hypothesis of counterfeit deviance. Unlike non-ID sexual offenders, accurate estimations of prevalence of sexual offending by men with ID are often difficult to establish. In reviewing the prevalence and reconviction rates for this client group they note that, because of poorly controlled studies and methodological differences, it is extremely difficult to conclude that there are any characteristics which might be considered unique to the client group. Nevertheless, there is some consistency in the literature that sex offenders with ID pose a greater risk of sexual recidivism in a shorter time period than their non-ID counterparts. Craig and Lindsay explore the specific types of offending and re-offending as well as the familial and offence characteristics.

Part One: Background, Theory and Incidence

We begin this section with Susan Hayes (Chapter 3) who explores the developmental pathways in intellectually disabled sex offenders. This chapter reviews the developmental pathways from adverse childhood experiences to juvenile sex offending and adult sex crimes. As there is a dearth of research and the limitations of existing research on developmental characteristics of sexual offenders with ID, Hayes draws upon studies of non-disabled populations of offenders in order to extrapolate factors, conditions and events experienced by those with ID. The influence of a person having an ID in relation to these developmental pathways is specifically considered and this is compared to individuals with neuro-developmental deficits (such as ADHD) and young people without deficits or disabilities. She concludes that the earlier the investment in young people's lives, the more cost-effective the intervention to prevent sex offending.

This is followed by Chapter 4 from Kevin Browne and Michelle McManus, who seek to identify the characteristics of family sexual abuse committed by adolescents with ID and its relation to sibling abuse and incest. The role of parents/carers and the potential impact on the family are discussed with the aim of identifying opportunities for prevention of sex offences by adolescents and adult with ID.

Finally in this section, Lynne Eccleston, Tony Ward and Barry Waterman (Chapter 5) consider the application of the self-regulation model (SRM) (Ward & Hudson, 1998) to sexual offending in men with ID. The SRM has seen a great deal of research since 2000 as part of understanding the relapse prevention process in non-ID (Bickley & Beech, 2002) and ID sexual offenders. The SRM represents a breakthrough in understanding the relapse process and links to the Good Lives Model which has also been tested with sexual offenders with ID (Keeling, Rose & Beech, 2006; Langdon, Maxted & Murphy, 2007; Lindsay, Steptoe & Beech, 2008). Eccleston, Ward and Waterman describe the aetiology of the model and provide case examples of how the model can be applied to sex offenders with ID. They argue that ID sexual offenders are capable of explicit planning in addition to implicit planning and they can be less impulsive and opportunistic than previously considered. This has implications for treatment and management strategies, and they offer guidance on therapeutic approaches and techniques.

Part Two: Diagnostic Assessment and Comorbidity

This section of the book deals with issues of diagnostic assessment frameworks and comorbidity. In Chapter 6, Fabian Haut and Eleanor Brewster discuss the prevalence of mental illness in people with ID and the diagnosis and treatment of some of the more common diagnosed disorders. From reviewing the literature they suggest there are significant issues with mental illness for people with ID and that the prevalence of schizophrenia and other non-affective psychoses is considerably higher in people with ID than in the general adult population. They describe some of the difficulties in establishing dual diagnosis in people with ID and go on to consider different forms of pharmacological treatment for differing disorders. They then discuss pervasive developmental disorders – for example, autism, Asperger's syndrome and attention deficit hyperactivity disorder, which are often identified in people with ID – and describe the difficulties in dual diagnosing forms of mental illness. Finally, they discuss offending and sexual offending in people with autistic spectrum disorders. They conclude that although there is little to link specific psychiatric diagnoses with sexual offences, effective

treatment of a comorbid psychiatric condition in people with an ID may help to reduce a person's offending behaviour, particularly if it is driven by mental illness.

In Chapter 7, Dorothy Griffiths, Paul Fedoroff and Deborah Richards discuss sexual and gender identity disorders identified within the DSM-IV-TR under three distinct sections: Sexual Dysfunctions, Gender Identity Disorders and Paraphilias. They review how these criteria are applied to persons with ID. The authors demonstrate how additional cautions should be applied when utilising the DSM-IV-TR criteria with persons with ID. Its application to this population requires knowledge of the nature of the disabling condition the person experiences and the impact of their life experiences on the commission of the offence. They make important but often overlooked points regarding the relationship between diagnosis of these disorders and sexual offences. As Seto (2008) points out, paedophilia (a psychiatric diagnosis) is an important factor in child molestation (a sexual offence) but the causal link between the two is not inevitable.

Part Three: Risk Assessment

In this section, three chapters consider issues around the assessment of risk and factors associated with sexual re-offending. William Lindsay and John Taylor (Chapter 8) begin this section and provide a comprehensive review of the risk factors associated with sexual offence recidivism within the mainstream literature and discuss how these risk factors can be applied to sexual offenders with ID.

Following on from this, in Chapter 9, Catrin Morrisey provides an overview of the relevant literature related to personality disorder and psychopathy in particular, both for forensic populations in general and for those with ID who offend sexually. Morrisey emphasises the importance of assessing for personality disorder in those referred to sex offender treatment in ID settings and that failing to recognise such disorder may result in a failure to provide appropriate treatment and management for the client. The chapter begins by describing the clinical symptomatology of personality disorder with particular reference to antisocial personal disorder and psychopathy associated with sexual offending. This is followed by a discussion on the problems in diagnosing personality disorder and psychoapthy in sexual offenders with ID. As an example of how this area is a new and developing area of research, Morrisey notes that no studies have thus far specifically examined the relationship between personality disorder and sexual offending in those who have ID. There seems little doubt that examination of personality disorder is likely to be relevant to some sexual offenders with ID. Morrisey goes on to provide a detailed analysis of the practical and ethical implications for assessing personality disorder and psychopathy in sexual offenders with ID and gives guidance on how to 'adapt' measures such as the Psychopathic Checklist-Revised (PCL-R) (Hare, 2003) when applied to offenders with ID. Morrisey highlights there are a number of intervention and management implications following a diagnosis of personality disorder in a person with ID who offends sexually and offers practical guidance to practitioners when working with this client group.

In Chapters 10 and 11, Douglas Boer, Matthew Frize, Ruth Pappas, Catrin Morrisey and William Lindsay review the use of the clinical structured risk assessment tools Historical Clinical Risk-20 (HCR-20: Webster, Douglas, Eaves & Hart, 1997) and Sexual Violence Risk-20 (SVR-20: Boer, Hart, Kropp & Webster, 1997) and provide alternative working definitions for sexual offenders with ID for both scales. Boer and colleagues make a number

of suggestions to the items of both scales in an attempt to standardise the use of the scales when applied to people with ID. They propose that the principles and strategies elucidated in these chapters applied in risk assessment of offenders with ID could potentially be adapted to provide an assessment framework for people with ID who, though not ever (or at least not currently) involved in the criminal justice system, exhibit behaviours labelled as 'challenging'.

Part Four: Assessing Treatment Need and Deviancy

The focus of this section is the assessment of treatment need and sexual deviant interests in sexual offenders with ID. It has been well established that the identification and assessment of sexual deviancy is a central factor in terms of sexual recidivism risk and treatment targets. In Chapter 12 Leam Craig and William Lindsay consider the concept of measuring sexual deviancy in offenders with ID. The 'concept' of sexual deviancy is explored as part of the Structured Risk Assessment (SRA) model described by Thornton (2002). Following the recent development in the number of psychometric measures standardised on sexual offenders with ID, Craig and Lindsay organise the various psychometric measures within the SRA framework of assessment. It is argued that such an approach to assessment may help structure limited and valued resources based on the '*risk*, *need* and *responsivity*' principle in determining the course of treatment or management for a particular individual.

Following on from this, Peter Langdon and Glynis Murphy describe the process of assessing treatment need in sexual offenders with ID in Chapter 13. They argue that while the assessment of sexual offending by people with ID is no different from that used when assessing non-disabled sexual offenders some additional factors should be considered. They emphasise the importance of developing a functional analysis for the behaviour as part of a clinical assessment which can inform risk and treatment need. They review some of the risk assessment scales currently available and psychometric measures used to assess psychological constructs which may be used as an indicator of treatment amenability. They argue that when considering whether or not people with ID are likely to be amenable to psychological interventions it is important to challenge previous assumptions of amenability. They conclude that the process of assessing sexual offenders with ID is multifaceted, covering several areas of bio-psycho-social functioning. There is some emerging evidence to suggest that people with ID can complete some of the necessary tasks of cognitive-behavioural therapy, improving sexual knowledge and victim empathy as well as reducing the distorted cognitions.

Part Five: Provisions and Treatment

In this section four chapters review a range of different treatment approaches designed for sexual offenders with ID both within community and secure settings. Aside from the ongoing research and development into the assessment and treatment of sexual offenders with ID, the impact on staff and the support required in order to maintain a therapeutic environment with this challenging client group are all too often overlooked. In an attempt to address some of these issues, Shawn Mosher begins this section with Chapter 14 on a discussion of the staff support requirements when working with sexual offenders with ID. It is noted that working with a challenging client group can often have a number of effects on care staff including burnout, isolation and subtle shifts in the therapeutic milieu. Mosher highlights some of the effects on

care staff and offers guidance in terms of staff training, supervision and support. It is crucial for all members of the care team to feel rewarded and valued, and issues around organisational structure, philosophy and staff isolation are also discussed. Equally important is the issue of security and managing the balance between client safety, staff safety and community safety. Here, Mosher describes a useful framework of the interplay between therapy and security. It is important to note that working with persons with an ID can be highly challenging but ultimately very rewarding employment and this chapter discusses several ways in which workers can be empowered to be good at their jobs, confident in their decisions and to build up a therapeutic and supportive rapport with the people they support.

In Chapter 15, William Lindsay, Amanda Michie and Frank Lambrick provide a review of the community-based treatment programmes currently available for sexual offenders with ID. They review the importance of placing treatment in the context of society and community. They go on to review the principles of treatment and its organisation, concentrating on cognitive behavioural methods. They also review research on characteristics of offenders and outcomes of treatment and management.

In Chapter 16, Fiona Williams and Ruth Mann describe Her Majesty's Prison Service 'Adapted' Sex Offender Treatment Programme (ASOTP). They begin by describing the development of the adapted programme using the same aims and objectives as those used in the mainstream programme based on the risk, need and responsiveness principle. They go onto describe the content and structure of the 14-block programme based on the Old Me/New Me model (Haaven, Little & Petre-Miller, 1990). They argue this approach is consistent with that of The Good Lives Model proposed by Ward (2002) because it is concerned with the enhancement of the offender's capabilities to improve their life. They highlight the importance of transitional care and maintenance when working with ID sex offenders and describe how the Adapted Better Lives Booster programme was designed to refresh, maintain and enhance the treatment gains made on the ASOTP. As is often the case in this area of research they highlight the difficulties of finding sufficient sample sizes in order to measure treatment efficacy. However, as part of a clinical evaluation of treatment effect they found evidence of positive cognitive shift by examining the pre- and post-treatment assessment measures. They note that the ASOTP is continually evolving to incorporate new ideas and as such a new adapted programme designed to meet the needs of those both in the community and in prison will be introduced in the coming years.

Finally in this section, in Chapter 17 Marleen Verhoeven discusses alternative approaches to working therapeutically with sexual offenders with ID and considers the application of dialectical behaviour therapy. She describes the complexities in the diagnosis of personality disorder for people with an ID and briefly describes psychological treatments for people who offend sexually. Dialectical Behaviour Therapy and various adaptations, both for offenders and for people with an ID are discussed in detail.

Part Six: Future Directions

In the final chapter of this book, Chapter 18, Hannah Ford and John Rose discuss improving service provisions for ID sexual offenders. Although offending by those with ID is not new, the detection and criminal justice response to offenders with ID is a developing area of debate. In this chapter Ford and Rose explore the possible pathways for ID sexual offenders through the criminal justice system, from reporting offences, police investigations and sentencing, to

possible disposals such as prison, probation, mental health or specialist services. This is contrasted with the services offered in the United States and Australia. They go on to review the treatment, delivery and outcome across different service models and consider factors in intervening with ID offenders in these different settings. They offer practical suggestions on ways to improve service delivery for this client group. They highlight the need to improve education and training for staff and carers at all levels, particularly in relation to the recognition of ID in the criminal justice system and the need for further resources to develop treatment approaches and monitor the outcome of treatments. The importance of grounding the theoretical underpinnings of the treatment programme is discussed as well the relevance of specific aspects of treatment to ID offenders.

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