WORKING WITH SEXUAL OFFENDERS: THE TRAINING AND SUPPORT NEEDS OF SOTP FACILITATORS

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ABSTRACT

Since the mid 1980s, a mass of scholarly material has been published on sex offender treatment, particularly relating to cognitive behavioural techniques. Alongside this, there has been a gradual recognition by academics and practitioners in the field of the particular challenges faced by those providing treatment for sexual offenders. As well as having to analyse detailed accounts of sexual violence, sex offender therapists are faced with the responsibility of working with some of the most difficult offenders in the system in terms of their generally poor motivation to change and the serious consequences of their reoffending. As a result, various detrimental impacts have been associated with providing treatment to sexual offenders, including stress, burnout and vicarious traumatisation.

This thesis presents the results of interviews conducted with a variety of Prison Service staff working with sex offenders on the Sex Offender Treatment Programme (SOTP), which has been hailed as the 'largest multi-site, cognitive behavioural treatment programme for sex offenders in the world'. Participants were asked about the positive and negative effects of working with sexual offenders, the quality of training they had received, and what types of personal and organisational support were available to them. The results show that the Prison Service needs to give greater consideration when selecting candidates to deliver the SOTP, and those individuals who have been a victim of sexual abuse should be excluded from the recruitment process. In addition, it is concluded that there should be further staff training for those working on the SOTP, and that existing sources of organisational support need to be improved.

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To Mom, Dad, and Paul

Also, to Sunny, who is dearly missed

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CHAPTER 1

A HISTORY OF SEX OFFENDER TREATMENT

I. INTRODUCTION

Attempts at treating unconventional sexual behaviour can be traced back to the late 1800s.[1] Over the past 60 years, however, Wood *et al* suggest that there have been three distinct approaches to the treatment of sexual offenders.[2] The first period began with the application of psychoanalytic techniques to mentally disordered offenders under the 'sexual psychopath' laws enacted in 1930s America. Due to various problems with the application of such legislation and growing concern regarding the efficacy of 'humanistic' treatments, this eventually gave way to the second approach: behavioural treatments which initially focused on altering deviant sexual preference. Further research into the nature of sexual offending revealed the complexity of abusive behaviour and led to the development of more comprehensive cognitive behavioural treatments (CBT) in the third and final phase. Cognitive behaviourism is now considered to be the most effective form of treatment for sexual offenders.[3] However, throughout its short history, proponents of CBT have had to deflect far-reaching scepticism regarding the ability of rehabilitative interventions to change offending behaviour as well as more specific criticisms of the theory itself.

[1] DR Laws and WL Marshall, 'A Brief History of Behavioural and Cognitive Behavioural Approaches to Sexual Offenders: Part 1. Early Developments' (2003) 15 Sexual Abuse: A Journal of Research and Treatment 75.
[2] RM Wood, LS Grossman and CG Fichtner, 'Psychological Assessment, Treatment, and Outcome with Sex Offenders' (2000) 18 Behavioural Sciences and the Law 23.
[3] MS Carich and MC Calder, *Contemporary Treatment of Adult Male Sex Offenders* (Russell House Publishing Ltd, Dorset 2003).

It can be further argued that, in the UK at least, sex offender treatment has entered a fourth 'phase', and has – since the early 1990s – been incorporated into a much broader agenda; namely that of 'risk management'. Treatment for sexual offenders is now delivered alongside a wide range of protocols designed to assess and manage the risk posed by such individuals. Moreover, in recent years, sex offender treatment has been supplied by a more extensive range of service providers, including the private and charitable sector. This chapter will chart the development of sex offender treatment and examine evaluative data on the effectiveness of treatment programmes. It will then outline sex offender treatment provision in the UK, which will be divided into two sections: treatment provided by the Prison Service for offenders in custody and treatment provided in the community. This latter section will consider the contributions of private organisations, charities, and government departments. Legislation drafted for the purpose of managing the risk posed by sexual offenders living in the community will also be considered.

II. HISTORICAL DEVELOPMENT OF TREATMENT FOR SEX OFFENDERS

1. Early Beginnings

According to Laws and Marshall, the earliest published account of an attempt to treat a sexual 'deviance' was documented by Charcot and Magnan in the early 1880s. Their approach endeavoured to treat homosexuality using what would today be known as masturbatory reconditioning.[4] The first coherent attempt at sex offender treatment, however, came in the

[4] Law and Marshall (n 1) 77.

guise of the sexual psychopath legislation passed in the USA in the late 1930s.[5] Under such laws, individuals suffering from a mental disorder or disease, and whose offences were considered to be repetitive and compulsive, could be detained for an indefinite period of time for the purpose of treatment.[6] Therapy, as with most early attempts to treat sexual offenders, was based on a psychodynamic approach[7] and delivered in either a psychiatric facility or a state prison.[8] Wood *et al* have argued that the Atascadero programme – run in a Californian state mental hospital - is a 'well documented example' of therapy under this early legislation. However, the authors criticise the programme on the grounds that '…much of the "treatment" patients received was directed by other patients, that treatment provided by professional staff was not consistent, and that termination could be determined by population pressure or time in the facility…'.[9] Indeed, evaluations of the programme reported discouraging results, suggesting that psychodynamic treatments of this type may even increase the likelihood of future offending.[10] In addition, difficulties emerged with the definition of 'sexual psychopath', which in turn led to inconsistent applications of the law.[11] Thus, perhaps unsurprisingly, the 1970s saw a rapid decline in the use of sexual psychopath laws and they were eventually repealed. Perhaps the most influential factor, however, was the emergence of Martinson's 'nothing works' ideology and the burgeoning notion of dangerous offenders being 'bad' rather than 'mad'.[12]

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[5] S Brown, *Treating Sex Offenders: An Introduction to Sex Offender Treatment Programmes* (Willan Publishing, Collumpton 2005).
[6] PM Harris, 'Prison-Based Sex Offender Treatment Programs in the Post Sexual Psychopath Era' (1995) 23 Journal of Psychiatry and Law 555.
[7] Brown (n 5) 18.
[8] Harris (n 6) 556.
[9] Wood, Grossman, and Fichtner (n 2) 31.
[10] Harris (n 6) 556. Although Laws and Marshall (n 1, 86) have argued that, despite the apparent failures of early psychodynamic treatments for sexual offenders, early programmes did '…set the stage for treatment endeavours and the data generated by them supported the search for alternative approaches'.
[11] Brown (n 5) 18.
[12] *Ibid.*

As Brown[13] has pointed out, Martinson's oft cited conclusion '…that education at its best, or that psychotherapy at its best, cannot overcome, or appreciably reduce, the powerful tendency for offenders to continue in criminal behaviour'[14] was a major setback for proponents of the rehabilitative approach in the 1970s. Martinson's pessimistic deductions were supported by other writers including Lipton *et al*[15] in the United States and Brody in the UK.[16] Upon re-examining such studies, however, later writers have argued that the negative conclusions upholding the 'nothing works' philosophy were unwarranted. Gendreau and Ross, for example, have questioned the quality of research included in Martinson's review of the literature. In their analysis of treatment evaluation studies conducted between 1973 and 1978, 86 per cent reported positive outcomes in terms of offender change.[17] In a similar review of treatment with juvenile offenders, Lipsey asserted that correctional treatment produced a 10 per cent average reduction in recidivism.[18] It has also been argued that Martinson himself was misquoted and his findings oversimplified when in actual fact he reported that: 'it is possible that some of our treatment programs are working to some extent, but that our research is so bad that it is incapable of telling'.[19] This said, Martinson's somewhat radical ideas held firm until the late 1970s. Indeed, unwillingness to let go of the idea that no form of rehabilitative treatment could appreciably reduce reoffending was exacerbated by 'anti-

[13] Brown (n 5) 19.
[14] R Martinson, 'What Works? Questions and Answers About Prison Reform' (1974) 35 Public Interest 22, 49.
[15] DN Lipton, R Martinson and J Wilks, *The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies* (Praeger, New York 1975).
[16] S Brody, *The Effectiveness of Sentencing* (Home Office Research Study 35, HMSO, London 1976).
[17] P Gendreau and RR Ross, 'Effective Correctional Treatment: Bibliotherapy for Cynics', in P Gendreau and RR Ross (eds), *Effective Correctional Treatment* (Butterworths, Canada 1980).
[18] MW Lipsey, 'What Do We Learn From 400 Research Studies on the Effectiveness of Treatment with Juvenile Delinquents?', in J McGuire (ed), *What Works: Reducing Reoffending – Guidelines From Research and Practice* (John Wiley & Sons Ltd, Chichester 1995).
[19] Martinson (n 14) 49.

psychology' criminologists and a political agenda that pursued the aim of punishing offenders proportionately for their crimes.[20]

2. Behavioural Treatment for Sexual Offenders

In spite of political reluctance to accept the idea that offenders could be swayed from their criminal behaviour via therapeutic intervention, an increasing number of research studies were revealing the effectiveness of some rehabilitative programmes, with certain offenders in certain situations.[21] This was aided by the advent of meta-analysis, a technique that can be used to summarise the results of a large number of research studies.[22] Thus, according to Lipsey, '[m]eta-analysis has the advantage…of revealing broad patterns of findings in a body of research with much more clarity and consistency than traditional research review techniques'.[23] In addition, advocates of treatment for sexual offenders argued that intervention was still necessary regardless of the prevailing practice in other areas of the criminal justice system, and especially because imprisoned sex offenders would usually – under the regime of determinate prison sentences - be released back into the community.[24] In light of the supposed ineffectiveness of previous psychodynamic approaches to sex offenders, practitioners began to experiment with other modes of treatment, and the 1970s saw a shift towards behavioural interventions. This was not limited to sexual offenders, however, and represented a more general move in psychology towards behaviourism as a method of analysis due to its practical, experimental and apparently 'commonsensical' nature.[25]

[20] DA Andrews and J Bonta, *The Psychology of Criminal Conduct* (Anderson Publishing Co, Ohio 1994).
[21] See for example Gendreau and Ross (n 17) and Lipsey (n 18).
[22] C Robson, *Real World Research* (2nd edn Blackwell Publishing, Oxford 2002).
[23] Lipsey (n 18) 66.
[24] Brown (n 5) 20.
[25] Laws and Marshall (n 1) 79.

Popularised by Watson in early twentieth-century America,[26] behaviourism emphasises the role of learning and external environmental factors in shaping behaviour rather than the unconscious processes of the mind as enshrined in the principles of psychoanalysis.[27] To behavioural theorists, positive and negative reinforcement is key; thus, behaviour that leads to a 'satisfying' consequence will be strengthened and likely to be repeated, whilst behaviour that leads to an 'unsatisfying' consequence is unlikely to be repeated.[28] As a result of the widespread acceptance of McGuire, Carlisle and Young's sexual preference hypothesis[29] – which highlighted early sexual experiences as paramount in developing adult sexual predilection - early behavioural therapies for sexual offenders focused on reducing deviant sexual arousal.[30] This was achieved via a number of different techniques, including aversion therapy (pairing problematic behaviour with negative stimuli, such as electric shock or nausea inducing substances), orgasmic and masturbatory reconditioning (pairing negative stimuli with deviant sexual arousal and positive stimuli with non-deviant arousal) and, later, covert sensitisation (pairing deviant thoughts with imagined distressing consequences).[31] Laws and Marshall identify a number of anecdotal accounts of such treatments;[32] however, there was mounting concern among practitioners as to whether certain aversion therapies were ethical – particularly those inducing sickness and involving electric shock – with some causing upset to the staff involved in administering them.[33] More importantly, evidence was limited on the long-term effectiveness of what are now recognised as simplistic behavioural techniques. A

[26] *Ibid* .78.
[27] MW Eysenck and MT Keane, *Cognitive Psychology: A Student's Handbook* (Lawrence Erlbaum Associates, Hove 1995).
[28] *Ibid.* 62.
[29] RJ McGuire, JM Carlisle and BG Young, 'Sexual Deviations as Conditioned Behaviour: A Hypothesis' (1965) 3 Behaviour Research and Therapy 185.
[30] Laws and Marshall (n 1) 84.
[31] Brown (n 5) 22.
[32] Laws and Marshall (n 1) 86.
[33] *Ibid.* 83.

number of studies questioned the effectiveness of specific behavioural treatments[34] whilst some authors went further, suggesting that '[t]here is as yet no evidence that clinical treatment reduces rates of sex reoffenses in general'.[35]

According to Brown, the apparent failure of behaviourism was not a result of the therapies themselves, but rather the simplistic theory that lay behind them. Being solely concerned with behaviours that could be measured and observed, behaviourism failed to consider the impact of cognition, for example the impact of memory and emotion.[36] Likewise, an increasingly popular feminist movement drew attention to the complex nature of sexual aggression which, according to proponents of the theory, involved the influence of patriarchal attitudes towards women and children as well as 'deviant' behaviours.[37] Theorists and practitioners alike were thus forced to consider the other potential components of sexually offensive behaviour. As stated by Laws and Marshall:

> Deviant sexual preference and deviant sexual arousal were undoubtedly important, but it was clear they formed a small portion of a much larger picture. By the mid to late 1970s it was clear that things had to change and that treatment interventions simply had to become more comprehensive if they were to eliminate deviant sexual behaviour.[38]

[34] See for example DR Laws and WL Marshall, 'Masturbatory Reconditioning with Sexual Deviates: An Evaluative Review' (1991) 13 Advances in Behaviour Research and Therapy 13; and ME Rice, VL Quinsey and GT Harris, 'Sexual Recidivism Among Child Molesters Released From a Maximum Security Psychiatric Institution' (1991) 59 Journal of Consulting and Clinical Psychiatry 381.
[35] L Furby, MR Weinrott and L Blackshaw, 'Sex Offender Recidivism: A Review' (1989) 105 Psychological Bulletin 3.
[36] Brown (n 5) 22.
[37] *Ibid.*
[38] Laws and Marshall (n 1) 87.

Acceptance of the complexity of sexually offensive behaviour was accompanied by a revised approach to the treatment of so-called 'deviants'. Simplistic behavioural programmes were augmented, first by introducing efforts to enhance appropriate sexual interests.[39] Over the course of the 1970s other elements were added to such programmes including social skills training,[40] sex education,[41] and treatment to enhance self esteem and address inappropriate gender role behaviour.[42] From these influences emerged what eventually became known as cognitive behavioural therapy for sex offenders.

3. Cognitive Behavioural Treatment for Sexual Offenders

As explained by Groome, the study of cognitive psychology analyses '…the way the brain processes information. It concerns the way we take in information from the outside world, how we make sense of that information and how we use it'.[43] 'Cognition' is therefore a broad umbrella term covering a range of thinking processes leading from the perception of a given stimulus, to learning, retrieving, and developing emotions in relation to the content of that stimulus.[44] Thus, in relation to sexual offenders, treatment programmes began to consider the perceptions, justifications, and other cognitive functions underlying deviant behaviour, rather than simply the behaviour itself. It also began to address cognitive distortions, issues of victim empathy, and the denial or minimisation of harm exhibited by some offenders.[45]

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[39] See for example WL Marshall, 'The Modification of Sexual Fantasies: A Combined Treatment Approach to the Reduction of Deviant Sexual Behaviour' (1973) 11 Behaviour Research and Therapy 557.
[40] WL Marshall, 'Letter to the Editor: A Combined Treatment Method for Certain Sexual Deviations' (1971) 9 Behaviour Research and Therapy 293.
[41] WL Marshall and S Williams, 'A Behavioural Approach to the Modification of Rape' (1975) 3 Quarterly Bulletin of the British Association for Behavioural Psychotherapy 78.
[42] GG Abel, EB Blanchard and JV Becker, 'An Integrated Treatment Program for Rapists', in RT Rada (ed), *Clinical Aspects of the Rapist (*Grune and Stratton, New York 1978).
[43] D Groome *et al*, *An Introduction to Cognitive Psychology Processes and Disorders* (Psychology Press Ltd, London 1999) 2.
[44] *Ibid*.
[45] D Perkins *et al*, 'Review of Sex offender Treatment Programmes' (Report, November 1998) <http://www.ramas.co.uk/report4.pdf> accessed 17 October 2009.

This transition from rigid behaviourism to cognitive behavioural techniques was initially spurred by changing perceptions of human behaviour within professional circles rather than any convincing empirical evidence demonstrating the efficacy of cognitive therapies in effecting offender change. Specifically, psychologists came to accept that behaviour could more adequately be explained as cognitively-mediated actions instead of simple stimulus response reactions.[46] Indeed, the shift happened at such a pace that, according to Marshall and Laws, 'by the end of the [1970s] strict behaviourists had become members of an endangered species'.[47] Treatment programmes for sexual offenders continued to expand throughout the 1980s, which resulted in the establishment of a number of large-scale sex offender treatment projects, most notably the Vermont Programme for the Treatment of Sexual Abusers[48] and the Californian Sex Offender Treatment and Evaluation Programme (SOTEP). Both programmes were 'comprehensive' in nature; indeed, the latter was one of the first treatment projects to include a relapse prevention component, the theory of which is widely considered to be the most significant development in sex offender treatment during that decade.[49] The effectiveness of cognitive behavioural techniques in treating sex offenders was further supported by an increasing array of positive results from evaluative studies. Thus, some writers began to question the validity of previous reviews on the effectiveness of treatment for sexual offenders. In reconsidering the work of Furby, Weinrott and Blackshaw,[50] for example, Marshall and Pithers argued that their conclusions were

[46] WL Marshall and DR Laws, 'A Brief History of Behavioural and Cognitive Behavioural Approaches to Sexual Offender Treatment: Part 2. The Modern Era' (2003) 15 Sexual Abuse: A Journal of Research and Treatment 93.
[47] *Ibid.* 97
[48] This programme was initially established in 1973, however, developed significantly during the 1980s in terms of the number of patients treated.
[49] Marshall and Laws (n 46) 98.
[50] Furby, Weinrott and Blackshaw (n 35).

'unnecessarily gloomy', possibly owing to the fact that the review had included data on obsolete programmes and had exhibited potential bias in the projects selected for analysis.[51]

Expansions in treatment programmes demanded more complex theoretical explanations of sexual deviancy, which were provided by the integrated theories of Finkelhor,[52] and later, Hall and Hirschman[53] and Marshall and Barbaree.[54] Thus, by the early 1990s, what had begun as a somewhat basic approach to sexually offensive behaviour had transformed into a comprehensive cognitive behavioural treatment framework. At this point, most programmes aimed to address a wide variety of factors shown to be related to deviant sexual behaviour, including cognitive distortions, empathy deficits, and intimacy problems. Although it has been suggested that, since the introduction of relapse prevention techniques, there have been 'no significant additions to…cognitive behavioural programmes',[55] this can easily be disputed. First, evaluation data has aided in the refinement of existing techniques, whilst further research has built on the facets of cognitive psychology applied in the treatment of sexual offenders;[56] second, some programmes have begun to add certain idiosyncratic elements to target specific offenders or behaviours;[57] third, research in the past decade has identified the impact therapists may have on the delivery of treatment, and thus its eventual effectiveness;[58] finally, actuarial tools incorporating dynamic risk factors have been noted by

[51] WL Marshall and WD Pithers, 'A Reconsideration of Treatment Outcome with Sex Offenders' (1994) 21 Criminal Justice and Behaviour 10, 10.
[52] D Finkelhor, *A Sourcebook on Child Sexual Abuse* (Sage, California 1986).
[53] GCN Hall and R Hirschman, 'Toward a Theory of Sexual Aggression: A Quadripartite Model' (1991) 59 Journal of Consulting and Clinical Psychiatry 662.
[54] WL Marshall and HE Barbaree, 'An Integrated Theory of the Etiology of Sexual Offending', in WL Marshall, DR Laws and HE Barbaree (eds) *Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender* (Plenum Press, New York 1990).
[55] Brown (n 5) 36.
[56] R Mann, 'Innovations in Sex Offender Treatment' (2004) 10 Journal of Sexual Aggression 141.
[57] Brown (n 5) 36.
[58] CR Hollin, 'The Meaning and Implications of "Programme Integrity"', in J McGuire (ed) *What Works: Reducing Reoffending – Guidelines From Research and Practice* (Wiley, Chichester 1995).

clinicians working in the field as the future of pre- and post-treatment risk prediction. As pointed out by Mann, such instruments have 'the potential to revolutionise our practice in the assessment of both treatment need and change following treatment'.[59]

4. The 1990s and Beyond

Throughout the 1990s and, indeed, up to the present day, cognitive behavioural treatment programmes have continued to expand in a number of ways. For instance, the number of cognitive behavioural programmes for sexual offenders has grown significantly. In a survey conducted in 1994, Freeman-Longo *et al* identified more than 1,700 programmes treating individuals suffering from sexual behaviour problems in North America alone.[60] Similar expansions have been documented in the UK, albeit not quite at the rate witnessed in the US. Completion rates of the Prison Service Sex Offender Treatment Programme have risen from 439 in 1993/4[61] to 1037 in 2007/8.[62] Increases have also been reported in the use of cognitive behavioural treatments with offenders involved in other forms of (non-sexual) crime. In their review of rehabilitative treatments in England and Wales, Hedderman and Sugg found that 57 per cent of the probation-based programmes in their sample used cognitive skills for more than half of their duration.[63] Moreover, Clarke, Simmonds and Wydall have argued that prison-based cognitive behavioural programmes – specifically the Enhanced Thinking Skills programme and the Reasoning and Rehabilitation programme – can provide short-term benefits in terms of improved prisoner behaviour, increased self-confidence, and enhanced

[59] Mann (n 56) 146.
[60] Brown (n 5) 36, citing RE Freeman-Longo *et al, 1994 Nationwide Survey of Treatment Programs and Models Serving Abuse-Reactive Children and Adolescent and Adult Sex Offenders* (Safer Society Press, Vermont 1995).
[61] Home Office, 'Prison Statistics England and Wales 2002' (Cm 5996, 2003).
[62] HM Prison Service, 'Annual Report and Accounts 2007 – 2008' (HC 860, 2008).
[63] C Hedderman and D Sugg, *Changing Offenders' Attitudes and Behaviour: What Works? Part II – The Influence of Cognitive Approaches: A Survey of Probation Programmes* (Home Office Research Study 171, HMSO, London 1997).

literary and interpersonal skills.[64] Thus, the impact of cognitive behavioural treatments has extended much further than the field of sex offender therapy alone.

As well as increasing in quantity, cognitive behavioural treatments have continued to increase in quality according to the results of evaluative research.[65] For instance, the work of Beech and Fordham confirmed the importance of group dynamics in the treatment of offenders on the UK SOTP.[66] Likewise, continuing research has built on certain theoretical aspects of cognitive behavioural therapy relevant to the treatment of sex offenders, particularly in the area of schema-focused interventions. The idea that sexual offenders distort information to facilitate and justify their behaviour (i.e. cognitive distortion) was initially recognised in the late 1970s.[67] However, since that time, Ward has shown such distortions to be manifestations of what he has termed 'implicit theories' that sexual offenders hold about individuals or the world in general.[68] Individual offence-related distortions therefore feature as part of a much wider framework of beliefs justifying sexually offensive conduct. These theories - or 'schemata' - are then used as a guide in the perception and interpretation of information. So, for example, a paedophile may hold the distorted belief that children are sexual objects that are capable of enjoying and desiring sexual intercourse, irrespective of their age.[69] Treatment

[64] A Clarke, R Simmonds and S Wydall, *Delivering Cognitive Skills Programmes in Prison: A Qualitative Study* (Home Office Research Findings 242, London 2004).
[65] See section III of this chapter, 'The Success of Sex Offender Treatment', for a more in-depth discussion of results of evaluative studies.
[66] A Beech and AS Fordham, 'Therapeutic Climate of Sex Offender Treatment Programmes' (1997) 9 Sexual Abuse: A Journal of Research and Treatment 219.
[67] WL Marshall, D Anderson and Y Fernandez, *Cognitive Behavioural Treatment of Sexual Offenders* (Wiley, Chichester 1999).
[68] T Ward, 'Sexual Offenders' Cognitive Distortions as Implicit Theories' (2000) 5 Aggression and Violent Behaviour 491.
[69] T Ward and T Keenan, 'Child Molesters' Implicit Theories' (1999) 14 Journal of Interpersonal Violence 821.

based on a schema-focused approach has now been implemented by the UK Prison Service for high risk sexual offenders.[70]

Moreover, the diverse ways in which offenders respond to treatment are now being considered, with the emergence of idiosyncratic elements in offender treatment programmes; for example, drama therapy.[71] Likewise, programmes have been developed for individuals with a low IQ,[72] and for those convicted of offences committed on the internet.[73] The way in which treatment programmes are delivered, and therapist characteristics, have also been considered in more recent times in terms of their impact on offender responsivity and treatment effectiveness overall. As argued by Hollin, treatment 'integrity' – namely the idea that a 'programme is conducted in practice as it is intended in theory and design' – can significantly influence the success (or failure) of therapy.[74] He discusses three ways in which programme integrity can be compromised through poor implementation and management: programme drift, characterised by the gradual shift of the aim of a programme over time; programme reversal, when staff work to undermine or reverse the theoretical approach of treatment; and programme non-compliance, where practitioners conducting the programme elect to change or omit parts of the agreed treatment.[75] Alternately, Marshall *et al* have identified ten therapist features that predict positive changes in a number of treatment outcomes. These characteristics include showing empathy and warmth, and asking open-

[70] Mann (n 56) 147.
[71] Drama therapy has been used as a therapeutic tool with sexual offenders in British institutions such as Broadmoor hospital. See the comments of Dr Kevin Murray, the Associate Medical Director of Broadmoor, at http://www.bbc.co.uk/radio4/science/chat_broadmoor.shtml, accessed 17 October 2009.
[72] For example, the Adapted SOTP, which was designed for those offenders who may have difficulty in keeping up with the language and literacy requirements of the Core programme.
[73] The Internet Sex Offender Treatment Programme (i-SOTP) managed by the Probation Service. This programme was accredited by the Correctional Services Accreditation Panel in December 2006. See Correctional Services Accreditation Panel, *Annual Report 2006/07* (London 2007).
[74] See Hollin (n 58) 196.
[75] *Ibid.* 197.

ended questions. The use of a confrontational therapeutic style was negatively related to increased coping skills.[76]

The final major development in the area of sex offender treatment provision during the past decade has been the increasing use of actuarial risk assessment tools in predicting the likelihood of recidivism. Acknowledged as superior to estimations from clinical judgement alone, actuarial measures use risk factors identified by research to calculate the probability of reconviction for a sexual (or violent) offence.[77] Most such tools rely on static risk factors – namely factors that cannot change – when calculating future risk, such as previous offence history and age. Increasingly, however, risk prediction instruments have introduced dynamic risk factors[78] which are potentially amenable to change via treatment.[79] This occurred as a result of criticism highlighting the potential injustice of failing to offer an offender a means of changing the result of their 'static' assessment.[80] Examples of dynamic risk assessment tools can now be found within the UK penal system, for instance, the Offender Assessment System (OASys). Developed by the Prison and Probation Service, OASys is a comprehensive risk/needs offender assessment tool, dealing with both static and dynamic risk factors. The main part of OASys examines factors proven to be related to a high risk of reconviction, such as offending history and current offence; social and economic factors (including employment issues and drug or alcohol misuse); and personal factors (including anxiety or depression). From this assessment, an individual's risk of harm to others, and to himself, is calculated.

[76] WL Marshall *et al*, 'Therapist Characteristics in the Treatment of Sexual Offenders: Tentative Data on their Relationship with Indices of Behaviour Change' (2003) 9 Journal of Sexual Aggression 25.
[77] A Beech and T Ward, 'The Integration of Etiology and Risk in Sexual Offenders: A Theoretical Framework' (2004) 10 Aggression and Violent Behaviour 31.
[78] Dynamic risk factors are generally split into two categories: *stable dynamic factors* are those that are amenable to change during therapy; and *acute dynamic factors* are those that may signal an individual is highly likely to commit an offence in the near future.
[79] A Beech, D Fisher and D Thornton, 'Risk Assessment of Sex Offenders' (2003) 34 Professional Psychology: Research and Practice 1.
[80] Brown (n 5) 10.

The OASys also contains sections on supervision and sentence planning and a self-assessment questionnaire, giving the offender an opportunity to provide a personal view on the state of his offending behaviour and lifestyle.[81]

The increased importance of risk prediction tools over the past ten years has coincided with – and perhaps been spurred by – a government agenda in England and Wales to 'protect the public' from serious sexual and violent crime. Indeed, in a statement to the House of Commons, Charles Clarke, in his position as Home Secretary, suggested that '[a]ccurate assessment must lie at the heart of our public protection arrangements…all chief officers of probation will have a specific objective to improve the quality of risk of harm assessments in their area…'.[82] Emphasis on protection of the public and risk management has been demonstrated in an array of legislation, providing for tougher sentences and tighter control of the most dangerous offenders in the criminal justice system.[83] Alongside this, however, the UK Government has vowed to provide 'a greater focus on rehabilitation'.[84] Whilst maintaining its stance of being 'tough on crime, [and] tough on the causes of crime', a recent policy review states the Government's intention to increase the number of places available on treatment programmes throughout the prison estate, and to make more effective use of non-custodial sentences.[85] It intends to do this via a number of system reforms and by uniting the efforts of the public, private and 'third sector'.[86] Thus it seems that, in the UK at least, the idea of rehabilitation has come 'full circle' and is beginning to re-emerge into penal practice.

[81] National Probation Service, 'OASys: The New Offender Assessment System' (Briefing Note, Spring 2003) <http://www.probation. homeoffice.gov.uk/files/pdf/info%20for%20sentencers%203.pdf> accessed 17 October 2009.
[82] Hansard HC vol 445 col 245 (20 April 2006).
[83] See section VI 2(a) of this chapter, 'Treatment Provided by the Probation Service', for a more detailed discussion on sex offender legislation.
[84] Cabinet Office, *Building on Progress: Security, Crime and Justice* (Policy Review) (London 2007).
[85] *Ibid.* 43.
[86] The charitable and voluntary sector.

However, with public protection being the key focus of current offender management plans, a very different form of rehabilitation seems set to emerge; one in which, according to Marshall *et al,* '…the primary aim of rehabilitating…is to avoid harm to the community rather than to improve the offenders' quality of life'.[87] It therefore remains to be seen how central the idea of treatment will be in practice and whether the objectives of risk management and successful therapeutic intervention can coexist within one policy framework.

III. THE SUCCESS OF SEX OFFENDER TREATMENT

Following the birth of behavioural treatment for sexual offenders in the 1980s, a large number of evaluative studies began to emerge in the academic literature. Looking at official police records of reoffending, Davidson, for example, reported that child molesters and rapists treated in a Canadian penitentiary demonstrated a sexual recidivism rate of 11 per cent, compared to a rate of 35 per cent in a matched control group.[88] In another study, Marshall and Barbaree reviewed official statistics, unofficial state records and self-report data to determine the recidivism rates of a treated group of child molesters released from the Vermont treatment programme and a matched untreated sample. Of the 58 'treated' participants, a recidivism rate of 13.2 per cent was recorded, compared to a rate of 34.5 per cent for the untreated group.[89] Moreover, those in the treated group who did reoffend committed a smaller number of offences compared to untreated patients.[90] In spite of such success, early evaluations were criticised for their lack of methodological rigour. For

[87] WL Marshall *et al*, 'Working Positively with Sexual Offenders – Maximising the Effectiveness of Treatment' (2005) 20 Journal of Interpersonal Violence 1096, 1098.
[88] WL Marshall *et al*, 'Treatment Outcome with Sex Offenders' (1991) 11 Clinical Psychology Review 465, citing P Davidson, 'Outcome Data for a Penitentiary-Based Treatment Program for Sex Offenders', paper presented at the Conference on the Assessment and Treatment of the Sex Offender, Kingston, Ontario (March 1984).
[89] WL Marshall and HE Barbaree, 'The Long Term Evaluation of a Behavioural Treatment Program for Child Molesters' (1988) 26 Behaviour Research and Therapy 499.
[90] *Ibid.* 507.

instance, Marshall and Barbaree's choice of comparison group was questioned on the basis that, although controls were assessed as suitable for treatment, they subsequently declined to attend. This, according to Quinsey *et al*, showed that 'untreated' participants were less motivated to change their offending behaviour, and were therefore of a higher risk than the treated patients from the outset.[91] However, as has been pointed out by Brown, many of the programmes evaluated in the 1980s and early 1990s bear little resemblance to the comprehensive cognitive behavioural therapies used today.[92] The mid-1990s onwards therefore saw the publication of further studies showing the effectiveness of sex offender treatment in changing offense-related behaviours.

Much of the evaluative data on the effectiveness of sex offender treatment has come from North America and Canada. The Sex Offender Treatment and Evaluation Project (SOTEP), based at the Atascadero State Hospital in California, has produced some of the strongest evidence supporting the continued use of sex offender treatment because of its sound methodological basis. Set up in 1985, the programme was specifically established to determine if '…an innovative program at Atascadero State Hospital can significantly reduce recidivism among convicted sex offenders'.[93] From the outset, the key aim of the project was to produce robust evaluation data and to follow-up all participants for five years. In one of the early studies produced, Marques *et al* were able to compare three matched groups of sex offenders – comprising a total sample of 326 participants - to assess the effectiveness of the project. Members of the treatment group were less likely to have committed a further sexual

[91] VL Quinsey *et al*, 'Assessing the Treatment Efficacy in Outcome Studies of Sex Offenders' (1993) 8 Journal of Interpersonal Violence 512.
[92] See Brown (n 5) 193.
[93] J Marques *et al*, 'Findings and Recommendations from California's Experimental Treatment Program', in GCN Hall, R Hirschman, JR Graham and MS Zaragoza (eds) *Sexual Aggression: Issues in Etiology, Assessment and Treatment* (Taylor & Francis, Washington 1993) 198.

offence upon entering the 'aftercare' phase of treatment or to have been guilty of a parole violation.[94] These results were replicated in 2000. After 5 years 'at risk' in the community, a sample of 167 'treated' sex offenders had the lowest sexual rearrest rate (10.8 per cent) compared to 225 volunteer controls who were randomly assigned to receive no treatment (13.8 per cent rearrest rate), and 220 non-volunteer controls who had refused treatment (13.2 per cent rearrest rate).[95] Unfortunately, the most recently published data on the effectiveness of SOTEP was not encouraging and showed that there was no overall treatment effect on offenders participating in the programme.[96] However, it was found that offenders who had derived benefit from the programme – i.e. scored well on a number of post-treatment measures - had lower reoffending rates than those who did not. Marques *et al* also discussed other reasons for the 'null' result, including the fact that, as SOTEP was initially designed over 20 years ago, it no longer represents the 'state of the art' in sex offender treatment.[97]

Other projects have used meta-analytic techniques to draw conclusions about the effectiveness of sex offender treatment. Meta-analysis brings together the results of a number of studies and so can assess the consistency of data across the research spectrum. By combining the samples of numerous reports – and thus increasing the power of statistical tests - meta-analysis can also reveal even small effects brought about by treatment.[98] In an early meta-analysis, Hall analysed 12 evaluations of sex offender treatment that he considered to be

[94] *Ibid.* 204.
[95] J Marques *et al*, 'Preventing Relapse in Sex Offenders: What we Learned from SOTEP's Experimental Treatment Program', in DR Laws, SM Hudson and T Ward (eds) *Remaking Relapse Prevention with Sex Offenders: A Sourcebook* (Sage, London 2000).
[96] JK Marques *et al*, 'Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results from Californias Sex Offender Treatment and Evaluation Project (SOTEP)' (2005) 17 Sexual Abuse: A Journal of Research and Treatment 79.
[97] *Ibid.* 100.
[98] Brown (n 5) 208.

methodologically sound.[99] These studies had an average follow-up period of 6.9 years and were chosen on the basis that they used samples of 10 or more offenders, compared treated offenders with a comparison group, and used official police records to measure sexual recidivism post treatment. The results showed that a higher proportion of untreated offenders (27 per cent) had been rearrested for a further sexual offence than treated populations (19 per cent).[100] However, this data has since been criticised on a number of counts; for example, on the basis of the very small number of studies included in the analysis. This reflects one of various concerns that have been voiced by researchers in the field about the overall validity of meta-analysis as an evaluative technique. It has been stated – even by proponents of the method – that 'every meta-analysis has some inherent bias by virtue of the inclusion/exclusion criteria and the methods chosen to review the literature'.[101] Even the most thorough searches will undoubtedly miss some relevant studies, particularly those that have not been published. Of those studies that are chosen, some may suffer from the use of sub-standard methodologies or there may be vast differences in the samples and definitions employed. Such varying approaches have the potential to obscure any clear understanding of the data analysed and highlights the essence of Hunt's 'apples and oranges' argument: namely that combining such an eclectic mix of research and subsequently taking an overall average of their effect sizes will provide a distorted and unreliable account.[102] Some of these problems have been overcome to an extent. For instance, in a much more recent meta-analysis, Hanson *et al* reviewed the results of a total of 43 treatment studies of sexual offenders.[103] This

[99] GCN Hall, 'Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies' (1995) 63 Journal of Consulting and Clinical Psychiatry 802.
[100] *Ibid*. 806.
[101] R Rosenthal and MR Dimatteo, 'Meta-Analysis: Recent Developments in Quantitative Methods for Literature Reviews' (2001) 52 Annual Review of Psychology 59, 66.
[102] Rosenthal and Dimatteo (n 101, 68) citing M Hunt, *How Science Takes Stock* (Russell Sage Found, New York 1997).
[103] RK Hanson *et al*, 'First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders' (2002) 14 Sexual Abuse: A Journal of Research and Treatment 169.

included 23 published and 20 unpublished studies, all of which compared a treated sample of offenders to a comparison group which had either received no treatment or a form of treatment that was judged to be inadequate. Their results showed that cognitive behavioural treatments were associated with a reduction in both sexual and general recidivism. Over an average period of 46 months, the rate of sexual recidivism[104] for treated offenders was 12.3 per cent, compared to 16.8 per cent for the untreated populations.[105] However, although the authors argued that their results 'could not be seriously disputed',[106] the analysis included programmes based in institutions and in the community, and a small number involved the treatment of adolescent offenders. Likewise, the studies selected for evaluation dated from 1977, with treatment being delivered between 1965 and 1999. As shown in the current chapter, treatment techniques have evolved enormously since the 1980s; thus, inclusion of such early interventions may have skewed the results.

Not all evaluative data has been based on US treatment programmes. Indeed, treatment success has also been documented in the UK in relation to the prison-based Sex Offender Treatment Programme, and the three probation-run programmes that are now in operation across the country. In the first evaluation of the SOTP, Beech *et al* analysed psychometric data on a total of 77 child abusers both before and after completion of the Core SOTP. They found significant improvements in terms of the offenders' levels of denial, their pro-offending attitudes, social skills, and relapse prevention skills.[107] Fifty-six men also agreed to be interviewed 9 months after they had completed the SOTP. Overall, the results showed that

[104] Wide definitions of recidivism were employed by the studies chosen for analysis and included reconviction, rearrest, parole violations, re-admission to institutions, and unofficial community reports of recidivistic behaviour.
[105] Hanson *et al* (n 103) 181.
[106] *Ibid*. 186.
[107] A Beech, D Fisher and R Beckett, *Step 3: An Evaluation of the Prison Sex Offender Treatment Programme* (Home office, London 1998).

the effect of the Core programme was maintained; although the ability of those men who had been released into the community to use their relapse prevention skills had deteriorated.[108] The effectiveness of the SOTP has since been evaluated again, this time by comparing the two-year reconviction rates of a group of 647 sex offenders who participated in the programme between 1992 and 1994, and a retrospectively selected sample of sex offenders who had not received treatment.[109] The treatment and control groups were matched according to risk of reconviction using the 'Static 99' risk assessment tool. The results showed that the two-year reconviction rates for both the treated population, and the untreated group were low. Perhaps unsurprisingly, the treated sample had only a slightly lower sexual reconviction rate than the control group. However, when sexual *and* violent reconviction rates were combined, treated individuals were significantly less likely to have reoffended.[110] Overall, the authors concluded that the Core programme was particularly effective with medium risk offenders, but was not sufficient on its own to reduce the risk of recidivism in high risk sexual offenders.[111]

The fact that Beech *et al*'s research shows a general reduction in sexual offenders' ability to use relapse prevention skills once living in the community highlights the importance of through-care, and perhaps even further treatment in the community. Overall, research into the effectiveness of probation-based treatment programmes in the UK has been limited. In the only evaluative study of the 'C-SOGP', offered to offenders living in the central regions of the UK and London, Allam found a reduction of 7.4 per cent in the rate of reoffending for

[108] *Ibid.* 59.
[109] C Friendship, R Mann and A Beech, 'Evaluation of a National Prison-based Treatment Programme for Sexual Offenders in England and Wales' (2003) 18 Journal of Interpersonal Violence 744.
[110] *Ibid.* 751.
[111] C Friendship, R Mann and A Beech, *The Prison-Based Sex Offender Treatment Programme – An Evaluation* (Home Office Research Findings 205, London 2003).

those who had completed the programme. She also found an 11 per cent reduction for violent offences, and a 22 per cent drop in reconvictions for other offences, such as theft.[112] Similarly, in a reconviction study of 183 sex offenders treated on the 'TV-SOGP' - the programme employed by probation in the East and South West of the country - a total of 5.4 per cent were found guilty of a further sexual offence over an average of 3.9 years.[113] This compared favourably with other data; for example, Hedderman and Sugg recorded a sexual reconviction rate of 9 per cent for 191 offenders given probation orders in 1991 with no cognitive behavioural treatment, after a two year follow-up period.[114]

A number of alternative studies have, nevertheless, shown negative outcomes regarding the effectiveness of sex offender treatment programmes. For example, in their much-cited review, Furby *et al* analysed the results of 42 studies on the recidivism rates of both treated, and untreated, sex offender populations.[115] Their results were not optimistic, and the authors concluded that 'we can at least say with confidence that there is no evidence that treatment effectively reduces sex offense recidivism'.[116] This said, the studies available for analysis differed massively in terms of quality. Indeed, this lack of methodological rigour meant that the authors were forced to employ qualitative techniques to analyse the data gathered, rather than their preferred method of meta-analysis. In another study, Rice *et al*[117] looked at the recidivism of 136 extra-familial child molesters who had been assessed in a maximum security psychiatric facility. Fifty had received behavioural treatment. After an average

[112] See <http://www.crimereduction.gov.uk/workingoffenders/workingoffenders1.htm#The> accessed 18 October 2009.
[113] A Bates *et al*, 'A Follow-Up Study of Sex Offenders Treated by Thames Valley Sex Offender Groupwork Programme, 1995 – 1999' (2004) 10 Journal of Sexual Aggression 29.
[114] C Hedderman and D Sugg, *Does Treating Sex Offenders Reduce Reoffending?* (Home Office Research Findings 45, London 1996).
[115] Furby, Weinrott and Blackshaw (n 35).
[116] *Ibid*. 25.
[117] ME Rice *et al*, 'Sexual Recidivism Among Child Molesters Released From a Maximum Security Psychiatric Institution' (1991) 59 Journal of Consulting and Clinical Psychiatry 381.

follow-up period of 6.3 years, the authors found that 31 per cent had gone on to commit a further sexual offence, but there was no significant difference between the untreated, and treated groups.[118] These results were mirrored in Quinsey *et al*'s later evaluation of a programme run at a Regional Treatment Centre in Ontario, Canada.[119] A total of 483 sex offenders – 213 of whom had received treatment - were followed for an average period of 44 months. The results showed that treatment was associated with a reduction in violent recidivism, but 'treated' offenders were recorded by official statistics as having a higher sexual reoffence rate than untreated participants. The authors subsequently suggest that 'the implications of this pattern of results for correctional policy are straightforward: an emphasis on incarceration and supervision for high-risk offenders and minimal intervention for low-risk offenders'.[120]

It can be said with some certainty, however, that many of the negative conclusions that have been drawn regarding the effectiveness of sex offender treatment revert back to the issue of methodology. As noted by Furby *et al,* 'methodological shortcomings are present in virtually all studies, making the results from any single study both hard to interpret and inappropriate for the use of conventional confidence levels'.[121] One of the key problems with evaluative research of sex offender treatment is the widespread use of quasi-experimental study designs.[122] Such studies attempt to ascertain the effectiveness of a given intervention by comparing the outcome data of a 'treatment' group with a 'comparison' group, matched as closely as possible in terms of demographic details and offending characteristics. A wide

[118] *Ibid.* 383.
[119] VL Quinsey, A Khanna and P Bruce Malcolm, 'A Retrospective Evaluation of the Regional Treatment Centre Sex Offender Treatment Progamme' (1998) 13 Journal of Interpersonal Violence 621.
[120] *Ibid.* 642.
[121] Furby, Weinrott and Blackshaw (n 35) 27.
[122] Brown (n 5) 158.

variety of comparison groups have been utilised by evaluative studies in the field, including offenders who have received a different form of treatment, offenders who were unwilling to undergo treatment, and offenders on a treatment waiting list.[123] However, as argued by Brown:

> …regardless of the type of comparison group employed, it is always possible that [any] differences identified between the treatment and comparison groups are attributable to some extraneous variable(s), rather than to the treatment programme under examination…[124]

Thus, some authors[125] – and the American Psychological Association[126] – have acknowledged the methodological superiority of randomised control trials (RCT) in assessing the effectiveness of a given treatment. RCT involves the random allocation of similar participants to one of two (or more) 'conditions'.[127] In relation to sex offender interventions, this has usually involved a number of participants being allocated to a treatment group, and an equal number having treatment withheld. Quinsey *et al*[128] have stressed the importance of random allocation in proving, conclusively, the efficacy of treatment, and have highlighted the dangers involved in promising effective interventions that have not been validated by such methods. However, the use of RCT has raised a number of ethical issues in terms of denying a potentially dangerous group of offenders the chance to reduce their risk of reoffending, and improve their quality of life. Alternatives to RCT have been suggested, including the possibility of assigning participants to one of two or more treatment programmes '…when

[123] *Ibid.* 159.
[124] *Ibid.*
[125] For example Quinsey *et al* (n 91).
[126] N McConaghy, 'Methodological Issues Concerning Evaluation of Treatment for Sexual Offenders: Randomization, Treatment Dropouts, Untreated Controls, and Within-Treatment Studies' (1999) 11 Sexual Abuse: A Journal of Research and Treatment 183.
[127] Brown (n 5) 153.
[128] Quinsey *et al* (n 91).

there is no acceptable evidence that one is superior to the other'.[129] Yet, even this method is only able to suggest which treatment produces better results, not whether treatment is actually effective. Taking this point further, Pawson and Tilley have suggested that no evaluative technique has yet revealed *why* treatment is effective, with most focusing simply on the statistical question of efficacy rather than which individual or collective components of treatment actually cause cognitive behavioural change.[130]

A further concern raised by sceptics of the effectiveness of sex offender treatment relates to *how* the success of a programme can be accurately measured. Most evaluation studies have used reoffending rates to measure effectiveness. However, in order to get a true sense of the rate of reoffending, it has been argued that recidivism studies should include a sample of 'sufficient size' to conduct appropriate statistical tests and a suitable follow-up period in which the commission of a further offence will constitute a relapse.[131] It has been estimated that a follow-up period of five years is needed to capture 75 per cent of offenders who would commit further crime in the official statistics;[132] although Friendship *et al* have reported that two-year follow-ups are the norm in England and Wales.[133] This seemingly short period creates serious problems in relation to sexual offenders due to their generally low base-rates of reoffending. For example, Hood and Shute *et al* found that only 4.3 per cent of a sample of 162 sex offenders had committed a further sexual crime after 4 years at liberty, and 8.5 per

[129] N McConaghy, 'Are Sex Offenders Ever "Cured"?' (1995) 162 The Medical Journal of Australia 397.
[130] R Pawson and N Tilley, 'What Works in Evaluation Research?' (1994) 34 British Journal of Criminology 291.
[131] Furby, Weinrott and Blackshaw (n 35) 7.
[132] Brown (n 5, 171) citing J Marques *et al, The Sex Offender Treatment and Evaluation Project: Fourth Report to the Legislature in Response to PC 1365* (California State Department of Mental Health, Sacremento 1991).
[133] C Friendship, AR Beech and K Browne, 'Reconviction as an Outcome Measure in Research' (2002) 42 British Journal of Criminology 442.

cent of a cohort of 94 offenders had reoffended after 6 years.[134] This can be compared to figures published by the Home Office[135] that showed around 75 per cent of offenders convicted of theft had reoffended within two years of being sentenced or released from prison.[136]

Underreporting of sexual crime has led to further complications in establishing true reoffending rates. Falshaw, Friendship and Bates[137] compared the official reoffending rates of a group of 173 sex offenders participating in a community based-treatment programme, to unofficial sources of data – taken from their 'programme' file - that recorded recidivistic behaviour.[138] They found that the recidivism rate of these offenders was 5.3 times that shown by the Offenders Index and Police National Computer. Such statistics have led some authors to call for the development of alternate outcome measures to supplement reconviction data. For instance, Marshall and Pithers have suggested that delay in offence onset and reduction in number of victims could also be used as indicators of treatment impact in addition to reconviction data.[139]

The main alternative to using reoffending rates to determine the success of a treatment programme has been the use of 'within-treatment studies'. Such studies test offenders on a

[134] R Hood and S Shute *et al*, 'Sex Offenders Emerging from Long-Term Imprisonment' (2002) 42 British Journal of Criminology 371.
[135] J Cunliffe and A Shepherd, *Reoffending of Adults: Results from the 2004 Cohort* (Home Office Statistical Bulletin 06/07, London 2007).
[136] However, those who had reoffended did not necessarily commit the same crime as their index offence. Still, sexual crimes, particularly those committed against children, ranked lowest in terms of reoffending rates in a list of 20 distinct offences.
[137] L Falshaw, C Friendship and A Bates, *Sexual Offenders – Measuring Reconviction, Reoffending and Recidivism* (Home Office Research Findings 183, London 2003).
[138] It should be noted that, in this study, recidivism included reconviction, reoffending, *and* recidivistic behaviour which was not always illegal. For example, a convicted child sex offender found loitering outside a school. Likewise, the sex offenders in the sample were 'at risk' for varying periods of time, ranging from 2 years, to 5 years and eleven months.
[139] Marshall and Pithers (n 51) 21.

number of variables both prior to, and post treatment, usually via psychometric testing. Any changes in results can then arguably be attributed to treatment. This method was applied by the STEP team in the first major evaluation of the UK SOTP;[140] however, further research has revealed numerous problems with the procedure. McConaghy has suggested that within-treatment studies can support ineffective treatments and false beliefs due to their inability to demonstrate a causal, rather than correlational, relationship between the intervention and offender change.[141] This has been supported by Brown who has claimed that '…it is always possible that identified differences were due to something other than the intervention…';[142] for example, initial testing procedures or motivation to change, which may not be sustained once an offender has been released into the community. Indeed, research has shown that sexual recidivism rates tend to increase the longer an offender is at liberty,[143] which demonstrates that the skills learnt on cognitive skills programmes are at risk of erosion once an offender has been released from prison. It could also be argued that developing an offender's cognition could, simultaneously, bestow an enhanced ability to provide 'positive' responses during post treatment psychometric tests. This would lead to a lower risk assessment rating, regardless of whether there has been any actual change in his offence-related beliefs and behaviours.

The general lack of methodologically robust research into 'what works' when treating sexual offenders could soon prove to be problematic in the UK, especially considering the recent recommendation of a joint inspectorate report that probation case managers should consider interventions that are '…most likely to be effective with sex offenders, based on research and

[140] Beech *et al* (n 107) 109.
[141] McConaghy (n 126) 187.
[142] Brown (n 5) 163.
[143] J Cann, L Falshaw and C Friendship, 'Sexual Offenders Discharged from Prison in England and Wales: A 21-Year Reconviction Study' (2004) 9 Legal and Criminological Psychology 1.

formally sharing good practice with each other'.[144] It will obviously be difficult to relate practice to research when very few high-quality investigations into prison- and community-based therapy with sexual offenders have actually been conducted. This said, it is apparent that criticism which focuses exclusively on methodological issues says very little – if indeed anything at all – about the content of treatment programmes themselves. Very few authors have been able to go as far as saying that treatment is not effective; rather, most have been forced to acknowledge that, at present, there is simply not enough evidence to conclude that it is because of the mediocre methodologies employed by researchers to date. The pursuit of the 'perfect' methodology in relation to sex offender treatment evaluation is, in any event, unrealistic. West highlighted this argument concisely when he commented that 'given the nature of the prison and probation approaches to treatment and rehabilitation of sex offenders, the prospect of rigorous scientific validation of outcome is remote'.[145] Although it has been claimed that randomised control trials are the gold standard in terms of measuring the effectiveness of a given intervention,[146] such techniques are simply not viable in relation to sex offenders because of the unacceptable risks involved in withholding treatment. As put by Marshall and Pithers:

> We cannot see how any ethically concerned researcher would suggest a random design treatment outcome study for sex offenders. The pursuit of ideal scientific standards is not, in our view, of greater concern than the protection from victimisation of innocent women, men and children.[147]

[144] HM Inspectorate of Probation and HM Inspectorate of Constabulary, 'Managing Sex Offenders in the Community: A Joint Inspection on Sex Offenders' (Report) (2005) <http://inspectorates.homeoffice.gov.uk/hmic/inspections/joint-area/joint-area-inspections/jai-sexoffenders-report05.pdf?view=Binary> accessed 18 October 2009.
[145] D West, 'Sexual Molesters', in N. Walker (ed) *Dangerous People* (Blackstone Press, London 1996) 65.
[146] Quinsey *et al* (n 91) 513.
[147] Marshall and Pithers (n 51) 24.

Empirical evidence can never prove anything *conclusively*; not least because the question of interpretation is so important. Indeed, studies analysing the same pool of data have produced conflicting results. Focusing on a sub-set of the sample examined by Quinsey *et al*[148] from the Regional Treatment Centre in Ontario, Canada, Looman *et al* reported much more positive results. They found that, whilst 23.6 per cent of the treated participants had reoffended sexually, 51.7 per cent of the matched untreated sample had reoffended, over an average of 9.9 years at risk.[149] Overall therefore, empirical research can do little more than support a hypothesis, until another study reveals otherwise.[150] The worth of such research should not, however, be underestimated. Although empirical study may never be able to provide conclusive answers to the treatment debate, it can certainly shed some light on whether there can be grounds for optimism regarding treatment outcome.[151] In the future, therefore, it will be important to create a climate in which researchers feel confident to report programme effectiveness whilst at the same time highlighting any methodological weaknesses. In this way, critics can review positive conclusions about programme development and efficacy with confidence rather than cynicism.[152]

IV. SEX OFFENDER TREATMENT IN THE UK

Sex offender treatment in the UK developed in a similar fashion to that in the USA, albeit at a slower pace than projects such as the Californian Sex Offender Treatment and Evaluation Programme (SOTEP) and the Vermont Programme for the Treatment of Sexual Abusers. Prior to the birth of the national strategies that are now in place, treatment for sexual offenders

[148] Quinsey *et al* (n 119).
[149] J Looman *et al*, 'Recidivism Among Treated Sexual Offenders and Matched Controls: Data from the Regional Treatment Centre (Ontario)' (2000) 15 Journal of Interpersonal Violence 279.
[150] Brown (n 5) 192.
[151] WL Marshall, 'The Treatment of Sex Offenders: What Does the Outcome Data Tell Us? A Reply to Quinsey, Harris, Rice and Lalumiere' (1993) 8 Journal of Interpersonal Violence 524.
[152] See Brown (n 5) 192.

was a marginal activity. Programmes were not centrally coordinated and generally dependent on only a few enthusiastic members of staff. Treatment content therefore varied widely from institution to institution, with no provision for monitoring and evaluation.[153] With such disparity in both the availability and quality of rehabilitative services for sexual offenders, the need for effective, research-based treatment was clear. The development of a coherent approach to the treatment of sex offenders was spurred by various factors over a period of years. Throughout the 1990s the Prison Service saw an estimated 65 per cent increase in the number of people imprisoned for a sex-related crime.[154] Alongside this came a spate of prison riots in many of which sex offenders were targeted and attacked by fellow prisoners.[155] As well as highlighting the difficulties involved in their containment, Lord Woolf's 1990 report into the Prison riots at HMP Strangeways highlighted the need to 'treat' sexual offenders so that they could be 'confronted with their offending'.[156]

Another key contributor to the development of sex offender treatment in the UK was the penal climate of the time, and a renewed acceptance of rehabilitation by both the Prison and Probation Service. The role of sexual offenders in this ideological shift has been seen as being highly significant, with Player suggesting that the return of rehabilitation to the prison regime was '…most closely associated with prisoners who [had] committed sexual offences'.[157] Re-acceptance of the treatment model in England and Wales was also heavily informed by both American and Canadian research, most of which claimed that cognitive

[153] D Briggs, 'The Management of Sex Offenders in Institutions' in T Morrison, M Erooga, and RC Beckett (eds) *Sexual Offending Against Children* (Routledge, London 1994).
[154] Home Office (n 61).
[155] Derek White, a prisoner remanded in Strangeways and accused of sexually assaulting his step-children, died of his injuries shortly after the riot began in March 1992. See A Sampson, *Acts of Abuse – Sex Offenders and the Criminal Justice System* (Routledge, London 1994) 85.
[156] Lord Justice Woolf, *Prison Disturbances April 1990 – Report of an Inquiry by the Rt Hon Lord Justice Woolf and His Honour Judge Stephen Tumin*, (Cm 1456, 1991) 12.215.
[157] E Player, 'Treatment for Sex Offenders: A Cautionary Note' (1992) 85 Prison Service Journal 2.

behavioural work with sex offenders could reduce reoffending.[158] In recent times the idea of treating sexual offenders has received further support from the UK Government, with the publication of a cross-government 'action plan' on sexual violence and abuse,[159] and the Home Office *Review of the Protection of Children from Sex Offenders.*[160] Whilst the action plan highlights the need for an increased number of treatment places on prison-based and community programmes, the Review confirms and expands this aim by discussing the development of pharmacological treatments to support existing therapies and more 'joined-up treatment' between the Prison and Probation Service. Both documents outline the Government's objective of maximising efforts to prevent sexual abuse, whilst also dealing with its effects, through three levels of intervention: first, by educating the general public and raising awareness of the issue of sexual abuse; second, by implementing measures to aid individuals 'at risk', both of victimisation and offending; and finally, by taking steps to provide support for existing victims, and to improve the management of existing perpetrators. It has been suggested that this system of primary, secondary, and tertiary prevention, denotes a shift towards a 'public health' approach to dealing with sex offenders in the criminal justice system.[161] Indeed, supporters of the approach have especially praised efforts at educating the public about sexual crime, highlighting the moral and commercial benefits of 'prevention

[158] See Marshall (n 39); Abel *et al* (n 42); Marshall and Barbaree (n 89); J Marques, 'The Sex Offender Treatment and Evaluation Project: California's New Outcome Study' (1988) 528 Annals of the New York Academy of Sciences 235; and RJ McGrath, SE Hoke and JE Vojtisek, 'Cognitive Behavioural Treatment of Sex Offenders: A Treatment Comparison and Long Term Follow Up Study' (1998) 25 Criminal Justice and Behaviour 203.

[159] HM Government, *Cross Government Action Plan on Sexual Violence and Abuse* (April 2007) <http://www.homeoffice.gov.uk/documents/Sexual-violence-action-plan?view=Binary> accessed 18 October 2009.

[160] Home Office, *Review of the Protection of Children From Sex Offenders* (June 2007) <http://www.homeoffice.gov.uk/documents/CSOR/chid-sex-offender-review-130607?view=Binary> accessed 18 October 2009.

[161] R Kennington, 'Towards a Public Health Approach to the Management of Sexual Offenders: The UK Experience', paper presented at the 8th International Conference of the International Association for the Treatment of Sexual Offenders, 7 October 2004.

rather than cure'.[162] Whilst this is undoubtedly true, it has been argued by the Chief Inspector of Probation, Mr Andrew Bridges, that not all serious sexual offences are preventable.[163] Thus, a commitment to providing high quality, research-based treatment will always be necessary. The current Government proposals relating to sexual violence and abuse seem to show this. However, it is still uncertain – especially in light of proposals to 'rebalance the criminal justice system in favour of the law abiding majority'[164] – whether there will be an equal allocation of resources between services devoted to the victims of sexual abuse and those devoted to the treatment of perpetrators.

1. Treatment in Prisons

In 1991, Kenneth Baker, the then Home Secretary, announced the launch of the UK Sex Offender Treatment Programme in his keynote speech at the Suzy Lamplugh Trust conference on the sentencing of sex offenders.[165] The programme has developed significantly since then, and now includes six different sub-programmes dealing with numerous offence-related behaviours, social competencies, and varying degrees of offender risk.[166] However, even before the establishment of the SOTP, a small subset of sex offenders was treated using the Therapeutic Community model, first trialled at HMP Grendon, which opened in 1962 as an experimental psychiatric facility. Although treatment for sexual offenders on Therapeutic

[162] *Ibid.*
[163] A Bridges, 'Working with Dangerous Offenders: What is Achievable?', paper presented at the Dangerous Offenders Conference, Centre for Criminal Justice Studies, Kings College London, 15 November 2006.
[164] Home Office, *Rebalancing the Criminal Justice System in Favour of the Law Abiding Majority – Cutting Crime, Reducing Reoffending and Protecting the Public* (July 2006) <http://www.homeoffice.gov.uk/documents/CJS-review.pdf/CJS-review-english.pdf?view= Binary> accessed 18 October 2009.
[165] Suzy Lamplugh Trust, 'The Sentencing of Sex Offenders: The Current Crisis and Essential Action Required', Report of an Interdisciplinary Conference, 7 June 1991.
[166] See section VI 1(a) of this chapter, 'The Sex Offender Treatment Programme', for a more detailed discussion.

Community units is still a marginal activity compared to the numbers that are treated via the SOTP,[167] both interventions will be considered in order to provide a complete history.

a) The Sex Offender Treatment Programme (SOTP)

The UK SOTP is the 'largest multi-site, cognitive behavioural treatment programme for sex offenders in the world'.[168] In 2000, the programme was commended in the Report of the Review of Sex Offences, *Setting the Boundaries*, where the authors argued that it is 'important that appropriate sex offender treatment should be available for as many offenders as could benefit from it'.[169] Since its introduction, the SOTP has developed into an internationally renowned intervention, with evaluations of the programme showing positive results. In their first examination of the SOTP, Beech, Fisher and Beckett found significant positive changes in levels of denial, pro-offending attitudes, social competency skills, and relapse prevention techniques.[170] Further encouraging results were also reported more recently by Friendship, Mann, and Beech[171] who found the programme to be particularly effective at reducing sexual and violent reconviction for medium risk offenders over a two-year follow-up period.

There are six main components of the SOTP,[172] which are designed to treat adult male offenders. These are:

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[167] Indeed, sex offenders residing in a Therapeutic Community will usually also be required to complete the SOTP during their time in custody.
[168] J Clarke, 'The Psychosocial Impact on Facilitators of Working Therapeutically with Sex Offenders: An Experimental Study' (PhD thesis, University of York 2004) 3.
[169] Home Office, *Setting the Boundaries: Reforming the Law on Sex Offences* (London 2000) 135 <http://www.homeoffice.gov.uk/documents/vol1main.pdf?view=Binary> accessed 20 October 2009.
[170] Beech *et al* (n 107) 55.
[171] See Friendship *et al* (n 109) 751 and Friendship *et al* (n 111) 4.
[172] Clarke (n 168) 4.

- the Core Programme, which the majority of offenders participating in treatment must complete before proceeding onto further components. It aims to meet the treatment needs of low deviance offenders and acts as a starting point in treatment for high-risk offenders.
- the Extended Programme, which is designed for those men who have completed the Core Programme but, because of their high risk, require further treatment in other areas.
- the Rolling Programme, which can be completed as an alternative to the Core programme if an offender is assessed as low risk. The Rolling programme covers similar areas to the Core and usually comprises between 45 and 60 sessions.
- the Adapted Programme, which is for offenders who fail to meet the language and literacy requirements of the Core Programme.
- the 'Better Lives' Booster Programme, for offenders who have successfully completed the Core or Extended programme. Two versions are available: a high intensity version for offenders close to release, and a low intensity course for those who have completed the SOTP early in their sentence and require maintenance work. The 'Better Lives' Booster is also available in Adapted format.
- the Healthy Sexual Functioning Programme, for men who have experienced problems with deviant sexual fantasies relating to their offending behaviour. The programme teaches techniques to alter inappropriate fantasies and encourages participants to think about what makes for a healthy intimate and sexual relationship. The programme is targeted at men for whom offence-related sexual interest is a particular treatment need.

At least one of the above programmes is operational at 25 prisons across England and Wales,[173] with most running either the Core or the Rolling Programme. Courses are led by

[173] See Appendix 1.

'facilitators' who work under the guidance of a supervisor (who provides day to day support to facilitators, and scheduled supervision – both group and individual) and a treatment manager (who oversees support provision for facilitators, whilst also sometimes providing supervision as well). All facilitators are trained to deliver either the Rolling or the Core Programme, which is the most long-established of the SOTP components.[174] Only after completing such training may tutors diversify and train to deliver other elements of the SOTP.

The Core Programme

The Core programme is offered on a voluntary basis[175] to all male inmates convicted of a sexual offence or a violent offence with a sexual component. Initially the Prison Service focused its efforts on those serving four years or more; however since the advent of fast-tracking in 1998, men serving sentences of two or three years have been accepted for treatment, provided they have enough time in which to complete treatment. Certain categories of offender are excluded from the Core programme, namely the mentally ill, those who do not speak English, those who have an IQ of less than 80, inmates deemed to be a suicide risk, and those diagnosed with a severe personality disorder.[176] Offenders who openly

[174] The Core SOTP was accredited by the Joint Prison/Probation Accreditation Panel (now the Correctional Services Accreditation Panel) in 1996.

[175] However, ethical concerns have been raised about the ability of imprisoned sex offenders to give free and informed consent to treatment. Refusal to participate will impact negatively upon the offender's chances of parole, and risk assessment rating; both of which are factors that might cajole an individual into enrolling onto the programme. On the other hand, some inmates might be unwilling to take part because because the programme does not admit individuals who deny their offence, some inmates might be unwilling to undergo treatment because of the implicit admission of guilt that comes with participating in the programme. This in itself could result in physical and verbal abuse from fellow prisoners. See D Grubin and D Thornton, 'A National Program for the Assessment and Treatment of Sex Offenders in the English Prison System' (1994) 21 Criminal Justice and Behaviour 55.

[176] Beech *et al* (n 107) 14.

deny their offence are also refused treatment. An offender's suitability for the programme is assessed by means of individual interview and psychometric testing.[177]

The Core programme consists of around 85 two-hour sessions of group-based therapy, meaning that the course generally takes around six months to complete.[178] Specially designed treatment manuals set out the aims and objectives of treatment 'block' (for example, 'coping strategies', 'my history', 'patterns in my offending'), how many sessions should be spent delivering each block, and what should be covered in each session.[179] Generally, eight male prisoners plus two facilitators make up a group.[180] A multidisciplinary approach has been taken regarding treatment teams, with tutors being drawn from a broad range of staff;[181] although in recent years, prison officers, probation officers and trainee psychologists have formed the bulk of those involved in delivering treatment. The Prison Service's use of para-professional staff in place of qualified therapists is a practice rarely followed in the US and Canada and has attracted criticism. It has been argued that, because of their lack of experience and qualifications, lay tutors are unable to meet the demands involved in treating sex offenders and deal with the complex issues that often arise during the course of treatment.[182] However, the use of para-professionals has the obvious advantages of cost effectiveness and flexibility. Likewise, prison officers involved in the programme are able to observe and interact with offenders outside of the treatment setting, allowing them to monitor

[177] S Boddis and R Mann, 'Groupwork in Prisons', in Nick Flynn (ed), *A Good and Useful Life: Constructive Prison Regimes* (Prison Reform Trust, London 1995). However, the penile plethysmograph is no longer used as a means of assessing an offender's suitability for the programme.
[178] HM Prison Service, *SOTP Core 2000 Treatment Manual*, Version 2, (Internal Offending Behaviour Programme Unit, London 2002).
[179] *Ibid.*
[180] Two facilitators will always be present in a treatment session; however, the treatment team itself will comprise three facilitators so that absences, sickness and holidays can be adequately covered.
[181] Grubin and Thornton (n 175) 61.
[182] *Ibid.* 62.

offenders' conformity with the goals and values of therapy.[183] Of course, facilitators receive training to equip them with the skills needed for the job: after being assessed as suitable for the role via psychometric testing, applicants must pass a two-week residential training course. Further training is a pre-requisite for those who wish to deliver other SOTP courses.

The main aim of the Core programme is to increase the individual's motivation to avoid further offending by breaking down the rationalisations used to justify his behaviour and by increasing empathy toward the victim. Following this, the programme focuses on relapse prevention techniques and providing the offender with the skills necessary to prevent further re-offending upon release into the community. This involves developing the offender's awareness of the thoughts, feelings, and situations that are likely to spur recidivism, and teaching strategies to avoid or control these factors.[184] Different treatment techniques are used - including role-play activities, brainstorming, and the use of videos and written materials relating to the victims of abuse – according to the treatment block being delivered.[185] However, some techniques are used throughout the duration of the programme, and act as the building blocks of treatment, namely: cognitive restructuring (helping the offender reassess the excuses used to justify his behaviour); modelling (the demonstration of anti-criminal attitudes and behaviours by tutors); and positive reinforcement (the process of rewarding positive behaviours, such as honesty, disclosure, or progress in therapy).[186]

[183] *Ibid*.
[184] Beech *et al* (107) 14.
[185] *Ibid*.
[186] HM Prison Service (n 178) 3.

Treatment almost always takes a group work format.[187] This is preferred to individual therapy for a number of reasons. Group work has been said to encourage learning and increase the motivation of offenders, whilst preventing the development of a collusive relationship between the therapist and patient. The group process also reflects the reality of society in terms of outsiders becoming aware of the offender's crimes.[188] According to Beech and Fordham, the importance of group dynamics, and the way in which group therapy is conducted, should not be underestimated.[189] They found that the most successful sex offender groups were 'highly cohesive, well organised and facilitated, encouraged the open expression of feelings, produced a sense of group responsibility and instilled a sense of hope in [their] members'.[190] This idea of group cohesiveness being related to treatment outcome has been endorsed by the later work of Beech, Fisher, and Beckett,[191] although the dangers of the group work format have also been highlighted. Sampson, for instance, has argued that the sharing of sexual experiences during group-based therapy may encourage offenders to use such material to form new masturbatory fantasies after treatment has ended.[192] Likewise, Boddis and Mann have suggested that individual therapy might in some way be more 'real' and personal for offenders.[193]

Criticism of Cognitive Behavioural Therapy (CBT)

[187] Although staff working for the Probation Service in Jersey are being trained to provide intensive one-to-one treatment for sexual offenders resident on the island. This alternative approach was spurred as a result of fears that group work could lead to the development of offender 'fraternities'. See 'Rehabilitation for Sex Offenders' *BBC News* (20 March 2007) <http://news.bbc.co.uk/1/hi/world/europe/jersey/6470283.stm> accessed 25 October 2009.
[188] See D Perkins *et al* (n 45) 10.
[189] Beech and Fordham (n 66) 232.
[190] *Ibid*. 219.
[191] Beech *et al* (n 107) 72.
[192] Sampson (n 155) 92.
[193] Boddis and Mann (n 177) 55.

Cognitive behavioural therapy now dominates the area of sex offender treatment. Not only has it been commended for the way in which it tackles both abnormal behaviour and thought processes, CBT programmes now attempt to confront a host of issues relating to offending behaviour and dysfunctional lifestyle. This said, CBT has not escaped criticism. It has been argued that the assumption of equating logical thinking with law-abiding behaviour is erroneous: because CBT aims to alter how a person thinks, rather than what they think, such treatments could ultimately manufacture more coherent and accomplished offenders.[194] Indeed, this was recently judged to be the case with the CALM programme (Controlling Anger and Learning to Manage it) run by both the Prison and Probation Service. As a result of recommendations from the inquiry into the murder of John Monckton,[195] the Home Office withdrew CALM for offenders convicted of purposeful, pre-meditated violence, stating that 'anger management interventions that seek to improve the offender's capacity to control their behaviour are considered to be wholly inappropriate and have the potential to equip the offender with additional control mechanisms and increase his/her capacity to manipulate a situation to their advantage and power'.[196]

[194] R Matthews and J Pitts, 'Rehabilitation, Recidivism and Realism: Evaluating Violence Reduction Programmes in Prison' in V Jupp, D Davies, and P Francis (eds) *Doing Criminological Research* (Sage, London 2000).

[195] HM Inspectorate of Probation, 'An Independent Review of a Serious Further Offence Case: Damien Hanson & Elliot White' (February 2006) <http://www.justice.gov.uk/inspectorates/hmiprobation/docs/hansonandwhitereview-rps.pdf> accessed 25 October 2009.

[196] National Probation Service, 'Guidance on the Implementation of Practice Recommendations Arising From an HMIP Independent Review of a Serious Offence Case' (Probation Circular) (15/2006) <http://www.probation.homeoffice.gov.uk/files/pdf/PC15%202006.pdf> accessed 25 October 2009. However, the circular also suggested that anger management programmes may still be viable for those offenders who can demonstrate a capacity for reflection and learning. Dr William Winogron, co-author of CALM, has argued that the programme was not designed, nor recommended, for offenders demonstrating 'instrumental' or 'purposeful' violence. See W Winogron, 'Anger Management has the Power to Rehabilitate Offenders' *Guardian* (London May 2 2006) < http://www.guardian.co.uk/commentisfree/2006/may/02/comment.prisonsand probation> accessed 25 October 2009.

Gorman has highlighted the potential discriminatory impact of CBT in terms of its tendency to label offenders as being psychologically different from non-offenders.[197] Indeed, cognitive behavioural therapies have been shown to be discriminatory on a number of levels: they generally fail to consider the impact of social issues on criminal behaviour; they are applied to a wide range of offenders regardless of age, ethnicity, or risk category; and standardised programmes are often incapable of adapting the intervention 'dosage' according to individual need.[198] Most of these criticisms cannot, however, be applied to the Prison Service SOTP. As a comprehensive treatment programme, it aims to identify and appropriately modify all thoughts and behaviours related to offending, as well as addressing deficits in social skills and lifestyle problems. Likewise, the various strands of the SOTP (namely the Core, Booster, Rolling, Extended, Adapted, Better Lives, and Healthy Sexual Functioning Programme) are designed to deal with different aspects of sexual offending and, to an extent, different categories of risk. Nevertheless, the UK SOTP has yet to deal with the specific needs of juvenile sex offenders, offenders from ethnic minority communities, and female offenders.

b) Therapeutic Communities

The therapeutic community model first entered the British prison system in 1962 with the opening of HMP Grendon.[199] Following the neo-Freudian concept of group therapy popularised in the 1930s, therapeutic communities are based on four basic principles: first, the democratic exercise of power over administrative and treatment issues, involving both inmates and staff equally; second, a sense of permissiveness in relation to previous or ongoing behaviour, allowing problematic conduct to be acknowledged and discussed; third, the

[197] K Gorman, 'Cognitive Behaviourism and the Holy Grail: The Quest for a Universal Means of Managing Offender Risk' (2001) 48 Probation Journal 3.
[198] *Ibid*. 6.
[199] E Genders and E Player, *Grendon: A Study of a Therapeutic Prison* (Clarendon Press, Oxford 1995).

confrontation of challenging behaviours to expose their negative impact on others; and finally, communalism, and the establishment of close, inter-active relationships.[200] Therapeutic communities are now applied in a wide variety of settings, including the National Health Service and in secure mental health units.[201]

Grendon Prison accepts category B and C male prisoners who have chosen to go there and who have a genuine desire to change their offending behaviour. Prisoners must be committed to abstain from drug use, and be serving sentences that will allow a stay of at least two years.[202] Upon arrival, inmates are housed in an assessment unit to evaluate their motivation to change, and capacity to cope with group psychotherapy.[203] They are then allocated to one of five therapeutic wings - housing 40 inmates each - and finally to a therapeutic group. This group (the *micro* therapeutic community) is usually led by a prison officer, psychologist, or psychiatrist, and meets three times per week to discuss the reasons behind their offending behaviour.[204] Inmates are encouraged to challenge the distorted beliefs of their peers, share problems, and learn from each other in the pursuit of an anti-criminal lifestyle upon release. As Smart puts it, 'everybody becomes an analyst'.[205] The content of group meetings are then summarised and discussed in wing community meetings (the *macro* therapeutic community), which involve all wing-inmates and a number of staff. The true democratic nature of Grendon is highlighted well at such meetings. It provides a forum for airing grievances,

[200] DA Wilson, 'HMP Grendon: A Maverick Prison' (1992) 87 Prison Service Journal 20.
[201] U Smart, *Grendon Tales: Stories from a Therapeutic Community* (Waterside Press, Winchester 2001).
[202] See <http://www.hmprisonservice.gov.uk/prisoninformation/locateaprison/prison.asp?id=397,15,2,15,397,0> accessed 25 October 2009.
[203] D Kennard, 'The Therapeutic Community as an Adaptable Treatment Modality Across Different Settings' (2004) 75 Psychiatric Quarterly 295.
[204] Genders and Player (n 199) 86.
[205] Smart (n 201) 10.

giving praise to individual inmates, as well as dealing with practical issues affecting the community.[206]

Since its opening, the clientele of Grendon has changed considerably. Gunn *et al* described the population of Grendon in the 1970s as being composed mostly of young property offenders, with an average age of 27.[207] Today, inmates tend to be older, with many more sexual and violent offenders,[208] and those suffering from personality disorders.[209] Although the SOTP is not offered as a form of treatment at HMP Grendon, there is a designated sex offender wing[210] which delivers the standard community-style therapy, along with psychodrama techniques.[211] Such therapies have produced some successful results in terms of reduced reconviction rates following release. For example, in a four-year follow-up study, Marshall reported lower reconviction rates for prisoners who went to Grendon than for those who were selected for the Prison but were not placed there.[212] Length of stay at the prison was also found to have a significant impact upon reconviction rates for sexual offenders convicted on two or more occasions; however, inmates convicted of only one sexual offence fared worse than their 'waiting list' counterparts in terms of reconviction.[213]

[206] Genders and Player (n 199) 93.
[207] J Gunn, G Robertson, S Dell and C Way, *Psychiatric Aspects of Imprisonment,* London: Academic Press.
[208] Smart (n 201) 15.
[209] R Taylor, *A Seven-Year Reconviction Study of HMP Grendon Therapeutic Community* (Home Office Research Findings 115, London 2000).
[210] This is generally reserved for high risk sex offenders. It is envisaged that other sexual offenders should be subsumed into normal prison life to prevent the establishment of offender hierarchies.
[211] Smart (n 201) 27.
[212] P Marshall, *A Reconviction Study of HMP Grendon Therapeutic Community* (Home Office Research Findings 53, London 1997).
[213] *Ibid*. 4.

Similar results were reported by Genders and Player[214] in their ten-year follow up study, which used the same sample, comparison group, and methods as Marshall.[215] The authors found that men who had spent 18 months or more at Grendon were much more likely to have progressed through the five stages that characterise treatment on the therapeutic community, namely: (1) that the offender identifies and defines his problematic behaviour; (2) that he expresses a desire to change; (3) that he recognises the ways in which his life outside of prison inter-connects with these problems; (4) that he identifies solutions to his problems; and (5) puts these solutions into practice.[216] In-depth interviews with a sample of 69 inmates who were due for release or transfer to another prison showed that, of those who had spent less than 12 months at Grendon, only 19 per cent had reached stage 5 of the therapeutic process. This compared to 88 per cent of those who had spent 18 months or more at the prison.[217]

Establishing the effectiveness of therapeutic communities will always be difficult owing to the fact that inmates are chosen for treatment based on their strong motivation to change. This makes it almost impossible to compile a 'matched' comparison group,[218] so positive results are often attributed to offender-willingness to change rather than the effectiveness of therapy itself.[219] Another problem is that no information is currently available on the comparative effectiveness of therapeutic community treatment and the SOTP. Yet in spite of this general inconclusiveness regarding the effectiveness of Grendon-style treatment, therapeutic communities have continued to develop throughout the prison estate with the

[214] Genders and Player (n 199).
[215] Marshall (n 212).
[216] Genders and Player (n 199) 149.
[217] *Ibid.* 150.
[218] This problem has been partly remedied by comparing the data of Grendon inmates to prisoners placed on a waiting list for Grendon. However, the problem remains that comparison groups may still lack true equivalence. For instance, the comparison groups in the Marshall (n 212) and Taylor (n 209) studies were much smaller than the Grendon treatment group. There were also differences in the offending history of inmates in the comparison group and those in the treatment group.
[219] Wilson (n 200) 21.

establishment of Dovegate Prison in 2001,[220] and Peterborough Prison in 2005, which offers therapeutic community treatment for its female inmates.[221] With the launch of the SOTP in the early 1990s – and its ensuing success in terms of programme evaluation[222] - the treatment offered by Grendon to sexual offenders could have become obsolete. In fact, the opposite seems to have occurred with the Prison estate effectively tripling its therapeutic community provision. Likewise, more recently, Grendon has admitted an increasing number of sexually violent offenders, and those suffering from personality disorders. However, given the continuing expansion of the SOTP, it is surely questionable whether the use of the therapeutic community model will continue to be applied to sexual offenders in the long-term. Much more evaluative research will need to be completed to compare the relative effectiveness of both programmes and determine whether standardisation of treatment approach would be a better option.

2. Treatment in the Community

Treatment for sexual offenders in the community has traditionally been provided by the Probation Service, although this has been supplemented in recent years by input from the voluntary and charitable sector, under the coordination of the National Offender Management Service. This reflects the Government's intention to provide an integrated, multi-agency approach to the management of sex offenders discharged from prison, or serving community sentences. However, the significance of treatment within this framework has shifted somewhat under current policy initiatives. Marshall *et al* have argued that there are two broad models of offender rehabilitation: the first concerned with improving an offender's

[220] HM Chief Inspectorate of Prisons, *Report on an Unannounced Short Follow-Up Inspection of HMP Dovegate Therapeutic Community* (HM Chief Inspectorate of Prisons, London 2007).
[221] Peterborough Prison was the first purpose-built prison to house both male and female inmates.
[222] Beech *et al* (n 107).

capabilities to enhance his quality of life; and the second concerned with managing offender risk avoiding harm to the community.[223] The latter model currently predominates in UK criminal justice policy, with treatment for sex offenders being subsumed into the much broader agenda of 'risk management'. The remainder of this chapter therefore outlines the treatment services available to sex offenders living in the community, provided by criminal justice and other organisations. It also considers recent legislation, the creation of the Multi-Agency Public Protection Arrangements (MAPPA) and the impact of risk management strategies on the delivery of community-based treatment.

a) Treatment Provided by Criminal Justice Agencies

For the past twenty years, treatment for sexual offenders living in the community has, in the main, been provided by the Probation Service. Such treatment developed in a piecemeal manner, with early programmes relying on the interest and enthusiasm of individual probation officers.[224] Indeed, it was only after the increase in imprisoned sex offenders during the latter part of the 1980s[225] and the Cleveland inquiry[226] into suspected cases of intra-familial child sexual abuse that Probation Services began to recognise the need for more comprehensive treatment services.[227] What followed was an upsurge in therapeutic interventions such that, by 1993, only 13 out of 55 service areas surveyed by Barker and Morgan were not providing some form of treatment for sexual offenders.[228] This led the authors to conclude that '[i]t is

[223] Marshall *et al* (n 87) 1098.
[224] M Barker and R Morgan, 'Probation Practice with Sex Offenders Surveyed' (1991) 38 Probation Journal 171.
[225] From 20 per cent in 1979, to 33 per cent in 1989. This followed Lord Lane's guideline judgement in *R v Billam* (1986) 82 Cr App R 347, where it was stated that '…rape is always a serious crime which calls for an immediate custodial sentence other than in wholly exceptional circumstances'. For the rape of an adult woman, without any mitigating or aggravating factors, a starting point of five years' imprisonment was recommended.
[226] Department of Health and Social Security, 'Report of the Inquiry into Child Abuse in Cleveland 1987' (Cm 412, 1988).
[227] Barker and Morgan (n 224) 171.
[228] M Barker and R Morgan, *Sex Offenders: A Framework for the Evaluation of Community-Based Treatment* (Home Office, London 1993).

clear that most Probation Services have recently begun to offer sex offenders a higher priority than was previously the case'.[229]

Shortly after the publication of Barker and Morgan's findings, Beckett *et al*[230] conducted the first comprehensive evaluation of community-based treatment programmes for sexual offenders. Six probation-based programmes were selected for analysis on the basis that they represented the range of treatments offered by the service. These consisted of a residential treatment programme, two long-term programmes, and four short-term programmes.[231] A sample of 45 convicted child molesters was eventually included in the study sample, and they were tested both pre- and post-treatment on factors relating to risk and sexual deviance. Comparisons were also made with a control group of 81 non-offending males. The authors found that 54 per cent of participants showed a treated profile following therapy, thus being psychometrically indistinguishable from the non-offending sample.[232] However, success rates differed for individual programmes, with residential therapy being the only intervention to have any significant effect on offenders deemed to be highly deviant.[233] It was also identified that probation-based treatments failed to assess clients systematically, provided inadequate relapse prevention skills, and poor long-term support to clients.[234] Following the introduction of programme accreditation to the Probation Service in 1999, sex offender treatment has been consolidated into three group work programmes, namely the C-SOGP, the

[229] *Ibid.* iv.
[230] R Beckett *et al, Community-Based Treatment for Sex Offenders: An Evaluation of Seven Treatment Programmes* (Home Office, London 1994).
[231] Three of these programmes offered up to 60 hours of treatment over two weeks, and one was a week-long programme with a 'co-working' component, where the offender worked on a one-to-one basis with their probation officer and group leader.
[232] See Beckett *et al* (n 230) 66.
[233] *Ibid.*
[234] *Ibid.* 80 – 84.

TV-SOGP and the N-SOGP.[235] These programmes were selected from the range of existing probation-based treatments, after having demonstrated some level of effectiveness in changing offending-related beliefs and behaviours.[236] All three programmes are similar in content; for example, all deal with victim empathy, cognitive distortions, risk management, and relapse prevention. However, the programmes have different points of entry according to an offender's assessed level of risk and deviancy, and – if applicable - their participation in the Prison Service SOTP.[237] The TV-SOGP is also slightly broader as it includes a 'partner's programme', designed for female partners wishing to continue their relationship with the offender.[238]

More recently, the Probation Service has introduced a further programme, aimed specifically at individuals convicted of offences involving the viewing, making, possession, or distribution of indecent images of children via the internet or mobile phone technology. The internet sex offender treatment programme (i-SOTP) was launched in 2006 and was seen as necessary in light of the high proportion of internet-related offenders waiting for treatment.[239] The programme focuses on issues specific to internet offending – such as compulsivity, emotional avoidance, and investment in on-line pseudo relationships – as well as treating general sex offender risk factors. It is available on a group or one-to-one basis for offenders assessed as

[235] The Central Sex Offender Groupwork Programme, the Thames Valley Sex Offender Groupwork Programme, and the Northumbria Sex Offender Groupwork Programme, respectively. The name of each programme reflects the location of their original development.
[236] Brown (n 5) 65.
[237] It should be noted that all probation-lead sex offender treatment programmes are compatible with the Prison Service SOTP, to enable a smooth transition from custody into the community.
[238] National Probation Service and HM Prison Service, 'The Treatment and Risk Management of Sexual Offenders in Custody and in the Community' (Report, October 2002) <http://www.probation2000.com/documents/The%20Treatment%20and%20Risk%20Management%20of%20Sexual%20Offenders%20in%20Cus.pdf> accessed 31 October 2009.
[239] National Probation Service, '*Launch of new internet sex offender treatment programme (i-SOTP)*' (Probation Circular, 92/2005) <http://www.probation.homeoffice.gov.uk/files/pdf/PC92%202005.pdf> accessed 31 October 2009.

high, medium, or low risk, and low deviancy. Internet offenders assessed as very high risk or high deviancy must be referred to one of the existing sex offender groupwork programmes offered by the Probation Service.[240]

In the past, the Probation Service has also been involved in delivering residential treatment for sexual abusers. Founded in 1988, the Gracewell clinic in Birmingham was the only residential treatment centre in the UK. In addition to providing treatment, the centre was responsible for providing training to practitioners during the developmental stages of community therapy for sexual offenders. As a result, most early treatment programmes adopted comparable methods to those employed at Gracewell.[241] The clinic received praise from Beckett *et al* in their evaluation of a sample of community-based treatment programmes, with 65 per cent of patients demonstrating such changes in their attitudes and behaviour so as to make them largely indistinguishable from the profile of a non-sexual offender.[242] The clinic was also effective with some high deviancy offenders; an area where most other community programmes had failed.[243] Despite this, the clinic was closed in 1994 following criticism from the media and members of the public because of its close proximity to local schools.[244] The Lucy Faithful Foundation, with the support of Government funding, continued the work of the Gracewell clinic and, 18 months after its closure, opened the Wolvercote clinic in Surrey in 1995. Taking between 6 and 12 months to complete, the Wolvercote programme was based primarily on cognitive behavioural techniques, with the addition of drama- and art-based therapies.[245] It was delivered via groupwork and individual

[240] *Ibid.* 2.
[241] Brown (n 5) 54.
[242] Otherwise known as showing a 'treated profile'. See Beckett *et al* (n 230) 68.
[243] *Ibid.* 78.
[244] Brown (n 5) 55.
[245] *Ibid.*

exercises, and included four core elements: victim awareness and empathy development; the role of fantasy in offending patterns; sexuality and relationships; and assertiveness and anger management. In an evaluation of the programme, Ford and Beech found that none of the men who achieved a 'treated' profile was reconvicted of a sexual offence, regardless of their deviancy level, after at least two years of living in the community. Moreover, the programme was twice as successful as the Core SOTP with high deviancy/high risk men, effecting overall treatment change in 25 per cent of such offenders.[246] However, it should be noted that nearly 70 per cent of patients left the clinic with an *untreated* profile, 86 per cent of whom were also not reconvicted of a further sexual offence.[247]

The Wolvercote clinic was closed in 2002 after the land on which it was situated was sold by the Government, and attempts at relocation were unsuccessful.[248] As a result, there is currently no residential treatment provision for sexual offenders in the UK.[249] However, given that 25 per cent of high risk/high deviancy men completing the Wolvercote programme demonstrated a treated profile, Ford and Beech have concluded that about 100 of the estimated 405 such offenders living in the community would benefit from intensive residential treatment. This led to a recommendation that four or five new centres should be established.[250] The Government has since reconsidered the provision of residential treatment

[246] H Ford and A Beech, 'The Effectiveness of the Wolvercote Clinic Residential Treatment Programme in Producing Short-Term Changes and Reducing Sexual Reconvictions' (National Probation Service, London 2004) <http://www.probation2000.com/documents/Research%20Findings%20Paper.pdf> accessed 31 October 2009.
[247] *Ibid*. 4.
[248] 'Top Paedophile Clinic Shuts' *BBC News* (31 July 2002) <http://news.bbc.co.uk/1/hi/england/2161518.stm> accessed 31 October 2009.
[249] M Stuart and C Bains, *Safeguards for Vulnerable Children – Three Studies on Abusers, Disabled Children and Children in Prison* (Joseph Rowntree Foundation, York 2004).
[250] H Ford and A Beech, 'An Assessment of the Need for Residential Treatment for Child Sex Abusers' (Report, National Probation Service, London 2004) <http://www.probation2000.com/documents/Analysis%20of%20Need.pdf > accessed 31 October 2009.

facilities for sexual offenders in the community,[251] although plans to create centres similar to Wolvercote and Gracewell are, at the time of writing, yet to be confirmed. Any future policy decision in this area would be, according to Home Office minister Paul Goggins, a 'tricky challenge',[252] owing primarily to public concern about the safety of young children living close to treatment centres. Similarly, Ford and Beech have acknowledged that further work is still necessary in order to identify those high risk/high deviancy offenders most suited to residential treatment, and thus how best to prioritise resources.[253] This should be achieved to some extent by the establishment of the National Offender Management Service (NOMS), which will allow for a more coordinated approach to sexual offenders, ensuring greater links between custodial and community treatment. Founded as a result of the Carter review of correctional services – which highlighted an 'urgent need for the different parts of the criminal justice system to work closer together'[254] - NOMS coordinates the work of prisons and probation. It also commissions treatment services from the private and voluntary sectors in an attempt to achieve an integrated approach to offender management.[255] However, Matravers has suggested that, within this management structure, rehabilitation in its broadest sense has become of secondary importance to risk management and public protection:

> …the demonisation of sex offenders has generated a narrow range of responses dominated by incarceration and tracking. In the community, sex offender management has been focused on registration and risk assessment, with treatment and rehabilitative measures taking a back seat.[256]

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[251] 'New Sex Offender Hostels Planned' *BBC News* (9 September, 2004) <http://news.bbc.co.uk/1/hi/uk/3639484.stm > accessed 31 October 2009.
[252] *Ibid*.
[253] See Ford and Beech (n 250) 6.
[254] P Carter, *Managing Offenders, Reducing Crime – A New Approach*, (Strategy Unit, Cabinet Office, London 2003) 1.
[255] See http://noms.justice.gov.uk/about-us/how-noms-works/, accessed 31 October 2009.
[256] A Matravers, 'Setting Some Boundaries: Rethinking Responses to Sex Offenders', in A Matravers (ed) *Sex Offenders in the Community - Managing and Reducing the Risks* (Willan Publishing, Cambridge 2003) 3.

Matravers has argued that this has resulted in the 'legislative isolation' of sexual offenders which began with the Criminal Justice Act of 1991.[257] Despite being based almost entirely on the principle of proportionality in sentencing, the 1991 Act allowed for the imposition of a custodial term longer than was commensurate with the seriousness of the offence where the offence was violent or sexual and it was deemed necessary to protect the public from serious harm.[258] Courts were also given the power to sanction compulsory supervision by the Probation Service following the release of an offender from prison, in the interests of protecting the public or securing rehabilitative treatment.[259] Although most sections of the 1991 Act have now been repealed, a wide range of legislative provisions have followed, designed to restrict the actions and movement of sexual offenders upon release from custody. These new laws have primarily been justified by the perceived 'dangerousness' of such offenders and the probability that they will engage in further criminal activity.[260] Most notable in this list are the Sex Offenders Act 1997 (SOA 1997) and the Sexual Offences Act 2003 (SOA 2003).

The SOA 1997 introduced notification requirements for sexual offenders, which has since come to be known as the sex offender 'register'. These arrangements have been replaced and amended by Part 2 of the SOA 2003, which laid down more stringent notification requirements for offenders to comply to comply with. However, under the 1997 legislation, offenders convicted or cautioned of a specified sexual offence[261] were required to inform

[257] *Ibid.* 12.
[258] Criminal Justice Act 1991, s 2(2)(b); repealed August 25 2000.
[259] Criminal Justice Act 1991, s 11(1) and s 11(2); repealed 25 August 2000.
[260] Matravers (n 256) 12.
[261] Contained in Sch. 1 of the Sexual Offenders Act 1997; repealed 1 May 2004.

police of their name, date of birth, address, and any changes to this information thereafter.[262] Non-compliance with registration requirements was punishable by a fine, a maximum of six months imprisonment, or both.[263] Despite providing one centralised source of information on the location of convicted and cautioned sexual offenders, the notification requirements were criticised for being non-retrospective, and thereby failing to capture an estimated 100,000 individuals who had committed offences before 1997.[264] The Sex Offender Order (SOO) was therefore introduced in the Crime and Disorder Act 1998[265] to fill this gap (although was later repealed by the SOA 2003). The SOO was available – upon application to a magistrates' court by a chief police officer - for convicted or cautioned sexual offenders acting in such a way as to give 'reasonable cause to believe that an order…[was] necessary to protect the public from serious harm…'[266] Individuals subject to a SOO were required to register under the SOA 1997, in addition to having to comply with the prohibitory conditions of the order.[267] Thus, the SOO acted as a useful device to 'catch' those offenders who were previously excluded under the legislation.

The SOO was followed by the introduction of disqualification orders[268] and restraining orders[269] in the Criminal Justice and Court Services Act 2000 (CJCSA 2000). However, the SOA 2003 revised much of the legislation that preceded it and, as mentioned above, laid

[262] Sexual Offenders Act 1997, s 2(1), 2(2), and 2(3); repealed 1 May 2004.
[263] Sexual Offenders Act 1997, s 3(1); repealed 1 May 2004.
[264] P Marshall, *The Prevalence of Convictions for Sexual Offending* (Home Office Research Findings 55, London 1997).
[265] Crime and Disorder Act 1998, s 2; repealed 1May 2004.
[266] Crime and Disorder Act 1998, s 2(1); repealed 1May 2004.
[267] Crime and Disorder Act 1998, s 2(5); repealed 1May 2004.
[268] Preventing certain sexual offenders from working with children. See Criminal Justice and Court Services Act 2000, s 28; although the definition of the disqualification order was repealed on 12 October 2009 by the Safeguarding Vulnerable Groups Act 2006. The repeal has effect for the purposes of enabling a disqualification order to be made in relation to a person who is barred from regulated activity by virtue of the s 3(2) of the Safeguarding Vulnerable Groups Act 2006.
[269] Prohibiting specified behaviours following a sentence of imprisonment. See Criminal Justice and Court Services Act 2000, Sch. 5, para 6; repealed 1 May 2004.

down much more stringent requirements in relation to sex offender notification. For instance, the 2003 Act requires that offenders confirm their details on an annual basis.[270] It also gives police the power to take fingerprints and photographs of offenders each time a notification is made,[271] and extends the maximum penalty for non-compliance to five years imprisonment on conviction on indictment.[272] The 2003 Act also introduced the Sexual Offences Prevention Order (SOPO), a civil preventative measure designed to protect the public from 'serious sexual harm'.[273] It combines and replaces the SOO and the restraining order, and is available on application by a chief officer of police to the magistrates' court or as an order added at the point of sentencing.[274] The SOPO encompasses a broader range of criminal activity than the orders that came before it, as it can also be imposed on offenders whose index offence is one of violence, but where there is an identified sexual component.[275]

The SOPO was accompanied in the Sexual Offences Act 2003 by a range of other civil preventative orders, including measures to prevent the foreign travel of certain sexual offenders,[276] provisions to enforce the notification of sexual offences committed in countries outside of the UK,[277] and measures to prevent the escalation of patterns of 'risky' sexual behaviour.[278] Thus, as pointed out by Shute, such civil preventative measures imposed 'severe restrictions on the rights of those against whom they are obtained'.[279] Moreover, the creation of the Multi-Agency Public Protection Arrangements (MAPPA) under the CJCSA

[270] Sexual Offences Act 2003, s 85(1).
[271] Sexual Offences Act 2003, s 87(4).
[272] Sexual Offences Act 2003, s 91(2)(b).
[273] Sexual Offences Act 2003, s 104(1).
[274] Sexual Offences Act 2003, s 104 (1) and s 104(5).
[275] Sexual Offences Act 2003, Sch. 5.
[276] The Foreign Travel Order; see the Sexual Offences Act 2003, s 114 - 122
[277] The Notification Order; see the Sexual Offences Act 2003, s 97 – 101
[278] The Risk of Sexual Harm Order; see the Sexual Offences Act 2003, s 123 - 129
[279] S Shute, 'The Sexual Offences Act 2003 – New Civil Preventative Orders: Sexual Offences Prevention Orders; Foreign Travel Orders; Risk of Sexual Harm Orders' (2004) Criminal Law Review 397, 438.

2000 provided another mechanism by which sexual offenders released from prison could be monitored and managed. The MAPPA was established in response to the SOA 1997 and associated Home Office guidance, which stressed the proactive nature of the registration process, and the importance of information exchange between the police and other relevant agencies on known offenders living in the community.[280] Thus, although having no authority of itself, the chief purpose of the MAPPA is to minimise the opportunity for serious reoffending to occur through the establishment of a framework to enable improved multi-agency cooperation.[281] The CJCSA 2000 designated the police and the Probation Service as the joint 'responsible authority' with a duty to 'establish arrangements for the purpose of assessing and managing the risks posed' by sexual and violent offenders in each MAPPA area.[282] These provisions were strengthened by the Criminal Justice Act 2003 (CJA 2003) in two ways: first by extending the responsible authority to include the Prison Service;[283] and second, by establishing a duty to cooperate between the responsible authority and a range of other social care agencies, including the NHS, local education authorities, Youth Offending Teams, and social landlords.[284] The CJA 2003 also imposed a duty upon the Secretary of State to appoint two lay advisors to each responsible authority[285] 'to bring a community perspective' to the MAPPA process.[286]

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[280] M Maguire *et al*, 'Risk Management of Sexual and Violent Offenders: The Work of Public Protection Panels' (Police Research Series Paper 139, Home Office, London 2001).
[281] National Probation Service, 'Sex Offender Strategy for the National Probation Service' (Strategy Document, September 2004) <http://www.probation2000.com/documents/Sex%20_Offender%20Strategy%20Sep%2004.pdf > accessed 1 November 2009.
[282] Criminal Justice and Court Services Act 2000, s 67 (1) and s 67(2).
[283] Criminal Justice Act 2003, s 325.
[284] Criminal Justice Act 2003, s 325(6).
[285] Criminal Justice Act 2003, s 326(3)
[286] J Scott, T Grange and T Robson, *MAPPA – The First Five Years: A National Overview of the Multi-Agency Public Protection Arrangements 2001 – 2006*, (Report, on behalf of the Responsible Authority National Steering Group, 2007) <http://noms.justice.gov.uk/news-publications-events/publications/strategy/MAPPA_five_years?view=Binary >, accessed 1 November 2009.

National guidance on the MAPPA clarifies that there are three categories of offender who fall within the remit of public protection arrangements: offenders subject to the notification requirements of the SOA 2003; violent and sexual offenders not subject to notification rules; and any other offender deemed to pose a risk of serious harm to the public as a result of previous criminal behaviour.[287] Risk assessment procedures then allocate offenders into one of three management levels, namely: level one, which deals with cases requiring ordinary agency management; and levels two and three, which require Multi-Agency Public Protection meetings (MAPP).[288] The National Offender Management Service has stated that the central question in determining the correct level of MAPPA supervision for a specified offender should be, 'what is the lowest level that a case can be managed at which provides a defensible risk management plan?'[289] Therefore, there is a correlation between the level of risk posed by an offender, and the level of MAPPA management to which an individual is allocated. However, there is no direct relationship between the two, and even high risk offenders can be managed at level 1 if a robust risk management plan is in place. Level one supervision arrangements account for around 71 per cent of the MAPPA population[290] and usually involve the police, Probation Service, or a Youth Offending Team as the lead agency. Cases referred to level two or level three management – sometimes described as the 'critical few' - will be subject to the decisions of a multi-agency public protection panel (MAPPP). MAPPPs involve the highest level of inter-agency working,[291] with level 3 meetings requiring senior

[287] National Offender Management Service, 'MAPPA Guidance 2007 Version 2.0' (2007) <http://www.probation.homeoffice.gov.uk/files/pdf/MAPPA%20Guidance%202007%20v2.0.pdf> accessed 1 November 2009.
[288] *Ibid*. 43
[289] *Ibid*.
[290] Scott, Grange and Robson (n 286) 4.
[291] A small number of level 3 cases will need to be registered as Critical Public Protection Cases (CPPCs). This will occur where there is evidence that the offender has caused serious harm through sexual or violent offending, which has resulted in death, or trauma (whether physical or psychological) that the victim is unlikely to recover from; where serious harm is likely to occur as soon as an opportunity is present; or where a case is likely to attract significant national media interest. See National Probation Service, 'Critical Public Protection Cases'

representatives from such agencies to effect resource-intensive risk management plans.[292] Under all levels of monitoring, an offender may be required to comply with a number of preventative measures including curfews, electronic tagging, restrictions on living arrangements, and compulsory participation in treatment programmes.[293]

Despite figures showing a reduction in the number of 'serious further offences' committed by MAPPA offenders in 2006 compared to 2005,[294] the Multi-Agency Public Protection Arrangements have been criticised. As recently as 2005, a report by HM Inspectorate of Probation, and HM Inspectorate of Constabulary, found a 'lack of integrated and accountable case management of sex offenders in the community, the delivery of which was poorly coordinated and inconsistent'.[295] This was exacerbated by the fact that police and probation staff were not confident that every MAPPA decision was properly followed through, and MAPPA meeting minutes were often missing from case files.[296] The report also found that the process for deciding at what MAPPA level a sex offender should be managed varied within and between areas,[297] and that offenders rarely attended MAPPA meetings themselves.[298] Bryan and Doyle have argued that, not only should the offender's self-management skills be encouraged via the MAPPA, but further that the correct identification of an offender's risk level is paramount to ensure the legality of any subsequent action.[299] This issue is particularly pertinent to those offenders assessed as requiring the level three

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(Probation Circular, 06/2007) <http://www.probation.homeoffice.gov.uk/files/pdf/PC06%202007.pdf> accessed 1 November 2009.
[292] National Offender Management Service (n 287) 45.
[293] Matravers (n 256) 14.
[294] Scott, Grange and Robson (n 286) 7.
[295] HM Inspectorate of Probation and HM Inspectorate of Constabulary (n 144) Foreword.
[296] *Ibid.* para 7.8.
[297] *Ibid.* para 7.1.
[298] *Ibid.* para 7.11.
[299] T Bryan and P Doyle, 'Developing Multi-Agency Public Protection Arrangements', in A Matravers (ed) *Sex Offenders in the Community – Managing and Reducing the Risks* (Willan Publishing, Cambridge 2003).

management of the MAPPP, the practices of which have also come under some scrutiny. Lieb, for example, has suggested that whilst housing is generally the 'centrepiece' of MAPPP management strategies, most protocols do not address whether and how individuals are to receive treatment services.[300] Similarly, as new offenders are assigned to level three supervision, the total number of people placed on the MAPPP's 'high risk list' will increase exponentially over time, thus having serious implications in terms of resources.[301] However, data gathered by the Home Office thus far suggests that the opposite is happening, and that the number of offenders being allocated to the MAPP decreased between 2004/05 and 2005/06.[302]

It can be concluded, therefore, that since the Criminal Justice Act of 1991, a range of legislative measures have been implemented in relation to sexual offenders, some of which have incorporated the possibility of referral to treatment services, and all of which have been increasingly stringent in terms of the restrictions placed upon such offenders in the community. These responses have been echoed in sentencing arrangements. The Criminal Justice Act 2003 now provides for 'extended sentences' for sexual and violent offenders,[303] and sentences of imprisonment for public protection,[304] which involve a determinate custodial element followed by a reviewable period, whereby an offender's eligibility for release is determined by the Parole Board.[305] According to Matravers, '[t]o get to this point, we have

[300] R Lieb, 'Joined-Up Worrying: The Multi-Agency Public Protection Panels', in A Matravers (ed) *Sex Offenders in the Community – Managing and Reducing the Risks* (Willan Publishing, Cambridge 2003).
[301] *Ibid.* 212.
[302] Scott, Grange and Robson (n 286) 6.
[303] Extended sentences involve a custodial term plus a period on licence of such length as the court feels necessary to protect the public from serious harm. See Criminal Justice Act 2003, s 227.
[304] Criminal Justice Act, s 225.
[305] When considering the release of prisoners, the Parole Board sits in a panel of three. Currently, where there is a difference in opinion on the suitability of an offender to be placed back into the community, the majority view prevails. However, under new government proposals, panels will be required to reach a unanimous decision before an offender can be released from custody. See Cabinet Office (n 84) para 2.72.

had to swallow a number of principles – including innocence until proven guilty, proportionate sentencing, the avoidance of double jeopardy, and the balance of individual and community rights…'.[306] Yet the question remains as to exactly how we have reached this particularly punitive stance on sexual offenders? The main justification for the use of such stringent and arguably disproportionate measures in relation to the disposal of sex offenders lies in the need to protect the public from their perceived dangerousness.[307] However, the concept of dangerousness itself has been shown to be notoriously difficult to predict: Hood and Shute *et al* found that 92 per cent of sex offenders assessed as high risk by at least one member of the Parole Board had not been reconvicted of a further sexual offence four years after release.[308] Similarly, it has been argued that government policy on sexual offenders has been fundamentally misdirected in its focus on predatory, extrafamilial offenders, when the vast majority of sexual abuse is perpetrated by individuals known to the victim, particularly within the family.[309]

This punitive response seems to reflect the portrayal of sex offenders in the media, and the heavy focus on high-profile cases involving the sexual murder of children by individuals with a history of previous sexual offending.[310] This has, in some cases, led to a 'knee-jerk' reaction in terms of subsequent legislative provisions, as a result of the Government's need to demonstrate its ability to deliver 'justice'. Some commentators have nevertheless pointed to much more complex reasons in explaining the emergence of the current 'risk penality'. Late

[306] Matravers (n 256) 15.
[307] *Ibid.* 12.
[308] Hood and Shute *et al* (n 134) 383. However, where sex offenders were not identified as high risk by a member of the Parole Board, predictions of reconviction were almost always correct, with only one such offender being reconvicted of a sexual offence six years after release (p 385).
[309] D Grubin, *Sex Offending Against Children: Understanding the Risk* (Police Research Series Paper 99, Home Office, London 1998).
[310] B Hebenton and T Thomas, 'Sexual Offenders in the Community: Reflections on Problems of Law, Community and Risk Management in the USA, England and Wales' (1996) 24 International Journal of the Sociology of Law 427.

'modern' society is, according to Hebenton and Thomas, characterised by uncertainty as a result of the erosion of traditional forms of social cohesion, and increased opportunities for crime.[311] Thus, 'social order is increasingly thought of as something which cannot merely be protected and maintained but which must, rather, be actively constructed and managed',[312] in order to minimise anxiety and feelings of insecurity. In terms of crime control, this has resulted in a societal acknowledgement of the inevitability of criminal activity, and accordingly an increased emphasis on the risk management of offenders to the detriment of rehabilitation.[313]

Yet, in spite of the fact that – as maintained in the 'late modernity risk thesis'[314] - crime is now commonly seen as a 'normal' part of everyday life, sexual offenders are still seen to breach the boundaries of acceptability in terms of the risk they present. This has led to a system of 'bifurcation', whereby sex offenders are dealt with very differently from other offenders in the criminal justice system.[315] This seems unlikely to change in the near future given that recent legislative enactments have granted ever more extensive powers to the relevant authorities to monitor sex offenders living in the community.[316] Moreover, HM Inspectorate of Probation has recently recommended that the MAPPA should 'maintain in practice a top priority focus on the public protection requirements' of cases referred to it, over and above human rights considerations.[317]

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[311] *Ibid.* 430.
[312] *Ibid.* 431.
[313] Matravers (n 256) 9.
[314] *Ibid.*
[315] H Kemshall, 'Public Protection: Recent Developments and Key Issues', paper presented at the Dangerous Offenders Conference, Centre for Criminal Justice Studies, Kings College London, 15 November 2006.
[316] For example, section 28 of the Offender Management Act 2007 allows for compulsory polygraph testing to be included as a licence condition of individuals convicted of specified sexual offences.
[317] HM Inspectorate of Probation, 'An Independent Review of a Serious Further Offence Case: Anthony Rice' (May 2006) <http://www.justice.gov.uk/inspectorates/hmi-probation/docs/anthonyricereport-rps.pdf> accessed 2 November 2009.

There can be no benefit from excluding sexual offenders from society and the prospect of reform. Although the consequences of sexual victimisation can be more devastating than in other forms of crime so that perpetrators require the highest possible levels of intervention for risk management purposes, most forms of community supervision are not indefinite. Further resources need to be deployed into efforts to treat sex offenders in the community to minimise the possibility of recidivism once licence conditions are lifted. Alongside this, greater efforts need to be made to ensure treatment goes beyond mere risk management and aids the offender in acquiring the skills necessary to achieve a good quality of life. As put by Marshall *et al*, '[t]his does not entail ignoring the needs of the community for security and safety; it simply reminds us that all human lives should reflect the best possible outcomes rather than the least worst possibilities'.[318] At present, however, treatment for sexual offenders released from prison features far below civil preventative measures on the 'pecking order' of community interventions. Although the Government action plan on sexual violence and abuse states that from 2007, treatment will be delivered to around 1200 sex offenders per year,[319] the number of registered sex offenders placed under the supervision of the MAPPA far exceeds this.[320] If funding cannot be secured in the short-term to allow for an increased number of treatment places in the community, further research into existing treatment provision should be conducted to ascertain which offenders benefit most from probation-led programmes.

b) Treatment Provided by Other Organisations

The partnership approach that has characterised the criminal justice response to sexual offending since the late 1990s has been extended in recent years to include charities, the

[318] Marshall *et al* (n 87) 1100.
[319] HM Government (n 159) 46.
[320] In 2005/2006 there were 29973 registered sex offenders being monitored by the MAPPA, 6594 of whom were categorised as management level 2 or 3. See Scott, Grange and Robson (n 286) 3.

voluntary sector, and statutory bodies not traditionally associated with offender management. For example, the Department of Health, working in conjunction with the Home Office and HM Prison Service, has established pilot projects in four high secure hospitals to identify, assess and treat offenders (including those convicted of sexual crimes) meeting the Dangerous Severe Personality Disorder (DSPD) criteria.[321] Treatment is provided on a one-to-one basis and adopts a cognitive behavioural approach, combining the methods of existing violence reduction programmes – particularly Chromis[322] – and the 'good lives' model, aimed at providing coping strategies to avoid re-offending. Through-care arrangements have also been established and include medium secure settings, hostels, community teams, and a joint health/probation supervision service.[323] In 2005, 109 cases were accepted on to the pilot programme. The index offence in nearly half of these cases involved violence, and a further 39 per cent a sexual and violent element. It is hoped that the data gathered from the project will strengthen the knowledge base on DSPD by providing expertise from a range of professional standpoints. A comprehensive evaluation of the programme has been commissioned, although it is too soon to comment upon its effectiveness. Moreover, any evaluation will have to take into account the fact that service delivery in this area is complex to say the least. The heterogeneous nature of the offending population in question makes it difficult to manage patients in one setting. Similarly, the risks posed by DSPD offenders are almost always life-long, thus requiring effective aftercare arrangements.[324] This may prove difficult given the minimal input health care services have traditionally provided in relation to offender treatment and management.

[321] National Probation Service (n 281) 11.
[322] Chromis is an offending behaviour programme aimed at reducing violence in high risk offenders whose level of psychopathy disrupts their ability to benefit from treatment.
[323] S Hadjipavlou, 'The Dangerous and Severe Personality Disorder (DSPD) Programme', paper presented at the Dangerous Offenders Conference, Centre for Criminal Justice Studies, Kings College London, 15 November 2006.
[324] *Ibid.*

More recently, the voluntary and charitable sectors have also been incorporated into the Government's strategy on managing sexual offenders in the community. Following the closure of the Wolvercote clinic, the National Probation Directorate established contracts with the Lucy Faithful Foundation[325] to provide consultancy services to offender managers, limited forms of intervention with female offenders, and outreach work with former Wolvercote residents.[326] In addition, a number of independent projects have been funded by the state and supported by the police, Probation and Prison Service, emphasising the multi-agency approach advocated since the establishment of the MAPPA. The most developed of these projects are the Stop It Now! Campaign, the Derwent Initiative, and Circles of Support and Accountability.

First developed in the USA 10 years ago, Stop It Now! is a public education campaign aimed at preventing child sexual abuse and increasing public awareness about issues relating to sexual victimisation. The project was implemented in the UK by the Lucy Faithful Foundation and offers a range of services, including a helpline to provide information and advice to individuals concerned about their own sexual behaviour or that of another person.[327] It also supports the development of network area initiatives across the country, which have included public information campaigns and community action schemes to improve public safety. Community involvement in attempts to monitor the behaviour of sexual offenders has also been pursued by The Derwent Initiative (TDI), a charitable organisation specialising in

[325] The Lucy Faithful Foundation is an independent child protection agency undertaking work with men, women and adolescents convicted or suspected of child sexual abuse. It also offers therapeutic services for survivors of sexual victimisation, and their families.
[326] National Probation Service, 'Support Services for Working with Sexual Offenders' (Probation Circular, 31/2005) <http://www.probation.homeoffice.gov.uk/files/pdf/PC31%202005.pdf> accessed 2 November 2009.
[327] See <http://lucyfaithfull.org/stop-it-now!.aspx> accessed 2 November 2009.

the promotion of an inter-agency response to the prevention of sexual crime, particularly that committed against children. As well as running conferences and undertaking research,[328] in 2002 TDI developed the Leisurewatch scheme, which has since become its most successful project. Based on the premise that 'the best way to improve public protection from offending behaviour is to increase safety in as many places as possible', the Leisurewatch project trains staff working in leisure centres to identify suspicious behaviour on the part of potential abusers and to liaise with police and other agencies to prevent an offence from occurring. Since it was established more than 2000 staff have been trained, and the project now offers accreditation and maintenance programmes to Leisurewatch sites, and continued support for those involved.[329]

The Circles of Support and Accountability scheme was designed to integrate sexual offenders back into society following release from prison and shares the aim of inter-agency working. Based on principles of restorative justice, between four and five volunteers from the community create a 'circle' of support for an individual offender.[330] Volunteers provide guidance and support, whilst also challenging inappropriate behaviour, and informing the police or Probation Service if they feel the offender is at risk of committing further crimes.[331] Three 'circles' projects have been established across the country in the Thames Valley, Hampshire, and Surrey. In the most recent evaluation of the Thames Valley scheme, the case files of all 16 offenders receiving the support of a circle between November 2002 and May 2006 were examined. The results showed that no offender had had been reconvicted of any

[328] The most recent research project conducted by the Derwent Initiative has focused on the mental health needs of adolescents convicted of sexual offences. See http://www.tdi.org.uk/Research.htm, accessed 2 November 2009.
[329] See http://www.tdi.org.uk/leisurewatch.htm, accessed 2 November 2009.
[330] Quaker Peace and Social Witness, *Circles of Support and Accountability in the Thames Valley – The First Three Years, April 2002 to March 2005* (Quaker Communications, London 2005).
[331] *Ibid.* 9.

new sexual offence, and six had showed no further problematic behaviour at all.[332] However, one offender had been convicted for breach of a Sex Offence Prevention Order, four had been recalled to prison after breaching the conditions of their parole licence, and five had exhibited some form of recidivist behaviour.[333]

In the past, projects like those described above have been supported by state funding but have never formed part of the strategic response to sexual offending.[334] This trend now seems set to change. Since the inception of the National Offender Management Service, it is envisaged that projects such as the 'circles' initiative will work on a purchase-provider basis, being bought as a service by Regional Offender Managers according to suitability and need.[335] Likewise, all of the schemes have strong working relationships with criminal justice agencies, and the local community, thus conforming to the government's desire to establish and maintain a multi-agency approach to the management of sexual offenders and public protection. The idea of treatment being provided by the private and voluntary sector nevertheless brings with it a number of potential problems. For instance, it is not clear whether such programmes will subject to any sort of accreditation process – which currently operates in relation to state-led interventions. Provision of services by organisations other than the state could also lead to wide disparities in the availability of treatment, according to demand in local areas. This is not to suggest that the 'contracting-out' of treatment services cannot be a successful enterprise; but measures must be established to ensure their quality and equal-distribution across the country.

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[332] A Bates, R Saunders and C Wilson, 'Doing Something About It: A Follow-Up Study of Sex Offenders Participating in Thames Valley Circles of Support and Accountability' (2007) 5 British Journal of Community Justice 19.
[333] *Ibid*. 23.
[334] Kennington (n 161).
[335] Quaker Peace and Social Witness (n 330) 47.

V. CONCLUSION

It could be argued that, with the revival of the public protection agenda and the introduction of legislation that aims to keep sex offenders imprisoned for longer, and subsequently subject to much more stringent supervision in the community, treatment for such offenders has made little progress since the sexual psychopath laws of 1930s America. However, Brown has rightly suggested that such an assertion would be an oversimplification.[336] It cannot be denied that treatment for sexual offenders has improved in quality over the past 60 years. Since its humble beginnings rooted in psychoanalysis, treatment programmes now bear little resemblance to early approaches. The cognitive behavioural interventions of today are comprehensive in nature, aiming to deal with a variety of offending behaviours and social skills deficits. Evidence-based practice is considered essential; so too are continual monitoring and evaluation of treatment methods. Debate continues, however, as to the most suitable methodology for evaluating the effectiveness of sex offender treatment programmes.

The position of sex offender treatment within the context of the UK criminal justice system has also improved. Established in 1991, the SOTP now constitutes an integral part of the Prison Service's response to incarcerated sex offenders. The Probation Service also offers three sex offender group work programmes across the country, as well as a specialised programme for individuals found guilty of 'internet sexual offences'. This increased emphasis on the importance of treatment has been evident in recent government policy,[337] with promises to increase the number of treatment places available to sex offenders as well as contract-in services from the private and charitable sectors to aid both perpetrators and victims of abuse. As pointed out by Perkins *et al*, 'joint initiatives involving police,

[336] Brown (n 5) 40.
[337] HM Government (n 159); Home Office (n 160).

probation, child protection and therapy services testify to the fact that the whole is better than the sum of the parts when it comes to developing coherent, comprehensive and effective approaches'.[338] But there are three key problems with this approach: first, it is unclear how treatment provided by non-governmental agencies will be monitored and evaluated; second, the delivery of rehabilitative programmes by private and charitable organisations could lead to disparities in the availability of treatment, according to the disposable resources of 'third sector' enterprises in regional areas; and finally, with provision for the victims of sexual abuse also under review, it is uncertain whether there will be an equal distribution of resources between services devoted to perpetrators and those aimed at the victims of sexual abuse. This seems particularly pertinent in light of the Government's aim to 'rebalance the criminal justice system in favour of the law abiding majority'.[339]

The re-emergence of treatment for sexual offenders in the UK penal system has also been accompanied by the introduction of a range of new preventative measures, designed to protect the public from 'dangerous' sexual and violent offenders upon release into the community. Thus, treatment is now situated within the much broader objective of risk management where the primary aim is to prevent harm to the community rather than rehabilitate the offender. It remains to be seen whether this current emphasis on risk will successfully incorporate the notion of treatment or whether strategies aimed at protecting the public will negatively affect the therapeutic alliance between offenders and treatment providers.[340]

[338] Perkins *et al* (n 45) 4.
[339] Home Office (n 164).
[340] Marshall *et al* (n 87) 1096.

CHAPTER 2

THE IMPACT OF WORKING WITH SEX OFFENDERS: A REVIEW OF THE LITERATURE

I. INTRODUCTION

Although the widespread treatment of sexual offenders is a relatively recent development, it has nevertheless been quickly recognised that individuals working with such offenders are presented with very particular challenges, for example, analysing detailed descriptions of sexual violence.[1] It is perhaps unsurprising then that it has been accepted that those treating sex offenders may suffer negative psychological effects, including stress, burnout, and vicarious trauma. This said, a number of studies have highlighted certain positive effects associated with sex offender work, such as the satisfaction that comes from seeing an offender's behaviour change and by aiding victims.[2]

Whilst some empirical evidence has emerged to support the assertions outlined above, data are still sparse – particularly in relation to the British SOTP.[3] This is perhaps an issue that should figure more prominently on the Prison Service agenda, given that several cases have emerged in which SOTP facilitators have sought compensation from the Home Office for severe stress-related health problems. In the most recent, the complainant, Mr Ronald Johnson, was granted £150,000 damages in an out-of-court settlement following allegations

[1] G Ryan and S Lane, 'The Impact of Sexual Abuse on the Interventionist', in G Ryan and S Lane (eds) *Juvenile Sexual Offending – Causes, Consequences, and Correction* (Lexington Books, San Francisco 1991).
[2] MA Kadambi and D Truscott, 'Concept Mapping Professionals Perceptions of Reward and Motive in Providing Sex Offender Treatment' (2006) 42 Journal of Offender Rehabilitation 37.
[3] Although Clarke's recent research has provided a much fuller account of the impact of sex offender work on SOTP facilitators. See J Clarke, 'The Psychosocial Impact on Facilitators of Working Therapeutically with Sex Offenders: An Experimental Study' (PhD thesis, University of York 2004).

that he received inadequate supervision and poor 'organised personal support'.[4] In order to become an SOTP facilitator, all applicants must now complete a series of psychometric tests and successfully pass a two-week residential training course organised by the Offending Behaviour Programme Unit - an arm of the Home Office. Regular supervision and counselling are also compulsory once a facilitator is qualified.[5] However, even since the resolution of Mr Johnson's case, his legal advisor has suggested that numerous other claims are being processed on behalf of other prison officers traumatised by their work on the SOTP.

This chapter reviews the published theoretical and empirical literature relating to the health impacts of working with sexual offenders. Five key concepts are discussed, namely stress, burnout, countertransference, vicarious traumatisation, and secondary traumatic stress. Consideration is also given to research which has examined the positive effects of working with sexual offenders as reported by treatment providers.

II. THE IMPACT OF WORKING WITH SEX OFFENDERS

Research analysing the impact of working with sex offenders is limited, with many studies being anecdotal rather than empirical and being based on small samples.[6] Over the last ten years, however, a growing body of literature has emerged which, although still showing some methodological weakness, has made a start at clarifying the types of stressors experienced by those working with sex offenders. Many negative health effects have been identified and, more recently, writers in the field have started to investigate the potential positive effects of

[4] P Johnstone, '£150,000 Reward for Prison Officer on Sex Wing', *The Daily Telegraph* (London 1 April 2003) <http://www.telegraph.co.uk/news/uknews/1426270/150000-award-for-prison-officer-on-sex-wing.html> accessed 6 December 2009.
[5] See chapter 3 for a detailed discussion of the training and support provided to SOTP facilitators by the Prison Service.
[6] L Ellerby, 'Impact on Clinicians: Stressors and Providers of Sex Offender Treatment', in S. Bird-Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997).

working therapeutically with such offenders. The fact that the work of sex offender therapists is now firmly established as a valid research topic is, according to Abel, an important development if it is accepted that the future of sex offender treatment lies with the psychological well-being of treatment providers.[7]

1. Stress

Although the idea of physical stress occurring in the workplace can be traced back to the work of Hippocrates,[8] the use of the term stress as a means of defining a psychological state is much more recent. Modern accounts[9] often attribute the development of stress theory to the 'fight or flight' model of Walter Cannon, which states that the emotions of fear and anger induce physical changes in the body (for example, increased heart rate and blood pressure) to deal with adverse situations and to prepare it either for action or escape.[10] The theory was further developed by Hans Selye, who identified that non-specific bodily or mental stresses can lead to a General Adaptation Syndrome (GAS) whereby the body's attempts to resist the adverse demands placed upon it result in certain negative symptoms.[11] However, since these early works, the concept of stress has been broadened to the extent that it has now become the dominant term for uniting a range of related concepts, all of which reflect the adaptational problems imposed by the pressures of daily living.[12] Most definitions of work-related

[7] GG Abel, 'Preventing Men from Becoming Rapists', in G Albee, S Gordon and H. Leitenberg (eds) *Promoting Sexual Responsibility and Preventing Sexual Problems* (University Press of New England, London 1983).
[8] H Goodell, S Wolf and FB Rogers, 'Historical Perspective' in SG Wolf and AJ Finestone (eds) *Health and Performance at Work: Occupational Stress* (PSG Publishing Company, Massachusetts 1986).
[9] D Wainwright and M Calnan, *Work Stress: The Making of a Modern Epidemic* (Open University Press, Buckingham 2002).
[10] WB Cannon, *The Wisdom of the Body* (revised and enlarged edn, Norton, New York 1939).
[11] H Selye, *The Stress of Life* (revised edition, McGraw Hill Book Company, London 1976).
[12] RS Lazarus, *Stress and Emotion: A New Synthesis* (Free Association Books, London 1999).

stress,[13] including that adopted by the Health and Safety Executive, focus on stress as being 'the adverse reaction people have to excessive pressure or other types of demand placed on them'.[14] This definition describes stress as being an imbalance between the demands placed on individuals (whether psychological or environmental) and their ability to cope with them, based on psychological and environmental resources.

It can be argued that sex offender treatment providers are faced with a number of different sources of stress. Most obvious are those stressors that have been associated with the role itself, such as having to analyse harrowing accounts of sexual abuse. However, facilitators working on the SOTP must also contend with stressors that have been specifically linked to working in the prison environment and those associated with providing psychological treatment, both of which are considered below.

a) Stressors of the Prison Environment

It has been suggested that 'prisons are one of the most negative environments in which we may work'.[15] Mortality statistics have shown prison officers to have a higher risk of heart disease and other medical conditions compared with the general population,[16] although the difficulties of linking such illnesses specifically to job-related stressors have been acknowledged.[17] Prison officers and other prison staff have to deal with difficult individuals - whose behaviour is frequently violent and unpredictable – in an environment that is often overcrowded. Certain sociological attributes of the role have also been recognised as

[13] See for example S Williams and L Cooper, *Managing Workplace Stress* (John Wiley & Sons, Chichester 2002), and MT Matteson and JM Ivancevich, *Controlling Work Stress: Effective Human Resource and Management Strategies* (San Francisco, Jossey-Bass 1987).
[14] See <http://www.hse.gov.uk/stress/furtheradvice/whatisstress.htm> accessed 6 December 2009.
[15] RE Freeman-Longo, 'Introduction: A Personal and Professional Perspective on Burnout' in S. Bird Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997) 8.
[16] DJ Cook, PJ Baldwin and J Howinson, *Psychology in Prisons* (Routledge, London 1990).
[17] *Ibid.* 126.

problematic; for instance, the lack of public understanding of the difficulties involved in the job and the fact that staff act as a 'buffer' between society and a group of individuals deemed to have violated accepted standards of behaviour.[18] Launay and Fielding have suggested that the stressors of the prison environment can be divided into two distinct categories: inmate-related stressors and management-related stressors.[19] However, there have been differences in academic opinion about which of these are the major determinants of stress for prison officers. Whilst Launay and Fielding contend that inmate-related factors are the main cause,[20] Cheek and Miller claim it to be administrative issues and 'a lack of clear guidelines for job performance'.[21]

b) Stressors of the Therapeutic Role

In addition to the challenges associated with prison work in general, treatment providers working in an institutional setting have to deal with the stressors associated with the therapeutic role. Deutsch[22] has noted numerous issues that may prove stressful, including suicidal statements by clients, expressions of anger toward the therapist, and severely depressed clients; all of which can be applied to sex offender therapy.[23] More subtle influences have also been documented, particularly therapists adopting their professional role within social relationships and attempting to interpret the emotions of family and friends in

[18] CM Brodsky, 'Long-term Work Stress in Teachers and Prison Guards' (1977) 19 Journal of Occupational Medicine 133.
[19] G Launay and PJ Fielding, 'Stress among Prison Officers: Some Empirical Evidence Based on Self Report' (1989) 28 Howard Journal of Criminal Justice 138.
[20] *Ibid.* 145.
[21] FE Cheek and MDS Miller, 'The Experience of Stress for Correction Officers: A Double-Bind Theory of Correctional Stress' (1983) 11 Journal of Criminal Justice 105.
[22] CJ Deutsch, 'Self-Reported Sources of Stress among Psychotherapists' (1984) 15 Professional Psychology: Research and Practice 833.
[23] This is not to suggest that all aspects of delivering psychotherapy are detrimental in health terms. In his study on the effects of psychotherapeutic practice upon clinicians, Farber (n 25) found that the most substantial personal changes noted in therapists after an average of ten years' experience were all in a positive direction. Likewise, Deutsch (n 22, 843) has explained how 'there may be an optimum level of stress that the therapist perceives as exciting, challenging, and which signals progress'.

domestic situations.[24] Likewise, feelings of isolation can result from the difficulties involved in explaining the nature and value of therapeutic work to family and friends.[25] This is a problem that is especially pertinent to individuals delivering sex offender therapy, since they may face hostility from colleagues working with victims of crime[26] or from those who are simply opposed to the idea of treating offenders.

c) Stressors Associated with Sex Offender Work

It can be contended that, as a group, sex offenders are the most challenging in the entire penal system in terms of the complex treatment needs that they regularly present with. Sex offenders often deny, minimise or try to rationalise their behaviour, showing little (if any) empathy for their victim.[27] Once enrolled in therapy, offenders' problems sometimes turn out to be worse than they initially appeared, with some fostering wholly unrealistic expectations of being 'cured' of their behaviour.[28]

During therapy itself, treatment providers are continually exposed to horrific accounts of abuse and sexually explicit material. On this point, Abel has noted how:

> One cannot ignore the very personal impact of working day in and day out with rapists and potential rapists. The recounting and exploring of the details of such violent fantasies and atrocious acts in effect serve to surround the therapist in an emotional world of violence on top of violence'.[29]

[24] D Guy and GP Liaboe, 'The Impact of Conducting Psychotherapy on Psychotherapists' Interpersonal Functioning', (1986) 17 Professional Psychology: Research and Practice 111.
[25] BA Farber, 'Dysfunctional Aspects of the Psychotherapeutic role'. in BA Farber (ed) *Stress and Burnout in the Human Service Professions* (Pergamon Press, Oxford 1983).
[26] Ellerby (n 6) 55.
[27] AC Salter, *Treating Child Sex Offenders and Victims: A Practical Guide* (Sage, London 1988).
[28] Ellerby (n 6) 53.
[29] Abel (n 7) 249.

Although all offenders involved in the SOTP must agree to participate in the programme, many still have the characteristics of those involved in coerced treatment, including anger, hostility towards staff, and a lack of motivation to change. Thus, the therapist must accept the possibility of an offender reoffending. Although the rate of reconviction for sex offenders has been found to be low,[30] it has been suggested that the use of police and court data is an inadequate means of estimating the true level of reoffending.[31] As there is no ultimate 'cure' for sexually offensive behaviour, drawing any definitive conclusions about recovery, or future risk, is almost impossible, making it difficult for sex offender therapists to measure the 'success' of their work.[32]

Various organisational stressors have also been identified as affecting sex offender therapists. In their study of occupational stress among sex offender treatment managers, Brown and Blount described a number of administratively based sources of stress, including lack of clear policy guidelines and members of the treatment team failing to 'pull their weight'.[33] Interestingly, they identified three distinct types of stressor affecting SOTP treatment managers: those intrinsic to the role, for example tutors resisting supervision; dealing with people outside of the immediate management team, such as the governor; and personal stressors, such as concerns regarding personal safety. The authors were then able to link the number of years spent working as a treatment manager with a particular set of stressors, illustrating how experience does seemingly play a part in the content of stress reactions. Managers with the least experience were more concerned with personal stressors, whilst those

[30] C Friendship and D Thornton, 'Sexual Reconviction for Sexual Offenders Discharged from Prison in England and Wales' (2001) 41 British Journal of Criminology 285; R Hood and S Shute *et al*, 'Sex Offenders Emerging from Long-Term Imprisonment' (2002) 42 British Journal of Criminology 371.
[31] Friendship and Thornton (n 30) 285.
[32] Ellerby (n 6) 54.
[33] J Brown and C Blount, 'Occupational Stress among Sex Offender Treatment Managers' (1999) 14 Journal of Managerial Psychology 108.

with between two and five years experience found stressors intrinsic to the role most difficult to cope with. Treatment managers who had been working in the job for five to six years found organisational issues to be the most stressful, including making policy decisions and dealing with outside agencies.[34]

Inadequate support provision and a lack of training have also been highlighted as areas affecting those providing treatment to sexual offenders. The issue of support for staff delivering the UK SOTP was first highlighted in the mid 1990s by Sheridan,[35] only a few years after the programme was launched. Moreover, the lack of support for sex offender treatment on the part of prison staff outside of the SOTP was noted by a number of participants in the empirical study of this thesis.[36] This lack of support for the programme has been attributed by other writers to differing reasons, including the fact that tutors involved in the programme are perceived by other staff as not doing 'real work' (i.e. not doing their fair share of the tasks necessary to run a wing) and because of a lack of confidence in the worth of sex offender treatment.[37]

In terms of training, many of those working in the field have been critical. This is despite the fact that staff training has been described as 'critically related to the successful implementation of a therapeutic programme'.[38] In their US study of 98 incest treatment providers, Plyer, Woolley and Anderson found that 72 per cent of respondents reported that their employer offered no tuition for work with perpetrators, and 85 per cent admitted that no

[34] *Ibid.* 117.
[35] M Sheridan, 'The Training and Support Needs of Staff Involved in the Sex Offender Treatment Programme' (1994) 94 Prison Service Journal 20.
[36] See chapter 8 of this thesis.
[37] Sheridan (n35) 21.
[38] TE Hogue, 'Training Multi-Disciplinary Teams to Work with Sex Offenders' (1995) 1 Psychology Crime and Law 227, 228.

specific training had been required of them before commencing treatment with incest offenders.[39] For facilitators working on the UK SOTP, training has taken a more structured approach.[40] After an initial competency based assessment, potential tutors must complete the national training course, lasting two-weeks, which covers the key skills required to deliver treatment.[41] However, during the early stages of the programme, both the content and delivery methods of the course were criticised. Whilst Waite[42] questioned the scant consideration of sex offending theories and group-work dynamics, Sheridan noted that those with no prior experience would be at a distinct disadvantage as a result of being trained with individuals who already possessed knowledge and skills in the field.[43] Of course, the true impact of working with sex offenders cannot be fully appreciated via a simulated training exercise that emphasises the importance of technical skill.[44] As explained by one interviewee in Jackson *et al*'s study, 'no person should enter this field without close supervision and treatment for their own issues. One college course will not prepare a person for this. Certification should be required and come at the end of much on-the-job training'.[45] It should be noted, however, that training provision for SOTP facilitators has evolved significantly since the publication of Waite and Sheridan's early papers. Moreover, the Offending Behaviour Programme Unit has been quick to point out that, after completing the initial two-

[39] A Plyer, CS Woolley and T Anderson, 'Current Treatment Providers', in AL Horton, BL Johnson, LM Roundy and D Williams (eds) *The Incest Perpetrator – A Family Member No One Wants to Treat* (Sage, London 1990).
[40] For a full account of the training provided to SOTP facilitators by the Prison Service, see chapter 3.
[41] A Beech and R Mann, 'Recent Developments in the Assessment and Treatment of Sexual Offenders', in J McGuire (ed) *Offender Rehabilitation and Treatment: Effective Programmes and Policies to Reduce Reoffending* (John Wiley & Sons, London 2002).
[42] I Waite, 'Tutor Training for the Sex Offender Treatment Programme – A Course for Concern?' (1994) 94 Prison Service Journal 23.
[43] Sheridan (n 35) 20.
[44] Clarke (n 3) 11-12.
[45] KE Jackson *et al*, 'Working with Sex Offenders: The Impact on Practitioners', in S Bird Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997) 69.

week training course, facilitators are provided with a number of further training opportunities, as well as 'on the job' training from supervisors and treatment managers.[46]

Therefore various stressors – both client-based and organisational – have been identified as affecting those who work with sex offenders. However, less is known about the symptoms experienced by therapists. This is because research has tended to focus on the stressors themselves rather than their tangible effects.[47] In one of the few studies that has emerged, Farrenkoph found that over half of his sample of 28 sex offender therapists reported becoming more cynical, and over 40 per cent had experienced a 'hardening or dulling of emotions'.[48] Participants suggested that they had become more confrontational and emotionally distant from family and friends although, conversely, another 17 per cent reported being more sensitive towards others and feeling increased empathy for human suffering.[49] Farrenkoph's results have been replicated in a more recent US study by Bird Edmunds who found that almost 30 per cent of a sample of 276 sexual abuse treatment professionals reported an overall increase in symptoms associated with burnout since taking up work with sex offenders.[50] Of this 30 per cent, at least one-third had experienced feelings of fatigue and frustration, sleep disturbances and general irritability, with a further quarter saying that they had experienced depression and difficulties in decision-making. Symptoms related to burnout were found to be particularly pronounced in those respondents who said that they had been a victim of sexual abuse. The author therefore tentatively suggests that clinicians with a history of sexual victimisation may be at a higher risk of experiencing the negative effects of burnout than

[46] Statement by Ruth Mann (personal email correspondence 5 August 2005).
[47] Ellerby (n 6) 55.
[48] T Farrenkoph, 'What Happens to Therapists Who Work with Sex Offenders?' (1992) 18 Journal of Offender Rehabilitation 217, 219.
[49] *Ibid.*
[50] S Bird Edmunds, 'The Personal Impact of Working with Sex Offenders', in S Bird Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997).

others.[51] Changes in sexual behaviour have also been documented, with most studies illustrating a decrease in sexual activity, and a more considerate approach to the sexual needs of partners after becoming involved in the field.[52] This said, more extreme effects have been reported. For example, in his UK survey of social workers involved in the treatment of sexual offenders, Garrison noted statements such as 'I feel sexually numb – neutral', and 'sex is a nightmare', as typical comments from respondents.[53] Likewise, 51 per cent of the 98 treatment professionals participating in the study conducted by Jackson *et al*[54] found the details of certain offending behaviour sexually arousing, and 41 per cent had experienced sexual fantasies about clients.[55]

So called 'boundary' or safety issues have been identified as another impact of sex offender work. Almost one-third of therapists in Farrenkoph's study felt that, since working in the field, they were more suspicious of others and concerned for personal safety.[56] This is perhaps not surprising given that over 50 per cent of the 98 sex offender workers in the study of Jackson *et al* had been either physically assaulted or verbally abused by a client, and many feared retributive attacks from those they treated.[57] Such results have been replicated in studies of other criminal justice professionals. For example, O'Beirne, Denney and Gabe showed that a total of 71 per cent of UK probation officers experienced fear at work, with this figure rising to 87 per cent when taking into account work with sex offenders.[58] In terms of

[51] *Ibid.* 23.
[52] See Farrenkoph (n 48), Bird Edmunds (n 50), Ellerby (n 6) and Jackson *et al* (n 45).
[53] K Garrison, *Working with Sex Offenders: A Practical Guide* (Social Work Monographs, Norwich 1992) 24.
[54] Jackson *et al* (n 45) 65.
[55] See KS Pope and BG Tabachnick, 'Therapists' Anger, Hate, Fear and Sexual Feelings: National Survey of Therapist Responses, Client Characteristics, Critical Events, Formal Complaints, and Training' (1993) 24 Professional Psychology: Research and Practice 142, for a fuller account of therapist sexual attraction to clients.
[56] Farrenkoph (n 48) 219.
[57] See Jackson *et al* (n 45) 66.
[58] M O'Beirne, D Denney, and J Gabe, 'Fear of Violence as an Indicator of Risk in Probation Work' (2004) 44 British Journal of Criminology 113.

sex offender therapists, however, a distinction has been drawn between the reactions of female and male therapists. While female clinicians have been shown to express a heightened sense of vulnerability - especially in personal relationships[59] - male therapists have reported feelings of a 'collective guilt' over the crimes committed by those receiving treatment.[60] For some therapists, such feelings have subsequently affected their interactions with children through fear of acting inappropriately. As explained by one American sex offender therapist, 'I was very uncomfortable holding my infant niece, and I flat out refused to have anything to do with bathing or diapering'.[61] Fifty-seven per cent of the participants in the study of Jackson reported experiencing heightened anxiety for the safety of their own children or grandchildren, and 65 per cent felt they had become more vigilant around strangers.[62]

Therefore, in conclusion, a number of stressors have been identified as affecting the work of sex offender therapists. Nevertheless, the importance of good practice upon the success of a treatment programme is clear. This was particularly evident in Stephenson's evaluation of eight community-based sex offender programmes delivered across four districts of Pacific-region Canada.[63] The evaluation addressed three components of the programmes, namely: administration of treatment; treatment content, delivery and outcome; and the quality of service provided by therapists to the Parole Board in terms of comprehensive record keeping, and prompt, detailed report writing. Only one district ('District 1') effectively met the majority of the author's evaluation criteria. This district was found to be more successful in terms of administering pre-treatment assessment, and implementing treatment plans.

[59] Ellerby (n 6) 56.
[60] Farrenkoph (n 48) 220.
[61] Freeman Longo (n 15) 6.
[62] Jackson *et al* (n 45) 66.
[63] M Stephenson, 'A Summary of the Community Sex Offender Program in the Pacific Region' (1991) 3 Forum Correct Res <http://www.csc-scc.gc.ca/text/pblct/forum/e034/034g_e.pdf> accessed 10 December 2009.

Offenders expressed respect for therapists, whereas the author reported significant disruption during treatment in the remaining districts.[64] There were also differences in recidivism rates: whilst District 1 offenders returned a recidivism rate of 4%, average rates of 12, 10 and 13 per cent were reported for offenders from District 2, 3 and 4 respectively.[65] What Stephenson's study therefore helps to demonstrate is the fact that well organised programmes, which employ confident, trained staff, tend to be more successful. However, for sex offender therapy to continue to progress in the way that it has over the past decade, we need to obtain a better understanding of how and why role-related stressors affect certain treatment providers and not others. This is something that has recently been explored by Clarke, who concluded that the negative impact of sex offender work was mostly a product of individual difference in facilitators.[66]

2. Burnout

The term 'burnout' was first used in the academic literature during the 1970s by Freudenberger, who described the condition as meaning 'to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources'.[67] Since this so-called 'pioneer' stage.[68] various definitions have emerged, ranging from the simplistic to the more descriptive. Whilst some writers have adhered to the traditional notion of burnout representing an imbalance between the demands placed on an individual and his ability to

[64] *Ibid.* 8.
[65] *Ibid.* 9.
[66] Clarke (n 3) 248.
[67] HJ Freudenberger, 'Staff Burn-Out' (1974) 30 Journal of Social Issues 159, 159.
[68] The development of the burnout concept has been described as occurring across the course of two distinct phases: first, in the mid 1970s, the pioneer stage; and second, the empirical stage. See C Maslach and WB Schaufeli, 'Historical and Conceptual Development of Burnout', in WB Schaufeli, C Maslach, and T Marek (eds) *Professional Burnout: Recent Developments in Theory and Research* (Taylor & Francis Ltd, London 1993).

cope,[69] others have included more descriptive factors. For example, in her definition of burnout, Cherniss includes a loss of concern for clients and a lull in motivation.[70] Moreover, burnout is now frequently referred to as a transactional process, rather than a static condition.[71] As a result, a very broad understanding of burnout has evolved, although there is still 'no clear definition…that is accepted as standard'.[72] This in itself has been widely criticised, and it has been argued that 'if burnout means everything, then it means nothing at all'.[73] Despite this, certain themes have been recognised. Maslach, for instance, has identified three key similarities among most descriptions:[74] first, it is generally agreed that burnout occurs at an individual level;[75] second, burnout is considered as an 'internal psychological experience'; and third, it is usually described in negative terms. These factors fulfil the terms of Maslach's own 'three-pronged' definition of burnout, namely when the individual experiences feelings of emotional exhaustion, depersonalisation, and reduced personal accomplishment.[76]

Most empirical research has focused on job-related stressors as a source of burnout, such as role ambiguity and role conflict.[77] Um and Harrison found that role conflict in particular intensified levels of job dissatisfaction and burnout, although social support acted as an

[69] See for example Freudenberger (n 67) and M Erooga, 'Where the Professional Meets the Personal', in T Morrison, M Erooga and RC Beckett (eds) *Sexual Offending Against Children* (Routledge, Lorna 1994)
[70] C Cherniss, *Staff Burnout: Job Stress in the Human Services* (Sage, London 1980).
[71] *Ibid.* 17
[72] C Maslach, 'Understanding Burnout – Definitional Issues in Analyzing a Complex Phenomenon', in W Pain (ed) *Job Stress and Burnout: Research, Theory and Intervention Perspectives* (Sage, London 1982) 34.
[73] *Ibid.*
[74] *Ibid.* 31.
[75] Although see Cherniss (n 70, 121) for a discussion of the impact of burnout in staff groups. She argues that groups of 'burnt-out' staff can lead to subcultures that are antagonistic towards employer goals, and who can also assist in socialising new staff into such value systems even before they have experienced job stress.
[76] C Maslach and WB Schaufeli, 'Historical and Conceptual Development of Burnout', in WB Schaufeli, C Maslach, and T Marek (eds) *Professional Burnout: Recent Developments in Theory and Research* (Taylor & Francis Ltd, London 1993).
[77] P Kennedy, 'Burnout-Out: Can We Risk Ignoring It?' (1993) 1 Journal of Nursing Management 185.

intervening and moderating factor.[78] More recently, other factors have been examined in relation to the burnout concept, such as demographic variables, personality factors, health, and family situation. In relation to personality, Cherniss identified five specific traits that are considered to heighten a person's response to burnout,[79] namely: neurotically anxious individuals; 'Type A' personalities;[80] locus of control factors;[81] excessively flexible individuals; and introverted personalities. In attempting to incorporate individual differences into a theoretical explanation of burnout, Cox and Ferguson argue that the onset of psychological strain is very much dependent upon the individual's perception of the demands in question, and his or her ability to cope with such demands.[82] The most recent trend, however, has leaned towards the development of multidimensional models of burnout. In his 'interactionist' explanation, Meier attempts to combine both individual and organisational factors to form a truly integrated perspective.[83] Similarly, Carroll and White have explained burnout in terms of 'the dynamic interaction of personal variables…and environmental variables…which also includes the influence of other ecosystems (for instance, the family)…'.[84]

The so-called 'helping' professions have frequently been associated with burnout, for example nursing[85] and social work.[86] Such client-centred work has been said to be

[78] MY Um and F Harrison, 'Role Stressors, Burnout, Mediators and Job Satisfaction: A Stress-Strain-Outcome Model and Empirical Test' (1998) 22 Social Work Research 141.
[79] Cherniss (n 70) 127.
[80] Individuals who exhibit characteristics of drive and competitiveness, and thrive on a high-pressure lifestyle. See M Friedman and RH Rosenman, *Type A Behavior and Your Heart* (Knopf, New York 1974).
[81] This refers to individuals who believe that they have no control over their destiny, and have therefore been said to be more likely to breakdown in a stressful situation.
[82] T Cox and E Ferguson, 'Individual Differences, Stress and Coping', in CL Copper and R Payne (eds) *Personality and Stress: Individual Differences in the Stress Process* (John Wiley & Sons, Chichester 1991).
[83] S Meier, 'Towards a Theory of Burnout' (1983) 36 Human Relations 899.
[84] JFX Carroll and WL White, 'Theory Building – Integrating Individual and Environmental Factors Within an Ecological Framework', in W Pain (ed) *Job Stress and Burnout: Research, Theory and Intervention Perspectives* Sage, London 1982) 42.
[85] J Carson, 'Self-Esteem and Stress in Mental Health Nurses' (1997) 93 Nursing Times 55.

emotionally draining, as the empathy and caring allied with the philosophy of most such professions requires the expenditure of significant psychological energy.[87] Generally clients are, by definition, 'people with problems';[88] therefore involvement in the therapeutic process requires the treatment provider to view the client in negative terms from the outset of the relationship. This is said to be compounded by the fact that people who work within the helping professions often display certain personality traits that make them more prone to the effects of burnout, for example, being sensitive towards others and being humanitarian.[89] Likewise, Rushton has suggested that people who are susceptible to depression are naturally drawn to careers in counselling and social work, hoping to solve their own emotional problems by helping others.[90]

In addition to the above, the very nature of the client-therapist relationship itself has been noted as problematic. From the outset, the relationship is unequal in that the therapist gives and the client receives. Although it has been argued that this can have its advantages in terms of limiting emotional involvement between staff and clients, it can also make the relationship more stressful.[91] The burden for treatment success (and failure) lies firmly with the therapist, which may be difficult if the patient becomes overly dependent,[92] or if there is a clash of personalities.[93] Maslach also contends that certain sociological factors have contributed to the stressful nature of those working in a 'helping' role. She argues that, while originally based in the community, many welfare-based services (for example social services) became

[86] C Lloyd, R King and L Chenoweth, 'Social Work, Stress and Burnout: A Review' (2002) 11 Journal of Mental Health 255.
[87] N Ratliff, 'Stress and Burnout in the Helping Professions' (1988) 69 Social Casework 147.
[88] C Maslach, 'The Client Role in Staff Burn-Out' (1978) 34 Journal of Social Issues 111, 114.
[89] Ratliff (n 87) 149.
[90] A Rushton, 'Stress Among Social Workers', in R Payne and J Firth-Cozens (eds) *Stress in Health Professionals* (John Wiley and Sons, Chichester 1987).
[91] Maslach (n 88) 119.
[92] *Ibid.* 119.
[93] *Ibid.* 115.

professionalised, bureaucratic, centralised and isolated following the Second World War. Government interference in such matters increased, and clients generally became more 'needy' following the establishment of the welfare state. Moreover, the gradual disintegration of those institutions forming the fabric of society resulted in a greater number of social problems being passed to professionals rather than being dealt with by friends, family, neighbours, and the community in general.[94] All this has contributed to what Wainwright calls the 'therapeutic state' in which the solution to most social problems is usually medical or therapy-based.[95]

The onset of burnout has been characterised by a variety of both physiological and psychological symptoms, including sleep disturbance, exhaustion, demotivation, anxiety, low mood, and difficulty in concentrating.[96] In client-orientated work, Cherniss has also noted how stress may result in staff blaming clients for their own problems, adopting more modest goals, and losing the sense of idealism that they initially brought with them to the job.[97] Such symptoms are said to affect performance in terms of employee arriving late at work and leaving early, 'clock-watching', taking extended breaks, and absenteeism.[98] In 2002 – 2003 it was estimated that Prison Service staff took 668,337 days sick leave, equating to 14.7 days per employee.[99] This compares badly to the rest of the public sector, and cost the taxpayer approximately 80 million pounds in the year 2002 to 2003.[100]

[94] Maslach and Schaufeli (n 76) 3.
[95] Wainwright and Calnan (n 9)158.
[96] Erooga (n 69) 204.
[97] C Cherniss, *Beyond Burnout – Helping Teachers, Nurses, Therapists and Lawyers Recover from Stress and Disillusionment* (Routledge, London 1995).
[98] Ratliff (n 87) 147.
[99] Public Accounts Committee, 'The Management of Sickness Absence in the Prison Service' HC (2003 – 2004) 146.
[100] *Ibid.* 3.

The burnout concept has frequently been linked to work with sex offenders and has become 'the predominant focus for researchers in the field'.[101] This is evidenced by its regular use in the relevant literature, and the widespread employment of the Maslach Burnout Inventory as a psychometric tool to assess the impact of the work upon treatment providers.[102] Indeed, when describing therapists' experiences in the USA, Ryan and Lane contend that burnout is now accepted as an inevitable consequence of working with sex offenders.[103] The reasons behind this conclusion have, amongst other things, been put down to the risk posed by offenders upon release, the traumatic content of offence accounts, and the threat to the personal safety of therapists.[104] In their US study of 70 individuals classified as working with sex offenders (including clinicians, jurists, frontline caseworkers and their supervisors), Thorpe *et al*[105] found an inverse relationship between the negative emotional impact of sex offender work and effective professional performance. Caseworkers reported significantly higher levels of emotional distress than lawyers and judges, although positive coping strategies – such as establishing social support in the workplace, and being aware of personal strengths and weaknesses – were associated with a less damaging impact. In a very different American study, Shelby *et al* compared levels of burnout between sex offender treatment providers, mental health workers and social workers using the Maslach Burnout Inventory. Compared with mental health staff, sex offender workers had higher levels of emotional exhaustion and feelings of depersonalisation. However, they also returned higher scores on the personal accomplishment scale.[106] In relation to social workers, levels of negative symptoms were

[101] Clarke (n 3) 35.
[102] *Ibid.*
[103] Ryan and Lane (n 1) 411.
[104] RA Shelby, RM Stoddart and KL Taylor, 'Factors Contributing to Levels of Burnout Among Sex Offender Treatment Providers' (2001) 16 Journal of Interpersonal Violence 1205.
[105] GL Thorpe, S Righthand and EK Kubik, 'Brief Report: Dimensions of Burnout in Professionals Working with Sex Offenders' (2001) 13 Sexual Abuse: A Journal of Research and Treatment 197.
[106] Shelby, Stoddart and Taylor (n 104) 1210.

similar between the two groups,[107] although sex offender therapists continued to demonstrate higher scores on the personal accomplishment scale. Additionally, the authors recorded higher levels of emotional exhaustion and depersonalisation for those therapists working in prison or in-patient services in comparison to out-patient settings, highlighting the difficulties associated with this type of treatment provision. This finding has been replicated by Farber in the USA who suggested that institutionally based therapists were more vulnerable to burnout due to various factors, including heavy caseload, lack of control, administrative issues, and conflicting relationships with those who hold medical degrees and those who do not.[108]

3. Countertransference

Derived from the psychoanalytic literature, countertransference has traditionally been defined as the activation of unresolved psychological conflicts within the therapist as a result of contact with patient material.[109] As described by Freudenberger and Robbins '[during therapy], the therapist's old scars and injuries are constantly rubbed anew'.[110] The concept of countertransference originated with the work of Freud who, in 1910, stated that 'we have begun to consider the "counter-transference", which arises in the physician as a result of the patient's influence on his unconscious feelings…'.[111] Freud did not regard countertransference as a useful tool in psychoanalysis, and recommended that therapists be independently analysed every five years to air any emotions that could potentially interfere

[107] This was attributed to the fact that both sex offender treatment providers and social service workers deal with 'resistant' clients, suggesting that client characteristics do contribute to levels of burnout.
[108] BA Farber, 'Burnout in Psychotherapists: Incidence, Types, and Trends' (1990) 8 Psychotherapy in Private Practice 35.
[109] J Sander, C Dare and A Holder, *The Patient and the Analyst* (2nd edn, Karnac Books, London 1992).
[110] H Freudenberger and A Robbins, 'The Hazard of Being a Psychoanalyst' (1979) 66 Psychoanalytic Review 275, 287.
[111] S Freud, 'The Future Prospects of Psychoanalytic Therapy', in E. Jones (ed) *Collected Papers - Volume II - by Sigmund Freud: Papers on Technique* (Hogarth Press and the Institute of Psycho-Analysis, London 1924).

with the therapeutic process.[112] However, this perspective has since been regarded as somewhat narrow, and from the 1950s onwards a much broader (or *totalistic*)[113] approach has been advanced by more contemporary writers. Heimann, for example, defined countertransference as the total emotional response experienced by the therapist in relation to the client - whether good or bad - which is essential to understanding the patient's unconscious.[114] Likewise, Reich has pointed out that 'countertransference is a necessary prerequisite of analysis'.[115] Thus, today, a much wider understanding of countertransference has been accepted. Rather than having a potentially damaging effect on therapy, professionals now generally associate countertransference with the evocation of *any* feelings within the therapist resulting from contact with patient material. This is not to suggest, however, that countertransference reactions are always advantageous. Indeed, it has been noted that the therapist must monitor their responses to ensure emotions experienced as a result of the therapeutic process do not interfere with patient progress.[116]

The notion of countertransference can be extended beyond the realm of psychoanalysis to most therapist-patient relationships.[117] Within the victimisation literature, commentary on countertransference has most often focused on the negative outcomes that may arise from working with traumatic material. As a result, a number of negative effects have been linked with the phenomenon, including the materialisation of disturbing feelings and behaviours,

[112] Sander, Dare and Holder (n 109) 84.
[113] GO Gabbard, 'A Contemporary Psychoanalytic Model of Countertransference' (2001) 57 Journal of Clinical Psychology 983.
[114] P Heimann, 'On Countertransference' (1950) 31 International Journal of Psychoanalysis 81.
[115] A Reich, 'On Countertransference' (1951) 32 International Journal of Psychoanalysis 25.
[116] JC Norcross, 'Introduction: In Search of the Meaning and Utility of Countertransference' (2001) 57 Journal of Clinical Psychology 981.
[117] Sander, Dare and Holder (n 109) 97.

such as grief and shame.[118] In sex offender therapists other reactions have been identified, ranging from inappropriate hostility, to resistance and under-involvement in the therapeutic process.[119] In their assessment of countertransference issues in the treatment of incest families in the USA, McElroy and McElroy suggest that the therapist may encounter feelings of extreme anger, hate, and a wish to punish the offender.[120] Conversely, a sudden improvement in the offender's state (perhaps self-induced in an attempt to be reunited with his family) may lead both the offender and therapist to minimise the damaging effects of the incest, and ultimately result in the provision of substandard treatment.[121] This issue has also been noted by Herman who argues that, with inadequate training, male therapists may identify with the perpetrator of abuse, rationalising his behaviour, and questioning the actions of the victim.[122] On the other hand, female therapists more frequently identify with the victim of abuse, which can sometimes lead to a recounting of incestuous acts present in their own childhood.[123] Resolution of such issues has been acknowledged as being essential for effective work with sex offenders.[124] Likewise, the importance of team working has been identified as a means of minimising the effects of negative countertransferences.[125]

[118] A Ellis, 'Rational and Irrational Aspects of Countertransference' (2001) 57 Journal of Clinical Psychology 999.
[119] W Scott, 'Group Therapy for Male Sex Offenders: Strategic Interventions' (1994) 5 Journal of Family Psychotherapy 1.
[120] LP McElroy and RA McElroy, 'Countertransference Issues in the Treatment of Incest Families' (1991) 28 Psychotherapy: Theory Research Practice and Training 48.
[121] *Ibid*. 48
[122] JL Herman, *Father-Daughter Incest* (Harvard University Press, London 1981).
[123] *Ibid*. 182 – 183.
[124] DM Peaslee, 'Countertransference with Specific Client Populations? A Comment on the "Treatment of Male Sexual Offenders"' (1995) 4 Journal of Child Sex Abuse 111.
[125] *Ibid*. 113.

4. Vicarious Traumatisation

The idea of vicarious traumatisation (VT) was originally expounded by Mcann and Pearlman[126] as an alternative to the various concepts that had previously been used to explain the effects of working with survivors of sexual abuse. Working with victims of trauma, they found, could potentially lead to negative psychological effects caused by disruptions in the cognitive schemas[127] and memory systems of the therapist. This has been supported by later writers, and VT is now regarded as a cumulative process 'through which the therapists' inner experience is negatively transformed through empathic engagement with the clients' trauma material'.[128] Accordingly, it has been argued that VT can lead to changes in the therapist's self-identity, cynicism in their view of the world, depression, anxiety and disillusionment.[129] Indeed, the symptoms experienced by VT sufferers have been likened to those associated with Post-traumatic Stress Disorder (PTSD),[130] albeit sometimes at a lower intensity.[131]

Certain ideological issues have, however, inhibited the development of the VT concept. Some have questioned whether the psychological literature needs a new construct to describe the symptoms arising from trauma work, while others have suggested that the evidence base

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[126] L McCann and LA Pearlman, 'Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims' (1990) 3 Journal of Traumatic Stress 131.

[127] Namely the cognitive frameworks that support the individual's beliefs, expectations and assumptions about the world. Janoff-Bulman has argued that 'victimising' life events can challenge an individual's beliefs about: personal vulnerability; viewing oneself in a positive light; and the world being a meaningful and orderly place. See R Janoff-Bulman, 'The Aftermath of Victimization: Rebuilding Shattered Assumptions' in CR Figley (ed) *Trauma and its Wake: The Study of Treatment of Post-Traumatic Stress Disorder* (Brunner/Mazel, New York 1985).

[128] LA Pearlman and KW Saakvitne, *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors* (W.W. Norton, London 1995) 279.

[129] DT Blair and VA Ramones, 'Understanding Vicarious Traumatization' (1996) 34 Journal of Psychosocial Nursing and Mental Health Services 24.

[130] *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, American Psychiatric Association, Washington DC 1994).

[131] Therefore it has been argued that vicarious traumatization should not be included in the general definition of PTSD. See D Lerias and MK Byrne, 'Vicarious Truamatization: Symptoms and Predictors' (2003) 19 Stress and Health 129.

to support the prevalence, or even the existence of VT is 'modest, to say the least'.[132] This has been primarily due to the lack of a standard definition of VT, and other methodological difficulties. Nonetheless, certain assumptions have been made regarding the difference between VT and other stress related conditions such as burnout and countertransference – particularly in relation to its theoretical roots. In their original account of VT, McCann and Pearlman explain the concept in terms of constructivist self-development theory.[133] They suggest that, across the life span, human beings construct their own personal realities through the development of cognitive schemas. Aligned with these schemas, the authors identify seven fundamental psychological needs, namely: safety; dependency/trust; power; esteem; intimacy; independence; and frame of reference. Trauma can disrupt an individual's schemas, resulting in a change in the way in which they make sense of their experiences. How trauma is encountered will depend upon which psychological needs are salient to the individual. So, for example:

> Images involving a loss of safety, including threats or harm to innocent people, may challenge the therapist's schemas within the area of safety. This will be particularly disruptive if the helper has strong needs for security.[134]

VT has been linked with various therapeutic and non therapeutic roles, including domestic violence counselling[135] and lawyers working in the field of criminal law.[136] In their review of the literature, Lerias and Byrne identify a number of factors deemed to be predictive of

[132] R Sabin-Farrell G Turpin, 'Vicarious Traumatization: Implications for the Mental Health of Health Workers?' (2003) 23 Clinical Psychology Review 449.
[133] McCann and Pearlman (n 126).
[134] *Ibid.* 138.
[135] G Iliffe and LG Steed, 'Exploring Counselor's Experience of Working with Perpetrators and Survivors of Domestic Violence' (2000) 15 Journal of Interpersonal Violence 393.
[136] LP Vrklevski and J Franklin, 'Vicarious Trauma: The Impact on Solicitors of Exposure to Traumatic Material' (2008) 14 Traumatology: An International Journal 106.

vicarious trauma, namely a history of previous trauma, life stress and mental health state, social support, age, gender, education, socio-economic status, and coping style.[137] The authors note, however, that not all therapists working with trauma survivors will necessarily suffer from the effects of VT, and 'an integration of a variety of variables is required to better explain why some people become traumatised and others, under the same conditions, do not'.[138] This links to Clarke's discussion about the dangers of labelling particular professions as inherently stressful:

> …to conceptualise a particular job or organisation as stressful of itself is erroneous and misleading. Regarding stress as an inevitable part of a job negatively structures worker's expectations regarding potential emotional reactivity, and denies the individual the opportunity to take responsibility.[139]

Most relevant to present thesis is the correlation between VT and therapeutic work with sexual offenders. Perhaps unsurprisingly, the condition has been identified in therapists working with sexual offenders as a result of their exposure to the graphic offence details described by perpetrators. In her exploratory study of US sexual abuse workers, Rich found that 62 per cent identified themselves as vicariously traumatised. Moreover, a higher proportion of this group – in comparison to non-VT respondents - reported experiencing flashbacks, bad dreams, and images of the traumatic material described by clients.[140] This said, the validity of Rich's results might be questioned on the basis that they rely entirely on self-diagnosis data, rather than independent clinical diagnosis.

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[137] Lerias and Byrne (n 131) 132 – 135.
[138] *Ibid*. 136.
[139] Clarke (n 3) 215.
[140] KD Rich, 'Vicarious Traumatisation: A Preliminary Study' in S Bird Edmunds (ed) *Impact: Working with sexual abusers* (Safer Society Press, Vermont 1997).

Most studies, however, have focused on the effects of working with sexual abuse survivors rather than perpetrators. For example, in their survey of 40 therapists working for the Sexual Assault Services of New South Wales, Australia, Johnson and Hunter[141] found that sexual assault counsellors experienced greater stress in their work than counsellors working in other areas of health.[142] Likewise, in the USA, Schauben and Frazier concluded that 'our data suggests that counsellors who work with a higher percentage of survivors report more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more "vicarious trauma" than counsellors who see fewer survivors'.[143] Respondents said that the most difficult aspects of working with survivors were related to therapy management, such as having clients terminate therapy prematurely, and establishing trust. Dealing with client emotions was also described as 'draining'.[144]

According to McCann and Pearlman, therapists can ameliorate the effects of VT by following a three-stage approach: acknowledging any discomfort they experience during therapy; understanding how their own schemas are disrupted; and finally, gaining access to the available sources of support within their professional network.[145] The authors state that 'just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatisation as a normal reaction to the stressful and sometimes traumatizing work with victims'.[146] However, it has to be said that, being a relatively new concept, there is still a shortage of data supporting the incidence of VT, and what studies there are often provide

[141] CNE Johnson and M Hunter, 'Vicarious Trauma in Counsellors Working in the New South Wales Sexual Assault Service: An Exploratory Study' (1997) 11 Work and Stress 319.
[142] However, the study can be criticised on the basis that it discusses vicarious trauma and burnout interchangeably, making it difficult to distinguish which concept the authors are attempting to measure.
[143] LJ Schauben and PA Frazier, 'Vicarious Trauma: The Effects on Female Counselors of Working with Sexual Violence Survivors' (1995) 19 Psychology of Women Quarterly 49, 61.
[144] *Ibid.* 57.
[145] McCann and Pearlman (n 126) 144 – 145.
[146] *Ibid.* 145.

inconclusive results. As argued by Clarke, this may be a result of 'insufficient consideration of individual differences in terms of susceptibility to the syndrome'.[147]

5. Secondary Traumatic Stress

In the late 1970s it was recognised that victims of particularly distressing events might need therapeutic support to remedy post-traumatic symptoms. Soon after came the realisation that those helping such individuals through the recovery process might also be secondarily affected by the primary trauma.[148] The idea of secondary traumatic stress (STS) was originally expounded by Figley in relation to professionals working with those who had suffered some form of trauma. He defined the concept as the 'natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person'.[149] Figley's work on STS evolved in relation to Post Traumatic Stress Disorder (PTSD), and the recognition that therapists were frequently known to exhibit similar symptoms to their PTSD clients.[150] Figley explained STS as a syndrome nearly identical to PTSD, except in terms of the original stressor: with PTSD arising from exposure to the original traumatic event, and STS from exposure to the traumatised person.[151] STS as an academic term has often been generically applied to encompass the various conceptualisations

[147] Clarke (n 3) 41.
[148] P Valent, 'Diagnosis and Treatment of Helper Stresses, Traumas, and Illnesses' in CR Figley (ed) *Treating Compassion Fatigue* (Brunner-Routledge, London 2002).
[149] CR Figley, 'Compassion Fatigue and Secondary Traumatic Stress Disorder: An overview' in CR Figley (ed) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatised* (Brunner/Mazel, New York 1995) 7.
[150] L Steed and J Bicknell, 'Trauma and the Therapist: The Experience of Therapists Working with the Perpetrators of Sexual Abuse' [2001] 1 Australasian Journal of Disaster and Trauma Studies (Electronic Journal) <http://www.massey.ac.uz/~trauma/isssues/2001-1/steed.htm> accessed 16 December 2009.
[151] Figley (n 149) 8.

that have emerged regarding the impact of therapeutic work upon professionals.[152] However, it has been distinguished from burnout in that it can emerge suddenly, and those suffering from STS have been said to have a faster recovery rate than individuals diagnosed with burnout.[153] The term 'compassion fatigue' has also been used as an alternative term for STS,[154] and was first used by Joinson in her discussion of burnout among nurses.[155]

A number of variables have been identified to explain why treatment professionals might be more vulnerable to STS. Figley noted four such factors: the use of empathy as a therapeutic tool; the fact that most trauma workers have experienced some form of traumatic event; the presence of any unresolved trauma in the therapist's life; and working specifically with traumatised children.[156] Various symptoms have also been associated with STS, including diminished concentration, irritability, withdrawal from social situations, and somatic reactions.[157] However, Valent has argued that many such symptoms are in fact contradictory; for example, apathy on the one hand, and arousal on the other.[158] In an attempt to catalogue this multitude of symptoms, Valent devised a framework that links specific biological, psychological and sociological reactions to one of eight survival strategies associated with STS, namely: rescue, attachment, assertiveness, fight, flight, competition, cooperation, and acceptance.[159] Valent contends that each survival strategy is characterised by either adaptive (positive) or maladaptive (negative) responses. So, for instance, the adaptive mode of the

[152] M Salston and R Figley, 'Secondary Traumatic Stress Effects of Working with Survivors of Criminal Victimisation' (2003) 16 Journal of Traumatic Stress 167.
[153] Figley (n 149) 16.
[154] BH Stamm, 'Work Related Secondary Traumatic Stress' (1997) 8 PTSD Research Quarterly 1.
[155] C Joinson, 'Coping with Compassion Fatigue' (1992) 22 Nursing 2009 116.
[156] *Ibid.* 16
[157] J Yassen, 'Preventing STSD' in CR Figley (ed) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatised* (Brunner/Mazel, New York 1995).
[158] P Valent, 'Survival Strategies: A Framework for Understanding Secondary Traumatic Stress and Coping in Helpers', in CR Figley (ed) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatised* (Brunner/Mazel, New York 1995).
[159] *Ibid.* 22.

rescue strategy invokes the emotions of care, devotion, and responsibility; whereas the maladaptive response involves the sufferer feeling depleted and anxious.[160] In terms of aiding professionals suffering from STS, Valent's theory helps to explain the variety of symptoms experienced, as well as contributing to the development of possible treatment approaches.

Although the available research has generally been useful in terms of exploring the origins, symptoms and effects of STS, research into the concept is still quite scarce – especially in relation to its prevalence in those providing treatment to sexual abusers. Possibly the only study focusing on STS and sex offender treatment providers was carried out by Steed and Bicknell in Australia.[161] They found that almost half of their sample of 67 clinicians were at a moderate or high risk of suffering from STS, with 97 per cent indicating a low level of work-satisfaction. Vulnerability to STS was linked to therapists who were new to the profession, and those who had between nine and 12 years' experience. It was concluded that working with sexual abusers had a negative impact upon therapists, and that the risk of suffering from STS appeared to arise once they started working in the field.[162]

Overall, however, the STS model requires much further development before it can be applied in any meaningful way. Indeed, given its somewhat vague definition, and the wide range of symptoms that STS currently encompasses, it is questionable whether the term can be honed to the extent where it will be useful to researchers studying the issue of work-related stress. It could also be argued that this particular field of research simply does not needs yet another label to describe the negative effects sometimes experienced by individuals working with sex offenders.

[160] *Ibid.* 31.
[161] Steed and Bicknell (n 150).
[162] *Ibid.*

6. Positive Effects

Given the significant stressors that have been associated with treating sexual offenders, it is questionable why so many therapists continue in the role. Although receiving less attention in the research literature, a variety of positive effects have been identified by therapists as stemming from sex offender work. According to Jackson *et al*, therapists feel a sense of 'mission' from their work, as well as experiencing a sense of gratification from witnessing positive change in clients, and thus vicariously aiding potential victims.[163] Likewise, other authors have identified high levels of personal accomplishment and job satisfaction in those working with sex offenders, in spite of the other deleterious effects associated with the job.[164] In their Canadian study, Kadambi and Truscott[165] highlighted seven key areas where sex offender therapists found reward from their work, namely: protection of potential victims; socially meaningful curiosity (i.e. a sense of being stimulated by the practical and academic nature of the work); enjoyment of counselling; professional benefits; relationship with colleagues; offender change and wellness; and offending specific change.[166] Of these, protection of the public was rated most highly in terms of perceived benefits of the role, followed by offender change and wellness;[167] although, overall '…the rewards associated with the perceived benefits their work has *for society* were consistently viewed as more important than rewards associated with *how offender clients were directly helped* by the treatment they provided' (emphasis added).[168] Kadambi and Truscott conclude that, to give a more balanced perspective of how sex offender work impacts upon treatment providers,

[163] Jackson *et al* (n 45) 69.
[164] See Shelby, Stoddart and Taylor (n 104) and RA Scheela, 'Sex Offender Treatment: Therapists' Experiences and Perceptions' (2001) 22 Issues in Mental Health Nursing 749.
[165] Kadambi and Truscott (n 2)
[166] *Ibid*. 49.
[167] *Ibid.*
[168] *Ibid.* 51.

continuing attention should be paid to the identified rewards.[169] Given the almost exclusive focus that has thus far been paid to the negative effects of working with sex offenders, this might, however, prove somewhat difficult.

Limited attempts have been made to explain the interaction between the stressors and rewards associated with treating sex offenders. Based on data gathered from interviews with 24 treatment providers, Farrenkoph's 'phases of impact' model describes the reaction to sex offender work as an ongoing and dynamic process that evolves over time.[170] Farrenkoph denotes *phase one* as the 'shock' stage, where feelings of fear and vulnerability are most evident. This is duly followed by *phase two*, where professional zeal and a desire to treat clients effectively takes over. Repressed emotions, feelings of anger, and a general confrontational attitude typify *phase three*, where offender denial and lack of empathy for the victim erode the therapist's sense of idealism. *Phase four* is essentially an extension of the previous stage, whereby mounting anger and intolerance lead to resentment. At this point in the survey, one-quarter of the respondents reported feeling 'burnt-out', and one-fifth had stopped working with sex offenders altogether.[171]

Thus, a relatively high proportion of therapists had experienced some negative symptoms as a result of their work. However, the vast majority continued in their role. To integrate this more frequent response into the phases of impact model, Farrenkoph proposed that 'therapists may regain their work motivation and therapeutic compassion' in *phase 4b*; namely the *adaptation* stage.[172] He hypothesised that by reducing expectations and adopting a more

[169] *Ibid.* 56.
[170] Farrenkoph (n 48) 220.
[171] *Ibid.* 221.
[172] *Ibid.*

detached attitude, clinicians could potentially moderate the negative impact of the role. Unfortunately, Farrenkoph did not explain why some sex offender therapists were able to reach this higher level of adaptation, and others were not, which would have useful in terms of identifying potential 'protective' factors. Moreover, when Scheela described Farrenkoph's model to her sample of US sex offender workers, all participants said that they could relate to parts of the process, but disagreed with the idea that it was 'linear' or 'necessarily progressive'.[173] Participants in Scheela's study more readily identified with the author's own 'remodelling process', which involves experiencing, at some point during their career: *falling apart*, after hearing stories of abuse, when there are treatment failures, and when faced with law suits; *taking on* the task of working with sex offenders, and gaining more knowledge and experience; *tearing out* old attitudes and values, and personal baggage; *rebuilding*, in terms of adopting new ways of working with sometimes difficult clients; *doing the upkeep*, by maintaining and increasing technical and theoretical knowledge; and finally *moving on* was reflected in the way staff were able to revise programmes to incorporate new knowledge and research.[174]

III. CONCLUSION

The growth in the provision of treatment for sexual offenders has brought with it a developing body of literature regarding the psychological impact of such work upon treatment providers. However, there is still a need for further investigation; not only because we still know so little about the effects of working with sexual abusers, but also because much of the work thus far conducted has been criticised in relation to its methodological rigour. Clarke has noted that most studies are descriptive in nature, lack a strong theoretical grounding, and neglect the

[173] Scheela (n 164) 760.
[174] *Ibid.* 761.

positive aspects of such work.[175] As has been seen in this review, almost all of the research done so far on the negative effects of working with sex offenders have conceptualised these effects within existing theoretical frameworks, taken from research examining the impact of trauma more generally.

To build upon Clarke's research, continuing study is required of how personality factors exacerbate or mitigate the negative effects that have been associated with sex offender work. Although it will always be difficult to prove a causal (rather than correlational) link between the two, this area of study remains an important one in terms of identifying the most prominent risk factors associated with the negative effects of treating sexual abusers. To strengthen the causal link between sex offender treatment provision and negative health effects, more research is also needed into the work/home interface and the impact of social environment and support. The pressures of daily life are rarely taken into account in studies of this type, let alone events such as divorce and bereavement, which would most likely have a significant effect on results gleaned from empirical research analysing the impact of working with sex offenders.

Another key area that has been entirely neglected is how sex offender typology might impact upon the well-being of treatment providers. Although most of the studies analysed in this review of the relevant literature provide a good description of the participants involved, very few, highlight how work with different types of sex offender may ultimately result in differential health outcomes. 'Sex offender' is a generic term and does nothing to explain the variations in social skill, patterns of deviant sexual arousal, and denial between, for example,

[175] See Clarke (n 3) 43 – 45.

a preferential paedophile with a long history of recidivism and a one-time incest offender. To understand how work with sex offenders impacts upon those who provide treatment, future research should seek to look at factors relevant to the offending population that requires treatment, in addition to the individual psychological background of treatment providers. This could be achieved with the aid of actuarial prediction tools which, by looking at factors such as offending history, allow therapists to predict the risk of an individual reoffending in the future.[176] The effects of treating different risk categories could then be compared. Alternately, other classificatory systems could be applied, such as theory-led classification, clinical classification, and statistical profiling.[177] There are, therefore, various avenues of investigation open to researchers.

Finally, there needs to be a greater focus on the positive effects of working with sex offenders. The current study aims to do this, although much more work is needed to get past the trend of the current research base; namely to focus almost exclusively on negative effects. Working with sexual offenders is undoubtedly a difficult job. However, the few studies that have asked therapists about the positive effects of working with these offenders have shown that there are also benefits; for example, experiencing a sense of job satisfaction from vicariously aiding victims.[178] Overall, more research is needed on the effects of working with sex offenders as a distinct group of individuals. Although the research presented in this thesis attempts to do this, more information is needed on four key areas, namely: the impact of individual personality factors of sex offender therapists; the impact of environmental

[176] A Beech and T Ward, 'The Integration of Etiology and Risk in Sexual Offenders: A Theoretical Framework' (2004) 10 Aggression and Violent Behaviour 31. For a fuller explanation of actuarial prediction tools, see page 14 of chapter 1.
[177] R Blackburn, *The Psychology of Criminal Conduct: Theory, Research and Practice* (Wiley, Chichester 1993).
[178] Kadambi and Truscott (n 2) 49.

influences, particularly the ‘personal’ life of the therapist; the type of sex offender treated; and the positive effects of sex offender work on treatment providers.

CHAPTER 3

TRAINING AND SUPPORT FOR SOTP FACILITATORS

I. INTRODUCTION

Over the past three decades a wealth of literature has been produced on the concept of social support. The provision of social support has been linked to a wide range of positive changes including decreased feelings of 'loss' in child sexual abuse survivors,[1] and more favourable prognoses in cancer sufferers.[2] However, one of the most popular strands of study has focused on the link between social support and stress, with many researchers proposing a decrease in stress levels where good social support is provided.[3] The findings of such research have gradually filtered down into the field of criminology, and have been found to be relevant to the challenges faced by those providing rehabilitative treatment to offenders in the criminal justice system. It has also been acknowledged that the provision of good quality training and support are factors which can improve the integrity of rehabilitative treatment programmes.[4]

From the outset of the SOTP, the Prison Service has endeavoured to provide a good level of both training and support to staff selected to deliver the programme. Individuals are required to pass a two-week training course designed to develop the skills necessary to deliver the

[1] M Murthi and DL Espelage, 'Childhood Sexual Abuse, Social Support, and Psychological Outcomes: A Loss Framework' (2005) 29 Child Abuse and Neglect 1215.
[2] B Garssen, 'Psychological Factors and Cancers Development: Evidence after 30 Years of Research' (2004) 24 Clinical Psychology Review 315.
[3] See section II of this chapter, '*The Importance of Support*', for a detailed account of the research literature.
[4] DJ Cooke and L Philip, 'To Treat or Not to Treat? An Empirical Perspective' in Clive Hollin (ed), *Handbook of Offender Assessment and Treatment* (John Wiley & Sons Ltd, Chichester 2000).

SOTP, which is supplemented by further training upon qualification. Indeed, I myself completed week one of the SOTP training course, and generally felt that the training provided was of a good quality. Once working on the programme, debriefing and supervision are provided by more experienced staff, and attendance at counselling (supplied by an external agency) is mandatory. This chapter will provide a brief outline of what the research literature has to say about the relationship between social support and the amelioration of stress. It will then go on to detail the training and support provided by the Prison Service to SOTP facilitators, and consider whether current arrangements are adequate to protect staff from the negative effects of working with sex offenders.

II. THE IMPORTANCE OF SUPPORT

It has been suggested that three key 'imperatives' lay behind the emergence of research into social support: the pragmatic imperative, to elucidate the relationship between social support and health; the theoretical imperative, to explain the social processes associated with human relationships; and the moral imperative to investigate 'the nature and limits of human goodness'.[5] Such diverse motivations for the study of social support have generated a mass of literature which has led to conceptual confusion.[6] For example, whilst early work on social support created an image 'of human beings and of friends as kindly and competent people who provide the culturally expected close personal relationships', contemporary authors have attempted to refine this idealistic definition, taking into consideration the dynamics of both providing and receiving social support, and also its negative aspects.[7] This has been termed

[5] BR Burleson *et al* 'Introduction' in BR Burleson, TL Albrecht and IG Sarason (eds), *Communication of Social Support: Messages, Interactions and Community* (Sage, London 1993).
[6] JE Hupcey, 'Clarifying the Social Support Theory-Research Linkage' (1998) 27 Journal of Advanced Nursing 1231.
[7] G Leatham and S Duck 'Conversations with Friends and the Dynamics of Social Support', in S Duck (ed) *Personal Relationships and Social Support*, (Sage, London 1990).

the 'communication' or 'interactional' approach, due to its focus on social support as a series of exchanges that frequently occur in enduring relationships.[8] With this in mind, social support has been defined as:

> …verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience.[9]

In terms of how social support can aid in the reduction of stress, two differing theories have been posed: the main effect and the 'buffering' effect of social support. With the main effect, support acts by either directly affecting well-being or changing the amount of stress or strain that an individual perceives.[10] Alternately, the buffering effect works via support being interjected at one of two specific points in the causal chain between a stressful event and the onset of illness or negative behaviour.[11] First, support may intervene between the stressful event itself and the stress reaction. Thus, the individual perceives that others will provide the necessary resources to deal with the stressor in question, which leads either to a redefining of the problem or boosts the individual's apparent ability to deal with the situation. Second, support may intervene between the stress reaction and the onset of illness or undesirable behaviour. In this case, support alleviates the impact of the stressor, or reduces the importance of the perceived problem by suppressing the body's reaction or facilitating healthy/positive behaviours.[12]

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[8] Burleson *et al* (n 5) xvii.
[9] TL Albrecht and MB Adelman 'Communicating Social Support: A Theoretical Perspective', in TL Albrecht and MB Adelman (eds) *Communicating Social Support* (Sage, London 1987).
[10] N McIntosh 'Identification and Investigation of Properties of Social Support', (1991) 12 Journal of Organisational Behaviour 201.
[11] S Cohen and TA Wills, 'Stress, Social Support and the Buffering Hypothesis' (1985) 98 Psychological Bulletin 310.
[12] *Ibid*. 312.

Amongst the various facets of social support that have been discussed in the literature, two key dimensions that have been consistently assessed are *type* and *source* of support. Regarding type, social support has been divided into emotional and instrumental support. Whilst emotional support has been characterised by 'the actions of caring or listening sympathetically to another',[13] instrumental support has been described as the provision of physical assistance or advice.[14]

Source of support, on the other hand, has often been split into the categories of work relationships and personal relationships. Both aspects have been empirically tested in terms of their ability to reduce the impact of stress. For example, in her investigation of 255 UK psychologists, Kahill found a significant negative correlation between burnout and support from friends and family members.[15] Likewise, Willmot found that friends were the most important source of support for his sample of British couples when talking over personal problems.[16] It has been suggested that the reason for this positive effect is that 'support from those to whom we are closest (friends and family whom we know at a psychological level)[17] helps because such persons are presumably in a better position to discriminate our distinctive needs and know the type of strategies that will and will not be effective with us'.[18]

[13] KJ Fenlason and TA Beehr, 'Social Support and Occupational Stress: Effects of Talking to Others' (1994) 15 Journal of Organisational Behaviour 157, 158.
[14] *Ibid.*
[15] S Kahill, 'Relationship of Burnout among Professional Psychologists to Professional Expectations and Social Support' (1986) 59 Psychological Reports 1043.
[16] P Willmott, *Friendship Networks and Social Support* (Policy Studies Institute, London 1987).
[17] In their early model of interpersonal communication, Miller and Steinberg suggest that relationships that have reached a psychological level are 'distinctly interpersonal'. Parties to the relationship can predict behaviour patterns. See GR Miller and M Steinburg, *Between people: A new analysis of interpersonal communication,* (Science Research Associates, Chicago 1975).
[18] Albrecht and Adelman (n 9) 36.

The study of work-based support and its impact upon health has generated a greater amount of empirical research. In one of the largest studies ever conducted in this area, Stansfield *et al* found that the characteristics of the work environment and provision of social support impacted upon physical, psychological, and social functioning.[19] The authors screened a cohort of over 10,000 UK civil servants between 1985 and 1988, which involved participants completing a health questionnaire, providing blood samples, having their blood pressure measured, and participating in an electrocardiogram. After this initial phase, further questionnaires were sent to participants in 1989 and additional health examinations conducted. The results showed that poor psychological functioning was predicted by low levels of support in the workplace and effort-reward imbalance in men and women.[20] This effect was compounded in lower employment grades.[21] Further research has mirrored these findings and revealed a relationship between the quality of organisational support and positive work-related behaviours, including a sense of accomplishment and contribution,[22] affective commitment,[23] and job involvement.[24] However, within this mass of work the concept of 'organisational support' has been operationalised very differently. Although many studies are comparable in terms of the variables used to measure organisational support, the range of such variables has grown steadily in number, with more recent work incorporating supervisory

[19] S Stansfield *et al*, 'Psychosocial Work Characteristics and Social Support as Predictors of SF-36 Health Functioning: The Whitehall II Study' (1998) 60 Psychosomatic Medicine 247.
[20] *Ibid.* 251.
[21] *Ibid.* 252.
[22] J Ajay and K Arvind, 'General Health in Organisations: Relative Relevance of Emotional Intelligence, Trust, and Organisational Support' (2005) 12 International Journal of Stress Management 257.
[23] Defined as 'an attitude that centres on emotional identification with the values and goals of the organization. See MP O'Driscoll and DM Randall, 'Perceived Organisational Support, Satisfaction with Rewards, and Employee Job Involvement and Organisational Commitment' (1999) 48 Applied Psychology – An International Review 197.
[24] *Ibid.*

support, collegial behaviour and training into the definition of what is organisational support.[25]

Much research has been undertaking into support provided by first line supervisors, and most of it has depicted such support in a favourable light. In their survey of 310 US nurses, Constable and Russell found supervisor support to be negatively correlated with burnout.[26] In particular, supervisory support was seen to have a moderating effect upon the relationship between job enhancement[27] and emotional exhaustion, and quality support from supervisors virtually eliminated the negative aspects of the work environment.[28] Similar findings were reported by Thompson and Prottas, who analysed the results of an American survey of the 'Changing Workforce'.[29] Looking at data from 2810 wage or salaried employees, the authors investigated the relationships between various sources of work-based and family support and employee attitudes and well-being. Their results showed a negative connection between supervisor (and co-worker) support and stress, employee intention to quit their job, and work-family conflict.[30] Fenlason and Beehr have argued that this relationship might be due to the fact that those acting in a supervisory capacity have a greater impact upon organisational decisions, thus making them more effective at tackling the sources of employee stress.[31]

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[25] See, for example, A Osca *et al*, 'Organisational Support and Group Efficacy: A Longitudinal Study of Main and Buffer Effects' (2005) 20 Journal of Managerial Psychology 292.
[26] JF Constable and DW Russell, 'The Effect of Social Support and the Work Environment upon Burnout Among Nurses' (1986) 12 Journal of Human Stress 20.
[27] The authors used the Work Environment Scale (as developed by Moos and Insel) to assess how nurses perceived the hospital environment. A number of subscales from this instrument were grouped together to form the overall dimension of 'job enhancement'. Thus job enhancement covers: employee ability to act autonomously; employee ability to focus on the task in hand whilst working on the job; clarity of work tasks; and the physical comfort of the work environment.
[28] Constable and Russell (n 26) 22.
[29] CA Thompson and DJ Prottas, 'Relationships among Organizational Family Support, Job Autonomy, Perceived Control, and Employee Well-Being' (2005) 10 Journal of Occupational Health Psychology 100.
[30] *Ibid.* 115.
[31] Fenlason and Beehr (n 13) 172.

Co-worker support has also been linked to positive health and organisational outcomes. Specifically, Greenglass, Burke and Konarski were able to link co-worker support with lower emotional exhaustion in female teachers, and higher levels of personal achievement in male teachers.[32] Using the Maslach Burnout Inventory, Kruger, Botman and Goodenow likewise discovered that high levels of co-worker support were consistently and positively related to greater personal accomplishment in their sample of US counsellors. This said, a number of other authors have been unable, via empirical investigation, to verify such assertions. For example, in one of the earliest studies conducted in this area, La Rocco and Jones failed to find any evidence that co-worker support alleviated the negative outcomes associated with stress in a sample of 3725 navy enlisted personnel.[33] Moreover, more recent research has suggested that social support may even be detrimental to the recipient. In her study of 450 managers from a range of 41 major organisations in Australia, Lindorff found that receipt of emotional support was connected with increased strain for men, and had no effect on women.[34] Similar results were reported by Bolger *et al* in their study of couples defined as being under stress.[35] Sixty-eight couples were surveyed, in which one member was preparing to take the New York State Bar Examination. For 32 days before the examination, and 3 days after it, examinees and their partners completed a brief questionnaire detailing provision of social support, receipt of support, and levels of anxiety and depression.[36] The results showed that examinees felt more depressed on days that followed the receipt of support. This led the authors to conclude that the best type of support is *invisible support*, namely the type where

[32] ER Greenglass, RJ Burke and R Konarski, 'Components of Burnout, Resources, and Gender-Related Differences' (1998) 29 Journal of Applied Social Psychology 1088.
[33] JM La Rocco and AP Jones, 'Co-Worker and Leader Support as Moderators of Stress-Strain Relationships in Work Situations' (1978) 63 Journal of Applied Psychology 629.
[34] M Lindorff, 'Is it Better to Perceive than Receive? Social Support, Stress and Strain for Managers' (2000) 5 Psychology Health and Medicine 271.
[35] N Bolger, A Zuckerman and RC Kessler, 'Invisible Support and Adjustment to Stress' (2000) 79 Journal of Personality and Social Psychology 953.
[36] *Ibid*. 954

examinees felt supported by their partners, but did not feel that they had received any tangible assistance.[37] These results have been replicated in Bolger and Amarel's most recent work which found that 'visible' support was either ineffective or increased emotional reactivity to a stressful event in 257 American psychology students.[38]

A number of hypotheses have been put forward to explain why social support – or at least 'visible' support - might enhance symptoms of stress. La Gaipa has suggested that the support provided may not match the true needs of the recipient, may not be provided effectively or be supplied at the wrong time.[39] Alternately, Gleason and colleagues have argued that the recipient may experience feelings of indebtedness as a result of the inherent inequity that accompanies support transactions.[40] The provision of social support undoubtedly constrains autonomy and independence, and it has been suggested that this poses a threat to the self-esteem of the recipient insofar as he or she may feel unable to deal with the problem single-handedly.[41] This idea substantiates the findings of McIntosh, who has contended that too many sources of support may exacerbate instead of mitigate strain. Overall, she concludes that 'practitioners need to avoid the temptation of assuming that social support is a cure-all'.[42]

[37] *Ibid.* 958
[38] N Bolger and D Amarel, 'Effects of Social Support Visibility on Adjustment to Stress: Experimental Evidence' (2007) 92 Journal of Personality and Social Psychology 458.
[39] JJ La Gaipa, 'The Negative Effects of Informal Support Systems', in S Duck (ed) *Personal Relationships and Social Support* (Sage, London 1990).
[40] MEJ Gleason *et al*, 'Daily Supportive Equity in Close Relationships' (2003) 29 Personality and Social Psychology Bulletin 1036.
[41] G Seidman, PE Shrout amd N Bolger, 'Why is Enacted Social Support Associated with Increased Distress? Using Simulation to Test Two Possible Sources of Spuriousness' (2006) 32 Personality and Social Psychology Bulletin 52.
[42] McIntosh (n 10) 216.

In spite of these findings, it could be contended that the link between social support and distress is still open to interpretation. For instance, it could be that a causal link between enacted support and negative behaviour does indeed exist 'but that it may stem from distress increasing support rather than the reverse'.[43] Another possibility is that an unknown third variable could influence both support and distress, resulting in an erroneous connection being made between the two concepts.[44] In light of these competing hypotheses, it is difficult to draw any firm conclusions regarding the effectiveness of support provision in reducing negative reactions to stressful events. This difficulty is compounded by the interference of several other problems affecting the literature in this area. First, as with most facets of empirical research, is the problem of establishing a causal link between support and a decrease (or increase) in stress-related symptoms. Second is the issue of definition. Concepts such as 'co-worker support' and organisational training have increasingly been subsumed under the broader heading of 'organisational support', which has made it difficult to differentiate between the exact effects of different sources of support. Finally, much of the literature in the social support field is American in origin, and this makes it difficult make comparisons with British working culture.

In conclusion, therefore, research has shown that the relationship between social support and stress reduction is complex to say the least. As a result, the line of research currently being explored by Bolger and Amarel[45] – regarding the relative effectiveness of visible and invisible support – warrants further investigation; not only to develop our understanding of the concept of social support, but also shed light on when, and in what circumstances, it will be necessary to withhold or curtail its provision.

[43] Seidman, Shrout and Bolger (n 41) 53.
[44] *Ibid.*
[45] Bolger and Amarel (note 38).

III. TRAINING AND SUPPORT FOR SOTP FACILITATORS

Research has shown that certain types of people, due to a range of static and dynamic factors including age, marital status and coping style, are more likely to experience negative emotional (and related physical) effects from working with sex offenders.[46] As a result, applicants wishing to deliver the SOTP must first 'pass' all elements of a selection procedure instituted by the Prison Service in 2004. This procedure is split into three parts: first, applicants must attain appropriate scores on a number of psychometric tests; second, they must be interviewed; and finally, they must pass a two-week training course designed to equip them with the skills needed to deliver the SOTP. If the applicant is selected to work on the programme, the support mechanisms offered by the Prison Service are then brought into play, which primarily involve the provision of debriefing, supervision, and counselling. The training procedure for SOTP facilitators and the support provided upon qualification are described below, as well as an ethnographical account of my experience of participating in the SOTP training course.

1. Initial Selection: Psychometric Testing

After registering their interest in facilitating on the SOTP, applicants must complete a questionnaire pack. This involves a series of psychometric tests which are designed to assess how the individual characteristically manages problems and emotions. Based on the results of Clarke's research,[47] which highlighted personality features associated with positive and negative reactivity to sex offender work, four areas of personality are tested:[48]

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[46] J Clarke 'The Psychosocial Impact of Working Therapeutically with Sex Offenders: An Experimental Study' (PhD thesis, University of York 2004).
[47] *Ibid.*
[48] HM Prison Service, *SOTP Facilitator Selection: Psychometric Test Scoring and Interpretation Manual,* (Internal, Offending Behaviour Programme Unit, London 2005).

- **Coping styles** – The coping styles questionnaire calculates how an individual will cope with a stressful situation. Four coping responses have been identified: detached (where the individual feels independent of the circumstances), emotional (where the individual feels overpowered and at the mercy of the situation), rational (where the individual copes by working out a plan to deal with the situation), or avoidance (where the individual 'daydreams' about times when things were better).[49] Clarke's research showed that facilitators with a detached coping style typically report less distress.[50]
- **Emotional control** – The emotional control questionnaire measures two phenomena: first, rumination, and the individual's propensity mentally to 'rehearse' emotional events, high levels of which have been shown to be associated with greater levels of distress in sex offender treatment providers.[51] Second, the questionnaire assesses emotional inhibition and the extent to which individuals suppress their expression of emotion. Emotional expression has been shown to be a protective factor in maintaining facilitator well-being.[52] However, Clarke's research shows that the tendency of SOTP facilitators to be open about the feelings they experience whilst working with sex offenders decreases after one year on the job. It has been suggested that this 'may possibly be indicative of attempts to preserve a professional image by not disclosing distress'.[53]
- **Interpersonal reactivity** – The interpersonal reactivity index measures dimensions of empathy, namely perspective taking (reaction to the distress of others); fantasy (the use of imagination to experience the reactions and feelings of others); empathic concern (regard

[49] D Roger, G Jarvis and B Najarian, 'Detachment and Coping: The Construction and Validation of a New Scale for Measuring Coping Strategies' (1993) 15 Personality and Individual Differences 619.
[50] Clarke (n 46) 96, 251.
[51] J Clarke and D Roger, 'The Construction and Validation of a Scale to Assess the Psychological Well-Being of Sex Offender Treatment Providers' (2007) 12 Legal and Criminological Psychology 83.
[52] M Mendolia and RE Meck, 'Effects of Talking about a Stressful Event on Arousal: Does what we Talk About Make a Difference?' (1993) 6 Journal of Personality and Social Psychology 283.
[53] HM Prison Service (n 48) 7.

and sympathy for another's feelings); and personal distress (response to another's difficult interpersonal situation).

- **Compassion fatigue/satisfaction** – The compassion fatigue/satisfaction self-test was originally developed from research into secondary traumatic stress. The test - which has been used in research with various groups of 'human service' professionals[54] - measures the negative and positive effects emanating from the 'compassion' that facilitators draw on when working with sex offenders. In terms of SOTP workers, a significant decline in compassion satisfaction (i.e. the positive effects of sex offender work) has been found after one year of facilitating.[55]

As discussed in the previous chapter, Clarke's research also established that certain static, demographic variables are associated with the adjustment and well-being of SOTP facilitators, specifically age; gender; length of time working for the Prison Service; experience of adult sexual abuse; and recent experience of a traumatic event.[56] Applicants are therefore required to provide information on the above issues in the questionnaire pack and during any subsequent interview.

2. Interview

Following completion of the relevant psychometric tests, applicants are interviewed by the SOTP treatment management team of the recruiting prison. Test scores are discussed and, where candidates have shown areas of potential concern (in terms of future negative impact),

[54] CR Figley and BH Stamm, 'Psychometric Review of the Compassion Fatigue Self-Test' in BH Stamm (ed) *Measurement of Stress, Trauma and Adaptation* (Sidran Press, Lutherville M.D. 1996).
[55] Clarke (n 46) 162, 246.
[56] *Ibid*. 71 – 76.

the team will discuss ways in which he or she might be supported if recruited as a facilitator.[57] Some applicants will be entirely unsuitable for the SOTP because of either static or dynamic factors that make them more 'at risk' from the negative effects of working with sex offenders. Others, however, even with psychometric scores illustrating potential areas of incongruity, will be taken on and monitored by the treatment team.

This is where problems might occur. If the results of Clarke's research – which, incidentally, have been wholly embraced by the Prison Service – show that specific personality traits mean certain individuals are more likely to experience the deleterious effects of sex offender work, then surely such results should be applied stringently during the selection process. If not, the whole process of psychometric testing is made redundant. Likewise, the Prison Service opens itself to the possibility of future legal action from employees experiencing stress at work, especially if it can be shown that early psychometrics demonstrated that they might not have been suitable for such work. Although it is my opinion that the tests have a valid use within the SOTP recruitment process, it is possible that test scores could be manipulated. As a large number of SOTP applicants have past experience in the field of psychology – whether from a higher educational course or from working on a prison/probation-run rehabilitation programme – there is a chance that individuals who are intent upon working on the programme will attempt to provide answers that they believe will lead to a more favourable psychometric rating. To avoid this, one option that might be explored is to administer psychometric tests to *newly qualified* SOTP facilitators to gauge their progress on the job. However, this approach would mean that any value that the test has in extricating 'weaker' candidates from the selection process is lost. The problem also remains that successful

[57] HM Prison Service, *SOTP Facilitator Selection: Questionnaire Pack* (Internal, Offending Behaviour Programme Unit, London 2005).

candidates with experience of testing procedures may draw upon that experience to promote professionalism via test responses, and thus mask any negative emotional reactions that they have genuinely experienced since being selected to facilitate on the programme.

3. SOTP Training

If applicants are successful at interview and produce suitable psychometric test scores, all must complete a mandatory two-week residential training course. All participants are trained to deliver either the Core or Rolling SOTP before being allowed to proceed onto the Extended, Booster, or Adapted training programmes. Three courses are held per year at various locations around the country. The course is split into two sections: week one assesses the 'fundamental skills' required for SOTP facilitation, and week two works through the content of the SOTP treatment manual.

a) Week One: Fundamental Skills Training

The first week of SOTP training assesses trainees on the 'fundamental skills' deemed necessary to deliver all SOTP programmes. There are 13 such skills, all of which are defined below:[58]

- **Using theoretical knowledge** – Facilitators should have good subject knowledge and use it to assist the treatment process.
- **Self-reflection** – Facilitators should be able to reflect on thoughts, feelings and behaviours in order to encourage professional development.

[58] Offending Behaviour Programme Unit, *Sex Offender Treatment Programme – Fundamental Skills Handout Pack* (Internal, London 2005).

- **Facilitator style** – Individuals should aim to facilitate in a personal style that will also meet the aims of treatment.
- **Reinforcement** – Facilitators should show approval or disapproval of offender thinking/ behaviour, in order to change positively such thoughts or behaviour.
- **Using the group** – Facilitators need to be able to use other group members to facilitate the progress of individuals, and the group as a whole.
- **Modelling** – Facilitators must demonstrate pro-social attitudes and behaviours upon which group members can base their own behaviour.
- **Co-facilitation** – Facilitators should be able to work effectively with co-facilitators, demonstrating pro-social, anti-criminal attitudes.
- **Using socratic questioning** – Facilitators must use questions that encourage learning to take place via an individual's own reasoning, rather than by imposing reasons upon them.
- **Aim awareness** – Facilitators must be able to work, all times, with an awareness of how treatment actions are meeting the aims of a session, and the programme generally.
- **Identifying factors contributing to offending or problem behaviour** – Facilitators must need to be able to help group members identify for themselves those factors that contributed to their problem behaviour.
- **Challenging problematic attitudes, thinking, and behaviour** – Facilitators should use techniques that make group members question their way of thinking/behaving, and to encourage them to consider alternatives.
- **Developing alternative attitudes, thinking, and behaviour** – Facilitators should encourage group members to create and develop alternative ways of thinking and behaving.

- **Using alternative thinking and behaviour** – Facilitators should aim to use techniques which enable group members to use alternative thinking and behaviour.

Training courses typically accommodate between 30 and 50 participants who are split into sub- or 'syndicate' groups. Most learning takes place in these groups, each of which is facilitated by a 'trainer'[59] who is the primary assessor for each syndicate group member. Course participants are assessed on a pass/fail basis. To pass, participants must demonstrate a good grasp of the thirteen fundamental skills and an ability to develop such skills. Although brief feedback is provided after every exercise, each participant spends a short time with the trainer of their syndicate group at the end of the first week to find out whether they have successfully demonstrated the relevant skills. At this stage, some trainees will be told that they are unsuited to SOTP work and will not be allowed to proceed on to the second week of training. However, some may simply be required to repeat the course or elements of it. The number of trainees who fail the first week (and indeed the second week) of training tends to be small. For example, of the 32 trainees who completed the course in April 2006, one failed. Of the 23 people in this cohort who continued on to the second week of Core SOTP training (eight proceeded onto the Rolling SOTP course), four failed. Successful trainees will be invited to attend the next stage of training and any feedback on their performance passed to their place of work. This can then be utilised by the resident treatment manager to identify areas that need improvement and any issues that may need to be discussed during supervision.

[59] Trainers are taken from a number of settings, and may be experienced 'primary' facilitators (i.e. experienced facilitators with advanced clinical skills and knowledge), supervisors, treatment managers, or members of the team at the Offending Behaviour Programme Unit. All have significant experience of SOTP, and will have completed relevant training for the role.

Each day of training is divided into two halves with two sessions in each. Most sessions involve: a presentation on the particular skill or topic to be discussed; a skill 'demonstration' by trainers; an exercise in pairs to understand and practice the skill; and a syndicate group exercise where two individuals practice being a facilitator whilst the remaining group members act as offenders (known as a 'skills practice exercise'). As well as targeting one or more of the 13 specified skills, each session attempts to encourage trainees to look for the personal factors associated with an offender's sexual offending for SARN requirements. The SARN (Structured Assessment of Risk and Need) is an assessment tool used by the Prison Service to identify an offender's risk level and treatment needs before being accepted onto the SOTP. The first stage of the SARN involves a 'static' risk assessment using the Risk Matrix 2000, developed by Thornton *et al.*[60] This measures the risk of sexual reoffending by assessing factors that cannot change, for example, offending history. This predicted risk level will not change following completion of treatment.[61]

The second stage involves an assessment of 16 'dynamic' (or changeable) risk factors and personal attributes, identified by research as being present in individuals who commit certain sexual crimes. The presence or absence of each of these factors will be assessed referring to case records, psychometric test results, interview data, and information gained from treatment sessions.[62] The 16 risk factors are categorised into four domains:[63]

[60] D Thornton *et al*, 'Distinguishing and Combining Risks for Sexual and Violent Recidivism' in R Prentky, E Janus and M Seto (eds) *Sexually Coercive Behaviour: Understanding and Management* (Annals of the New York Acadmeny of Sciences, New York 2003).
[61] PowerPoint presentation at the Fundamental Skills training week (Internal, Offending Behaviour Programme Unit, London 2005).
[62] *Ibid.*
[63] Offending Behaviour Programme Unit (n 58) 8-11.

- **Sexual interests** – This domain distinguishes between whether an offender is obsessed with sex, has a sexual interest with children, is sexually interested in rape or violence or shows signs of any 'other' offence-related sexual interest.
- **Offence related attitudes** – This domain looks specifically at whether the offender believes men should dominate women sexually; believes men have a right to sex; holds beliefs that justify or excuse the sexual abuse of children; holds beliefs that excuse or justify rape; or thinks that women cannot be trusted.
- **Relationships** – This domain focuses on the offender's emotions surrounding relationships and assesses whether they have feelings of inadequacy; feel more comfortable with children than adults; are suspicious, angry or vengeful about others; or have limited emotional intimacy with adults.
- **Self-management** – This domain assesses whether the offender has an impulsive, unstable lifestyle; has difficulty in solving 'life's problems' or has out-of-control emotions or urges.

On the SOTP training course, participants are expected to apply their knowledge of these domains during skills practice exercises. For example, in an exercise focusing on relapse prevention and coping styles, trainees would be encouraged to consider the elements of the self-management domain, as well as incorporating a number of the 'fundamental skills'. The SARN is therefore introduced at an early stage due to its essential role in identifying the personal attributes of sexual offenders, potential 'triggers' to future deviancy and overall risk.

Throughout the whole of the first week of training, participants are also encouraged to apply the 'stages of progress' model to skills practices. This is a framework used by facilitators to

identify the three phases of treatment through which an offender should progress; namely *spotting* the thoughts and feelings that contribute to deviant behaviour; *changing* these thoughts and behaviours, and generating healthier alternatives; and finally *using* these new and acceptable means of thinking and behaving. Once qualified, facilitators are expected to use the model continuously throughout the treatment process in an attempt to build on offender learning and eventually change inappropriate thoughts and behaviours.

I attended the fundamental skills training course held on 5 - 9 September 2005. Whilst I initially thought that I was only going to observe the course, upon arrival I was invited to take part. I agreed and, from that point forward, was treated as an SOTP 'trainee' for the entire week. The first day of training was devoted primarily to discussions about the format of the course and key concepts; for example, discussion of what constitutes a sexual offence, the factors that lead an individual to offend, and the meaning of cognitive behavioural therapy, the SARN and the stages of progress model. The thirteen 'fundamental skills' were also explained. Thereafter, the course focused on practising the relevant skills. Within my syndicate group, I took part in a number of exercises; sometimes working as a pair with another group member, and sometimes working with the entire syndicate group in a skills practice exercise. Throughout the week, the focus of exercises covered many of the key elements of treatment on the SOTP Programme; for example, exercises that focused on: the relevance of an offender's background to his offending behaviour, methods of challenging denial and cognitive distortions, how to use Socratic questioning and praise, and teaching relapse prevention techniques. As explained above, two group members were selected to play the role of facilitator during syndicate group exercises and, during the course of the week, each syndicate group member was provided with the opportunity to play the role of facilitator

at least once. When it was my turn (working with another group member) I was given a scenario relating to a fictional offender called 'Brian', who had been convicted of indecent assault and rape (a further group member played the role of Brian). I had been provided with a description of Brian's background and offending history, and my task was to focus on the 'relationships' domain of the SARN. At the end of the course, I was assessed as being competent to proceed to the second week. However, as a result of time and funding constraints, I did not complete week two of the training course.

On the final day of the course, the trainers gave a very brief presentation on the negative effects of working with sex offenders, following which I too gave a presentation on the subject matter and objectives of my own research. This gave me the opportunity to make my research known to a wider audience, and a number of trainees discussed my work with me at the end of the final day. More importantly, however, taking part in the SOTP training allowed me to observe how the course was managed and how participants dealt with the assessment process. A general observation that I made was that most trainees at the course I attended were female. This was surprising considering that prison establishments lose audit points if facilitator teams fail to include at least one member of the opposite sex. Teams comprising men and women are also preferred to show offenders that men and women can form mutually respectful relationships. One male Prison Officer taking part in the course believed the lack of other male trainees was due to the dominant masculine culture that permeated the prison system, and prison officers in particular. He stated that most of his colleagues were unsupportive of treatment for sex offenders as they had little faith in the rehabilitative approach. This is something that was also highlighted in the empirical study of this thesis.[64]

[64] See chapter 8, '*The Impact of Support on SOTP Facilitators*'.

This said, only a very small number of trainees in both weeks showed any concern about the potential negative effects of working with sexual offenders – including unhelpful attitudes from fellow staff members - and most had a real interest in, and enthusiasm for, sex offender treatment. This is encouraging as believing that treatment can 'work' is surely a pre-requisite to facilitate on the SOTP. However, it seems equally important that trainee facilitators have a good understanding of the type of negative impacts that are associated with the work so as to prepare themselves as best they can. The course devoted very little time to issues relating to the impact of sex offender work: only a short session on the final day of week 1. This was not ideal, particularly on the last day of training when participants were tired, anxious to find out whether they had passed, and eager to go home. It is therefore debatable whether a more detailed discussion of the effects of sex offender work should have been incorporated into the training schedule. But with such a large amount of material to cover, it could also be argued that the 'effects' of sex offender work should not take priority at such an early stage in the training process – especially given that some facilitators will not experience any negative impact throughout the course of their career. Consequently, it is my opinion that, in its current format, the course devotes an adequate amount of time to these issues. This is especially so since the inauguration of the 'Staying Strong' course, which aims to develop the 'resilience' of SOTP facilitators to the more deleterious effects of the work.[65] As will be seen in the concluding chapter of this thesis, it will also be recommended that the Prison Service institute a programme of awareness workshops for staff wanting to work on the SOTP. These short sessions would aim to inform prospective facilitators of the positive and negative health impacts of working with sexual offenders so that staff can make a more informed choice as to whether they want to commit to this line of work.

[65] For more details, see '*Further Support*' at page 141 below.

At the time I attended the Fundamental Skills training, attempts by the Prison Service at course evaluation were simplistic to say the least. Instead of providing a standardised evaluation form, trainees were simply requested to write down their thoughts on a scrap of paper prior to departure. These responses were then analysed by the programme leader responsible for managing the training, to identify themes from trainee feedback. Alterations to the programme were made only if the benefits of change were thought to outweigh current practice. I contacted the Offending Behaviour Programme Unit to discuss the issue of training evaluation and was told that programme leaders are committed to adapting training packages in response to feedback from trainees and trainers, and that the Fundamental Skills course had been amended almost every time it had been run in response to participant feedback.[66] However, this informal approach can be criticised. First, the lack of systematic data collection means that feedback will not necessarily be gathered from all participants. Second, because of the informal nature of the data collection process, some trainees may be concerned about issues of confidentiality or question whether their opinions will be taken seriously. A more systematic approach to course evaluation would make data analysis a much easier task.

Since I attended the Fundamental Skills training course, however, HMPS has announced that it is standardising the evaluation procedure for all of its training courses. Trainees will be approached once they have completed the relevant course, and will then be followed-up after three months to see whether training has been effective in providing them with the skills needed for their particular job. At this point, further feedback will also be sought from the individual's line manager to gauge a second opinion on the effectiveness of training. Data

[66] Statement by Christopher Dean (personal email correspondence, 8 May 2008).

will not be gathered from all training events but from a percentage of courses which will put the Prison Service in a better position to demonstrate how feedback is coordinated and how training is subsequently reviewed. However, details as to what percentage of courses will be evaluated, how the data will be analysed, and who will conduct such work, are still sketchy.

b) Week 2: SOTP Treatment Manual

If trainees successfully pass the first week of training, they are invited to attend week two which, depending on which course the individual will be delivering upon qualification, focuses on the content of the SOTP Core or Rolling treatment manual. The manual explains the details of each treatment 'block' – for example, victim empathy – and also what exactly should be covered in each session of a treatment block. It provides details of the treatment targets of each block, their theoretical basis, and session structures. Most blocks will have more than one treatment session, depending on its length, complexity, and importance to treatment as a whole. For example, 'active accounts', which allows offenders to discuss the events and behaviours that led up to their crime, has 16 allocated sessions.[67]

As in the first week, trainees are divided into syndicate groups to complete tasks, each group being headed by a trainer. Assessment is based on trainees' ability to achieve treatment targets in skills practice exercises, whilst applying and building on the fundamental skills learnt in week one. Participants are evaluated on a pass/fail basis, with results being conveyed on the final day of training. Those who fail to meet the standards required to work on the SOTP are told of their unsuitability to deliver the programme or invited to repeat all or part of the course. At the end of the course, trainees on the Rolling Programme also discover

[67] HM Prison Service, *SOTP Core 2000 Treatment Manual*, Version 2 (Internal, Offending Behaviour Programme Unit, London 2002).

whether they have been recommended to act as a 'primary' facilitator, having demonstrated a more advanced understanding of the skills needed to deliver treatment. Primary facilitators are required only for the Rolling and Extended SOTP. For the Rolling programme, one primary facilitator is expected to be present in every treatment session; for the Extended, primaries must be available for more psychologically demanding sessions. The number of trainees who are conferred primary status tends to be very low because of their inexperience in the area of sex offender treatment.[68]

4. Support upon Qualification

Organisational support theory states that employees tend to develop global beliefs about the extent to which their employer cares about their well being and appreciates their contributions.[69] Perceived organisational support can have an effect on rates of absenteeism,[70] which in turn supports the view that 'employees' commitment to the organization is strongly influenced by their perception of the organization's commitment to them'.[71] When the SOTP was first implemented by the Prison Service, early evaluations of support provision for facilitators were critical. In 1994, Sheridan, herself an SOTP facilitator, questioned whether there was adequate support for staff delivering the programme and argued that the effects of working with sex offenders was not considered to be an important issue by HMPS.[72] Likewise, in a study of 82 qualified facilitators, Turner reported that more than 40 per cent felt they had received inadequate support provision, and that managers had a poor

[68] Statement by Fiona Ainsworth of the Offending Behaviour Programme Unit (personal email correspondence, 1 April 2008).
[69] R Eisenberger *et al*, 'Perceived Organizational Support' (1986) 71 Journal of Applied Psychology 500.
[70] *Ibid.* 504.
[71] *Ibid.* 500.
[72] M Sheridan, 'The Training and Support Needs of Staff Involved in the Sex Offender Treatment Programme' (1994) 94 Prison Service Journal 20.

understanding of the effects of the work.[73] As a result, Turner recommended the implementation of a variety of support mechanisms to protect facilitators from the negative impact of sex offender work, including supervision, debriefing, counselling, and further training.[74] Most of these recommendations have now been put into practice by the Prison Service and formalised in the 'Accredited Offending Behaviour Programme Audit Document', which outlines the minimum standards that prisons offering rehabilitative programmes must meet in relation to treatment delivery. Institutions are graded on their performance in four key areas, namely institutional support, treatment and management integrity, continuity and resettlement, and quality of delivery. Points are awarded for full or part compliance with the grading criteria, giving each institution a total score and an indication of which areas of practice require improvement.

The audit document outlines a number of support mechanisms that are available to facilitators upon qualification, specifically debriefing, counselling and supervision. The following discussion considers each of these in terms of their role and function in the overall support 'package' provided to SOTP facilitators by HMPS. Theoretical origins and research literature are also discussed.

a) Debriefing

Debriefing is popularly known as the practice of talking about a traumatic event in its aftermath.[75] On a more technical level, however, it has been described as 'a form of crisis

[73] C Turner, *The Experience of Staff Conducting the Core Programme (A Brief Summary)* (part of the SOTP Managers' Manual) (Internal, Offending Behaviour Programme Unit).
[74] *Ibid*. 15.
[75] B Raphael and JP Wilson, 'Introduction and Overview: Key Issues in the Conceptualization of Debriefing', in B Raphael and JP Wilson (eds) *Psychological Debriefing: Theory, Practice and Evidence* (Cambridge University Press, Cambridge 2000).

intervention…designed to reduce initial distress and to prevent the development of later psychological sequelae…following traumatic events by promoting emotional processing through the ventilation and normalization of reactions, and preparation for possible future experiences'.[76] Various theoretical approaches to debriefing have been expounded, but the most widely used model in recent times has been Critical Incident Stress Debriefing, developed by Mitchell in the 1980s.[77] This model, and indeed most others, describe debriefing as a single-session, group-based treatment that aims to discuss the facts of the incident in question, the patient's thoughts and reactions to the incident, and the symptoms experienced. Debriefers provide information about the 'normality' of the patient's reaction, give advice on how to reduce further symptoms of stress, and discuss any further issues of concern.[78] From a theoretical perspective, proponents have suggested that psychological debriefing provides '...a structure in which the traumatic experience is confronted and the trauma memory developed…[allowing] the trauma to be emotionally processed…'.[79] It has been argued that the experience of trauma conflicts with the individual's established cognitive schemas, namely their established beliefs, expectations and assumptions about the world. As a result, existing schemas must be revised in order to incorporate the new experience.[80] However, Foa, Steketee and Rothbaum have propsed that this can only be achieved by activating the 'fear network'; namely by recounting the memories associated with the

[76] JI Bisson *et al*, 'Psychological Debriefing' in EB Foa, TM Keane and MJ Friedman (eds) *Effective Treatments for PTSD* (The Guildford Press, New York 2000) 43.
[77] J Mitchell, *Guidelines for Psychological Debriefing: Emergency Management Course Manual* (Federal Emergency Management Agency, Emergency Management Institute, Emmitsburg MD 1983).
[78] J Mitchell, *Critical Incident Stress Debriefing: An Operations Manual for CISD, Defusing and Other Group Crisis Intervention Services* (Chevron Publishing Corporation, Elliot City 1993).
[79] P Stallard and E. Salter, 'Psychological Debriefing with Children and Young People Following Traumatic Events' (2003) 8 Clinical Child Psychology and Psychiatry 445, 447.
[80] MJ Horowitz, 'Stress Response Syndromes: A Review of Posttraumatic and Adjustment Disorders' (1986) 37 Hospital and Community Psychiatry 241.

trauma.[81] This is where psychological debriefing steps in: memories are reappraised and challenged, emotions resulting from the trauma are normalised and, supposedly, distress is reduced or even prevented. This has been illustrated in a number of research studies. For example, in their meta-analytic review of 10 empirical investigations into the effectiveness of group psychological debriefing, Everly, Boyle and Lating found a 'significantly positive effect' in terms of the power of debriefing to mitigate the symptoms of distress following trauma.[82] The studies chosen for analysis were included on the basis that they met 'adequate group or statistical control mechanisms',[83] but no specific criteria were imposed in terms of the subject groups treated, nor the type of trauma experience. This was not viewed as problematic by the authors who instead argued that such generalisability showed how debriefing is not situation-specific and can be effective with diverse populations and traumatic events.[84]

In another meta-analysis, Arendt and Elklit reviewed the results of 25 studies measuring the effectiveness of psychological debriefing.[85] The criteria for inclusion in this analysis were more detailed than those used by Everly, Boyle and Lating[86] and required that studies used a controlled design (preferably randomised), were longitudinal in nature, and used standardised measures to assess the psychological symptoms of subjects. The authors' concluded that there was no evidence to show that psychological debriefing can prevent, or mitigate, the

[81] EB Foa, G Steketee and BO Rothbaum, 'Behavioural/Cognitive Conceptualizations of Posttraumatic Stress Disorder' (1989) 20 Behaviour Therapy 155.
[82] GS Everly, SH Boyle and JM Lating, 'The Effectiveness of Psychological Debriefing with Vicarious Trauma: A Meta-Analysis' (1999) 15 Stress Medicine 229.
[83] *Ibid.* 230
[84] *Ibid.* 232
[85] M Arendt and A Elklit, 'Effectiveness of Psychological Debriefing' (2001) 104 Acta Psychiatrica Scandinavica 423.
[86] Everly, Boyle and Lating (n 82) 75.

symptoms that can follow a traumatic experience.[87] However, a preventative effect was identified when the debriefing exercise followed a traditional approach, i.e. the intervention was directed at professional 'helpers' (rather than the victims of more randomised traumatic incidents), used a group format, was applied soon after the traumatic event, was based on only one meeting, and employed qualified professionals to conduct the treatment.[88]

A significant drawback that has affected the reliability of such positive results has been the poor methodologies employed by researchers when measuring the effectiveness of psychological debriefing. Many do not use comparison groups, making it impossible to measure the differences – if any - between treated and untreated populations.[89] Of those that have used treatment and control groups, a significant proportion allow for subjects themselves to opt in or out of treatment, creating a potential source of bias.[90] Moreover, some studies have failed to measure the level of trauma in subjects prior to debriefing, making it impossible to determine if debriefed and non-debriefed groups had comparable levels of trauma prior to treatment.[91] Such problems have occurred against a backdrop of more generalised confusion over the definition of debriefing, and conflict over whether it actually works as a method of psychological support. A number of authors in the field have concluded that there is, at present, no evidence to support the idea that psychological debriefing can prevent negative psychological reactions to trauma.[92] Some have gone even further to suggest that debriefing can compound the negative emotions experienced by victims. The reasons for this are numerous. First, it has been argued that debriefing places too great an emphasis on

[87] Arendt and Elklit (n 85) 432.
[88] *Ibid.* 430.
[89] *Ibid.* 428.
[90] *Ibid.*
[91] R Robinson, J Mitchell and P Murdoch, 'The Debate of Psychological Debriefings' (1995) 2 Australasian Journal of Emergency Care 6.
[92] Raphael and Wilson (n 75) 5.

'revisiting' the traumatic event, resulting in emotional overload.[93] As a result, it can also create an expectation in participants that psychological symptoms will inevitably occur, when in actuality it has been estimated that no more than 25 per cent go on to suffer from post-traumatic stress disorder.[94] Second, it has been contended that, despite the popular notion that 'talking things through' can help to resolve underlying emotions, the process of verbalising traumatic memories is not a natural process for all individuals.[95] Indeed, it is questionable whether a highly traumatised person can participate effectively in a debriefing session at all, and may feel 'unsafe' in a group environment.[96] On the other hand, a person who believes that he does not need to be 'debriefed' may feel resentful at being coerced into treatment, and participate minimally in the session.[97] Finally, the practice of debriefing has led to the medicalisation of the most minor psychological symptoms. As Raphael and Wilson put it:

> Some suggest that the pendulum may now have swung too far away from denial of the effects of psychologically traumatic experiences, with even minor experiences being identified as stressors that must be dealt with by debriefing or trauma counselling, and an excessive adoption of victim status in a stressed society.[98]

It is therefore arguable that the widespread use of debriefing has led to groups of people being subjected to psychological intervention in spite of never having received any formal diagnosis

[93] S Rose and N Tehrani, 'History, Methods, and Development of Psychological Debriefing' in N Tehrani (Working Party Co-ordinator) *Psychological Debriefing* (British Psychological Society, Leicester 2002).
[94] J Ormerod, 'Current Research into the Effectiveness of Debriefing' in N Tehrani (Working Part Co-ordinator) *Psychological Debriefing* (British Psychological Society, Leicester 2002) citing D Richards, 'Debriefing: Evaluation and Active Ingredients', paper presented at the Trauma Hot Topics II Networking Day (December 1997).
[95] Raphael and Wilson (n 75) 3.
[96] C Stuhlmiller and C Dunning, 'Concerns about Debriefing: Challenging the Mainstream', in B Raphael and JP Wilson (eds) *Psychological Debriefing: Theory, Practice and Evidence* (Cambridge University Press, Cambridge 2000).
[97] JI Bisson and MP Deahl, 'Psychological Debriefing and Prevention of Post-Traumatic Stress' (1994) 165 British Journal of Psychiatry 717.
[98] Raphael and Wilson (n 75) 4.

that they are suffering from a treatable condition. This reliance on debriefing as an all-encompassing remedy to the adverse effects of stress also ignores the potential availability of other coping mechanisms that do not involve 'treatment'.[99]

Evidence to support the potentially detrimental impact of psychological debriefing goes further than theoretical postulation, however, and the negative consequences of such interventions have also been borne out in empirical research. Mayou, Ehlers and Hobbs reviewed the effectiveness of psychological debriefing on 106 road accident victims, who were assigned randomly to either an intervention group or a non-intervention control group. Subjects receiving debriefing were interviewed by a research worker within 24 hours of the accident or as soon as they were physically fit to be seen. A proportion of this group were followed up after four months and again after three years.[100] The results showed that the initial one-hour debriefing session - which also provided subjects with written information on debriefing and further avenues of support – had no benefit on the psychological outcomes of patients. Likewise, it was found that those subjects with high initial IES[101] scores (i.e. those with the most severe levels of psychological intrusion and avoidance symptoms) were suffering from significantly worse PTSD symptoms at follow up.[102] In a similar follow-up study, Carlier *et al* assessed the psychological symptoms of a group of police officers who had responded to a civilian plane crash – first at eight months after the incident, and then at 18 months.[103] Forty-six of the officers in the sample had been debriefed after the crash, compared with a control group of 59 officers who had received no intervention. The groups

[99] Stuhlmiller and Dunning (n 96) 311.
[100] RA Mayou, A Ehlers and M Hobbs, 'Psychological Debriefing for Road Traffic Accident Victims' (2000) 176 British Journal of Psychiatry 589.
[101] Impact of Events Scale, which is used to measure the psychological distress after a traumatic event.
[102] Mayou, Ehlers and Hobb (n 100) 592.
[103] IVE Carlier *et al*, 'Disaster-Related Post-Traumatic Stress in Police Officers: A Field Study of the Impact of Debriefing' (1998) 14 Stress Medicine 143.

did not differ in their levels of pre- or post-event distress; nor did they differ significantly in their motivation to take part in debriefing. Eight months after the plane crash, there were no significant differences between the debriefed and non-debriefed officers; however, at 18 months, the results of structured clinical interviews showed that debriefed subjects exhibited significantly more negative psychological symptoms related to the disaster.[104]

With this in mind, questions can at least be raised about why the Prison Service has opted to retain psychological debriefing as a method of support available to SOTP facilitators. Nevertheless, debriefing is a mandatory part of the support 'package' offered to those working with sex offenders, and the audit document stipulates that each treatment session should be followed by at least 45 minutes of 'debriefing'.[105] After observing an SOTP treatment session at a prison in the north of England, I was able to watch a debriefing session with two facilitators and their treatment manager.[106] Although the facilitators seemed to appreciate the opportunity to discuss whether they had achieved the aims of the session, and the progress of individual group members, it did not follow the format of a 'traditional' debrief. For instance, there was very little discussion of the reactions of the facilitators to what had transpired in the session or if they felt affected by what had been said. This begs the question whether the emotions experienced after a treatment session (if indeed a facilitator experiences any emotions at all) can be classed as a type of 'trauma' that requires debriefing. Batt has argued that the answer to such a question is yes.[107] She refers to the work of Maggio and Terenzi who, in turn, have suggested that 'critical incidents' – i.e. those traumatic events

[104] *Ibid*. 146.
[105] HM Prison Service, *Combined Accredited Offending Behaviour Programmes Audit Document* (Internal, Offending Behaviour Programme Unit, London 2005) 13.
[106] For reasons relating to confidentiality, it should be noted that none of the facilitators participating in the empirical study of this thesis was employed at Wakefield Prison.
[107] E Batt, 'Application of Psychological Debriefing Principles and Techniques to Sex Offender Treatment Facilitators in HM Prison Service' (Internal, Prison Service, 2006).

that may benefit from the application of debriefing techniques – share five common characteristics, namely: (1) they are generally sudden and unexpected; (2) they can disrupt an individual's sense of self-control; (3) they can disrupt established beliefs and values; (4) they involve the perception of a life-damaging threat; and (5) may involve an element of physical or emotional loss. Batt subsequently applied each of these characteristics to the work of SOTP facilitators, arguing that: (1) unexpected events can occur within a treatment session, such as difficult or challenging behaviour; (2) a therapists' level of control can be diminished if an unexpected event occurs, the facilitator is inexperienced, or the session has been poorly planned; (3) effects such as relationship difficulties and problems with sexual behaviour – both of which have been associated with SOTP work[108] – could disrupt a facilitator's established belief system; (4) facilitators who develop a heightened sense of personal vulnerability and sensitivity to violence could be said to have experienced a life-damaging threat. In relation to the fifth characteristic of a 'critical incident' (as identified by Maggio and Terenzi), Batt concedes that 'it is difficult to ascertain how [physical or emotional loss] might be related to sex offender treatment…'[109]

Batt concludes that it may be possible to apply the methods of traditional psychological debriefing to sex offender treatment providers.[110] Moreover, research has shown that adherence to these 'traditional' principles is more likely to result in a benefit to the recipient.[111] However, one significant problem with the current audit document is that it does not specify the format or content of debriefing sessions, leading to the assumption that 'different establishments could be conducting debriefing in different ways to varying degrees

[108] See Chapter 2 for a full account of the research literature in this area.
[109] Batt (n 107) 10.
[110] *Ibid.*
[111] Arendt and Elklit (n 85) 430.

of effectiveness'.[112] It is surprising, to say the least, that the Prison Service is purporting to provide SOTP facilitators with a method of support that has no sound theoretical basis. This point becomes especially pertinent when considering that, to become accredited, all offending behaviour programmes must have a strong theoretical grounding and be backed by research evidence regarding efficacy.[113] The Prison Service is undoubtedly practised in meeting such criteria, as evidenced by the number of programmes that have been accredited over the past 10 years – more than 40 to date.[114] Why it has failed to institute such rigorous standards in relation to the support offered to its staff remains unanswered. Failure to establish some purpose and structure to debriefing with SOTP staff could at best be having no effect at all (thus raising the issue of cost-effectiveness) or, at worst, be having a negative impact on facilitators.

b) Counselling

Counselling services for employees have been a part of organisational life, in some shape or form, since the 1930s.[115] However, provision of work-based counselling has increased more rapidly over the past 20 years, with some authors suggesting that 75 per cent of medium and large organisations in Britain and North America now having counselling services available to their staff.[116] Although this undoubtedly comes at some expense to the employer, it has been argued that workplace counselling schemes 'cover their costs' by reducing staff absenteeism. Likewise, additional benefits of workplace counselling have been identified following the

[112] Batt (n 107) 10.
[113] Correctional Services Accreditation Panel, *Annual Report 2006/07* (London 2007).
[114] Correctional Services Accreditation Panel, *Annual Report 2007/2008* (London 2008).
[115] J McLeod, *Counselling in the Workplace: The Facts* (The British Association for Counselling and Psychotherapy, Rugby 2001).
[116] J McLeod and M Henderson, 'Does Workplace Counselling Work?' (2003) 182 British Journal of Psychiatry 103, citing M Carroll and M Walton, *The Handbook of Counselling in Organisations* (Sage, London 1999).

decision of the Court of Appeal in the case of *Sutherland v Hatton.*[117] In this case, the Court of Appeal suggested that an employer offering a confidential advice service – with the possibility of referral to counselling – would be unlikely to be found in breach of its duty to take reasonable steps to protect employees from psychiatric injury, caused by adverse working conditions.[118] Counselling is an essential component of the SOTP support package, and the audit document stipulates that all facilitators working on the Core SOTP *must* attend at least three sessions per programme, which are available flexibly.[119] The document suggests that counselling should aim to 'reduce the likelihood of facilitators experiencing the adverse effects of working with serious/high risk offenders', and counsellors should therefore focus on discussing the impact of the programme on facilitators' personal lives and relationships, and encourage the use of coping strategies to manage the effects of stress.[120] The counsellors themselves are hired via an independent agency and are not employed by HMPS directly. This makes it an entirely confidential service, and anything reported by a facilitator to a counsellor is not subsequently discussed with SOTP managers. A thematic report is produced each year by counsellors, which summarises the main themes discussed during counselling and how far facilitators have been encouraged to talk about the personal impact of SOTP work.[121]

A number of studies have shown how workplace counselling can reduce the symptoms of stress[122] and sickness absence.[123] Such results have more recently been supported by the

[117] [2002] EWCA Civ 76; [2002] 2 All ER 1.
[118] [2002] 2 All ER 1, 16
[119] HM Prison Service (n 105) 17.
[120] *Ibid.*
[121] *Ibid.*
[122] See for example CL Cooper and G Sadri, 'The Impact of Stress Counselling at Work' (1991) 6 Journal of Social Behaviour and Personality 411.
[123] See for example S Mitchie, 'Reducing Absenteeism by Stress Management: Valuation of a Stress Counselling Service' (1996) 10 Work and Stress 367.

findings of McLeod's wide-scale review of research into the effectiveness of workplace counselling.[124] Thirty-seven studies were selected for review, with the only real inclusion criteria being that the intervention used was counselling or psychotherapy (excluding debriefing) and delivered to employees suffering from work-related psychological problems.[125] Methodological rigour did not have an impact upon whether any one study was chosen for review as it was thought that this would limit the amount of research available for inclusion. In recognition of this, outcome studies were divided into three categories at the 'results' stage of the project ('best evidence', 'supporting evidence' and 'authenticating evidence') to denote the quality of the methodology used. The author's findings illustrated how 14 of the 19 studies placed in the 'best evidence' category[126] showed workplace counselling to be highly effective, particularly at reducing negative psychological symptoms, and sickness absence.[127] Only two of the 37 studies included in the review showed counselling to have no significant impact on these measures, and none proved counselling 'to be harmful or less effective than other alternative interventions'.[128] Moreover, more than 90 per cent of participants in the studies analysed expressed themselves as highly satisfied with the service they received, said they would use it again, and would recommend it to colleagues.[129]

Despite these positive results, McLeod's data have been criticised. Henderson has suggested that the fact McLeod failed to find a single study that showed a negative outcome for

[124] McLeod (n 115).
[125] *Ibid.* 13.
[126] In section two of the report, it is stated that 16 studies fell within the 'best evidence' category. However, a closer reading reveals that 19 studies were actually included. This is because three of the authors selected for inclusion had produced two papers on counselling in the workplace that had revealed similar, positive results. These studies (for example Barkham and Shapiro (1990) and Barkham and Shapiro *et al* (1999)) were categorised as one item within the best evidence category, rather than two.
[127] McLeod (n 115) 20.
[128] *Ibid.* 18.
[129] *Ibid.* 4.

workplace counselling strongly suggests publication bias. Likewise, studies varied widely in terms of sample size, follow-up periods, and form and content of the therapy provided, making comparison difficult.[130] Only five of the 19 'best evidence' studies used a form of non-treatment control group. Of these, two utilised RCT whereby participants were randomly allocated to either a treatment, or a non-treatment group. However, of the remaining three studies, two used controls who were not seeking help at all, and the other used respondents who had dropped out of counselling after the first session. Henderson therefore asserts that, due to a lack of non-randomised research in this area, very little can be said about the effectiveness of workplace counselling. This, Henderson contends, is unsurprising: as the concept of 'workplace stress' covers such a vast array of problems, a 'one-size-fits-all' approach to dealing with these problems (via workplace counselling) will inevitably be inadequate.[131] Moreover, the concept of workplace stress itself implies that work is the sole, causative factor of stress, to the exclusion of all other potential stressors (for example, those emanating from family and home life). Thus, Henderson argues that 'despite an individual being unhappy at work and using a work-based outlet to complain, symptoms may be explained in several other ways'.[132] Ultimately, workplace counsellors may be ill-equipped to deal with problems which are not wholly related to work, even if they are able to provide some basic support.

These latter criticisms can be applied to the type of compulsory counselling provided to SOTP facilitators. As shown by the results of the empirical study reported in this thesis, a small number of qualified facilitators simply disagreed that they needed to attend three counselling sessions per programme. The idea of facilitators attending counselling when they are

[130] J McLeod and M Henderson (n 116) 104.
[131] *Ibid*.
[132] *Ibid.*

psychologically healthy not only raises the question of cost effectiveness but also more serious ethical concerns; in particular, whether it is appropriate to compel an individual to undergo a form of 'treatment' when they are actually in good health. Even if a facilitator is experiencing emotional health problems, the idea of forcing them to discuss such problems may do more damage than good. The alternative, of course, would be to make counselling an optional source of support. However, this raises additional problems. Should counselling be offered on an optional basis, those that choose to attend may be stigmatised as a result, and this may ultimately mean that those who feel that they would genuinely benefit from the service do not use it. This point was raised by facilitators during interviews for the empirical study reported in this thesis, and all thought that counselling should remain as a compulsory requirement for these reasons. In terms of liability for work-induced stress, the provision of counselling services to facilitators is also valuable in protecting the Prison Service (but not making it immune) from compensation claims. On balance, therefore, it seems that counselling should remain as a compulsory source of support to SOTP facilitators.

c) Supervision

Of all of the methods of support offered by HMPS, supervision has provoked very little academic debate as regards its ability to aid SOTP facilitators in their role. High-quality supervision has been associated with a number of favourable outcomes in a range of organisational settings. Rhoades and Eisenberger conducted a meta-analysis of 73 studies that considered the effect of 'perceived organisational support', i.e. employees' belief that the organisation they work for values their contribution and cares for their well-being.[133] The results showed that supervisor support (along with fair treatment, and organisational rewards

[133] L Rhoades and R Eisenberger, 'Perceived Organisational Support: A Review of the Literature' (2002) 87 Journal of Applied Psychology 698.

and good job conditions) was associated with perceived organisational support.[134] This in turn was associated with a number of positive organisational outcomes, including commitment to the organisation, increased job involvement, and a lessened inclination to leave the organisation.[135] Likewise, perceived organisational support was also linked to favourable employee outcomes, such as job satisfaction and positive mood.[136] Perhaps more relevant to the current study, supervisory support has also been linked to reduced levels of burnout.[137] In an early study of 310 American nurses, Constable and Russell analysed how effectively the issues of work overload, role ambiguity, and lack of occupational self-esteem, could predict burnout, and if social support (including supervisory support) could have an effect on preventing or minimising stress in the workplace. It was found that supervisor support was negatively correlated with burnout – in particular, the 'emotional exhaustion' dimension. Similar results were revealed in a slightly later study by Coady *et al*, who surveyed 151 US social workers working with patients suffering from cystic fibrosis.[138] They found that social workers who reported no perceived supervisory support achieved much higher scores on the depersonalisation measure of the Maslach Burnout Inventory. Thus, the authors concluded that workers who feel their supervisors are supportive are less likely to suffer from burnout.[139]

Of course, poor quality supervision could have the opposite effect. In his early study of the experience of staff conducting the Core SOTP, Turner found that 41 per cent of a sample of

[134] *Ibid.* 707.
[135] *Ibid.* 709.
[136] *Ibid.*
[137] See chapter 2 of this thesis for a more detailed discussion of burnout.
[138] CA Coady, VD Kent and PW Davis, 'Burnout among Social Workers Working with Patients with Cystic Fibrosis' (1990) 15 Health and Social Work 116.
[139] *Ibid.* 121.

82 qualified facilitators did not feel they were receiving adequate support.[140] One participant commented that 'I would have preferred time to offload after sessions. Often the time would be given over to discussing the progress inmates were making etc, and not enough time was given for discussing such issues that had affected the group leaders'.[141] As a result, Turner recommended that the amount of supervision provided to facilitators should be increased and that there should be regular 'debriefing' sessions to enable group leaders to discuss the content and delivery of sessions, as well as problems with particular inmates.[142] These recommendations were subsequently incorporated into the Accredited Offending Behaviour Programme Audit Document which states that facilitators working on the Core SOTP should receive, per programme, at least 12 hours' team supervision and at least two hours' individual supervision.[143] It also notes that 'new tutors may need extra individual supervision',[144] thus recognising the difficulties involved in entering this type of work for the first time. The audit document provides some detail on what activities should be included in the supervision process, and specifically highlights that supervisors should:

- review previous sessions, give advice on session delivery, and aid in the planning of future sessions, in order to maintain treatment integrity;
- provide feedback to facilitators (from observation of treatment sessions) to develop their skills;
- encourage facilitators to raise questions or bring session tapes for review;
- discuss issues of co-working;
- discuss treatment style and group process.

[140] Turner (n 73) 22.
[141] *Ibid.* 14.
[142] *Ibid.* 15.
[143] HM Prison Service (n 105) 24.
[144] *Ibid.*

The results of this study suggest that, in relation to the provision of supervision, things have improved since Turner's report. Indeed, as will be shown later in this thesis, all of the qualified facilitators interviewed said they found supervision to be either 'important' or 'very important' as a means of support. However, the results also showed that a small proportion of participants had not received the minimum amount of supervision - as stipulated in the audit document - and there were numerous complaints regarding the quality of supervision provided.

d) Further support

There are various other processes and practices – outlined in the audit document – that are designed to support SOTP facilitators once qualified. For example, it is stipulated that facilitators:

- should be given at least 45 minutes planning time for each SOTP session;[145]
- should take a break of at least eight weeks after the completion of any Core programme;[146]
- must be properly trained and kept up to date with SOTP developments;[147] and
- should be paired with more experienced tutors[148] when running their first course.[149]

More significantly, every four years, all facilitators have their involvement with the SOTP formally reviewed by management.[150] This is referred to as the 'health check' and is designed to ensure that facilitators are not suffering emotional harm as a result of working

[145] *Ibid.* 12.
[146] *Ibid.* 18.
[147] *Ibid.* 22.
[148] An experienced tutor is defined in the SOTP audit document as 'someone who has run one group of that type of programme'.
[149] HM Prison Service (n 105) 23.
[150] *Ibid.* 19.

intensively with sex offenders. A break of at least six months is recommended at this stage, and facilitators should not re-enter the programme unless managers are satisfied that they are not suffering from any adverse emotional effects. At the same time as the health check, facilitators are also required to complete the Assessment of Dynamic Adaptation (ADA), which was developed in response to the lack of measures targeted specifically at SOTP facilitator well-being.[151] It measures 'negative reactivity' to offenders (the extent to which facilitators experience hostile emotions towards their work), ruminative vulnerability (the extent to which facilitators ponder over their work in a way that leaves them feeling vulnerable), and organisational dissatisfaction (the level of dissatisfaction with colleagues and managers). The ADA can only be completed by those who have experience of the programme, which is why it is completed after several years' experience of the programme and not at initial selection.[152]

It can be contended, however, that the idea of leaving facilitators simply to 'get on with the job' for four years is inadequate. In its defence, the Prison Service does offer a wide range of other types of support from the point of qualification onwards; although - as the above discussion points out – these are far from perfect. Moreover, it should not be presumed that, because a number of these support mechanisms (particularly supervision and counselling) are compulsory in nature, they are administered correctly by the responsible staff, and utilised fully by facilitators.[153]

[151] Clarke and Roger (n 51) 92.
[152] HM Prison Service (n 48) 12.
[153] In the current study, two facilitators were forced to take time off due to work-related stress, and both complained of poor support provision leading up to their absences. The implications of such results and my recommendations for how support services might be improved in the future are contained in the chapter eight of this thesis.

The fact that facilitators usually wait for four years before receiving a thorough health check is mitigated by the introduction of the 'Staying Strong' training course. Held over two days, the course aims to give facilitators the opportunity to learn more about how working with sex offenders affects them on an individual level, and involves small-group discussion, work in pairs, personal work, self-disclosure, role-play and case examples.[154] The individual here is key; the course was heavily influenced by the work of Clarke[155] and recognises that facilitators have a different combination of strengths and weaknesses and will react differently to the stressors presented by the SOTP. For this reason, all course participants are given a personal development log. Facilitators are encouraged to fill this in throughout the duration of the course when they discover something new about how they cope with SOTP work or a novel way of managing a stressful situation. It is also recommended that facilitators add to this log upon return to their individual establishments.[156] The first day of the course is very much theory-based and introduces facilitators to the literature in the field. This provides an opportunity to identify what particular vulnerabilities they have with coping with the demands of the SOTP and their particular strengths. On the second day, participants are taken through a series of exercises to demonstrate techniques to build up resilience to the negative effects of working with sex offenders.[157] The programme is now available on a national basis although evaluation data is not yet available.

IV. CONCLUSION

Over the preceding four decades, a huge amount of research has been conducted into the nature, substance and effect of social support. One outcome of this is that the definition of

[154] HM Prison Service, *Staying Strong: Training for Facilitators in Resilience,* (Internal, Offending Behaviour Programme Unit, London 2007).
[155] Clarke (note 46).
[156] HM Prison Service (n 105) 11.
[157] *Ibid.* 2.

'social support' is now very wide. Source of support, for example, can no longer be discussed simply in terms of personal relationships and work relationships as both - particularly the latter - have been fragmented to create various sub-categories of support. Depending on the study in question, organisational support can include the more conventional help from managers and supervisors, down to assistance from work colleagues, and even the provision of training by the organisation. A large number of these studies have argued that such support can have a positive impact upon health and organisational outcomes, particularly by reducing stress levels. However, a significant minority of researchers working in the field have also contended that, in terms of alleviating the impact of stress, social support has at best no effect at all, and can at worst actually make stress symptoms worse. Indeed, more recent work has shown that invisible support (i.e. where the individual feels supported, but does not realise that they have received any tangible assistance) might be most effective at combating the effects of stress.[158]

The Prison Service has been successful in providing a wide range of training and support services to its SOTP facilitators. Staff interested in working on the programme must complete a series of psychometric tests to check their emotional suitability to the work, and get through a recruitment interview before they are enrolled on the SOTP training course. Once qualified, audit criteria published by the Offending Behaviour Programme Unit stipulate that facilitators should receive debriefing after each treatment session and 12 hours of team supervision, two hours of individual supervision, and three counselling sessions per programme. It therefore seems as though the Prison Service is doing the right things to protect itself from liability 'stress at work' claims, particularly given the decision of the Court of Appeal in *Sutherland v*

[158] Bolger and Amarel, (n 38).

Hatton.[159] However, support to SOTP facilitators needs to be more than just a paper exercise. Although Prison Service managers and staff working at the Offending Behaviour Programme Unit appear to be thoroughly committed to providing the best possible support to facilitators, the above discussion illustrates that a number of weaknesses still permeate current practice. These issues will be further explored in chapter eight of this thesis, which details the responses of newly qualified facilitators to the support they received during their first year working on the programme.

[159] [2002] EWCA Civ 76; [2002] 2 All ER 1.

CHAPTER 4

EMPLOYER LIABILITY FOR STRESS AT WORK

I. INTRODUCTION

Since the Factories Acts of the industrial revolution, successive governments have given thought to the issue of health and safety in the workplace.[1] However, the incorporation of stress-related mental injury into legislation has not been easy. Gustavsen has noted that concepts like 'stress' are difficult to regulate by statute due to inherent problems with definition and measurement.[2] Likewise, once legislation is enacted, it becomes very difficult to update due to a need for solid documentary evidence pointing to a definite need for change.[3] This said, there is now a significant body of legislation regulating the issue of health and safety at work, and a growing body of case law supporting the idea that employers owe a duty of care to their employees regarding work-related stress. As pointed out by Lord Slynn in *Spring v Guardian Assurance plc*, there are now '…far greater duties imposed on the employer than in the past, whether by statute or by judicial decision, to care for the physical, financial and even psychological welfare of the employee…'.[4] Existing UK law has also been supplemented with contributions from the European Union in the form of Article 136 and 137 EC, and various directives pertaining to health and safety at work. Such measures are clearly required given that recent figures have estimated that occupational stress costs the

[1] L Doyal, *The Political Economy of Health* (Pluto Press, London 1979).
[2] B Gustavsen, 'Improving the Work Environment: A Choice of Strategy', (1980) 119 International Labour Review 271.
[3] *Ibid.* 273.
[4] [1995] 2 AC 296 (HL) 335.

UK economy approximately £3.7 billion each year and has now overtaken musculoskeletal disorders as the primary cause of working days lost through ill-health.[5]

As discussed in chapter 2, there is a distinct possibility that SOTP therapists may experience adverse effects from working with sex offenders. At present, very few SOTP facilitators have taken action against the Prison Service for stress experienced whilst working on the Programme, and those cases that have come to light have been resolved by out-of-court settlements. However, in the most recent case involving a claim by an ex-SOTP facilitator, the complainant received a £150,000 payout from the Home Office following allegations that he received poor supervision and support.[6] Moreover, it was suggested at the time that several other claims were being processed on behalf of prison workers alleging that they too had been traumatised by their work on the SOTP.[7] The question then remains as to whether a court would find the Home Office liable for any psychiatric injury incurred by a facilitator working on the SOTP and, if so, under what conditions. It is this issue of liability that will be considered in this chapter.

II. TORTIOUS LIABILITY: NEGLIGENCE

As stated by Lord Macfadyen in the case of *Cross v Highlands and Islands Enterprises*, there is little doubt that an employer's duty of care extends to taking 'reasonable care not to subject the employee to working conditions which are reasonably foreseeably likely to cause him

[5] L Pointing, 'Uptight Top-Ranking: Which Jobs Carry the Highest Stress Risks?' (2004) 331 Health and Safety Bulletin 8.
[6] P Johnstone, '£150,000 Reward for Prison Officer on Sex Wing', *The Daily Telegraph* (London 1 April 2003) <http://www.telegraph.co.uk/news/uknews/1426270/150000-award-for-prison-officer-on-sex-wing.html> accessed 24 November 2009.
[7] *Ibid.*

psychiatric injury or illness'.[8] If the complainant can show that his employer breached this duty of care and can establish both factual[9] and legal causation,[10] then the employer is likely to be held to have been negligent in his role.

The origins of the duty to prevent 'injury' to another was first suggested in the late eighteenth century by Buller, who stated that 'every man ought to take reasonable care that he does not injure his neighbour; therefore wherever a man receives hurt through the default of another…if it be occasioned by negligence or folly, the law gives him an action to recover for the injury so sustained'.[11] According to Lunney and Oliphant, the idea that liability in negligence should be based on a duty owed by one party to another was slow to take hold.[12] Although the issue was partly resolved by the case of *Ansell v Waterhouse*[13] – where it was accepted that damages could be sought for 'the negligent or wilful conduct of the party sued, in doing or omitting to do something contrary to the duty which the law casts on him' – this still left the question of *when* such a duty would be imposed. The landmark case of *Donoghue v Stevenson*[14] was the first to deal with this issue. Here, the complainant alleged that, after realising she had consumed some ginger beer that contained the remains of a decomposing snail, she suffered shock and gastro-enteritis. As the bottle containing the beer was made of green glass, the complainant argued that she had been unable to inspect the

[8] [2001] IRLR 336, 351.
[9] Also known as the 'but for' test. To establish factual causation the claimant must show that the prohibited consequence would not have occurred, as and when it did, *but for* the respondent's conduct. See M Lunney and K Oliphant, *Tort Law: Text and Materials* (3rd edn, Oxford University Press, Oxford 2008).
[10] In tort law, legal causation is more commonly referred to as the test of 'remoteness' of damage. Once factual causation has been established it is necessary to show that, as a matter of legal policy, the respondent should be held liable. Thus, the question of legal causation is closely connected to the ideas of responsibility and culpability, and whether the prohibited result can be said to be fairly imputable to the respondent. See Lunney and Oliphant (n 9) 268.
[11] H Bathurst, *An Introduction to the Law Relative to Trials at Nisi Prius* (H. Woodfall and W. Strahan, London 1767).
[12] Lunney and Oliphant (n 9) 106.
[13] (1817) 6 M&S 385; 105 ER 1286, 1289 (Bayley J).
[14] [1932] AC 562 (HL).

product before consumption. The majority of the Court of Appeal subsequently held that the manufacturer of an article of 'food, medicine, or the like' would be under a legal duty to the end consumer to take reasonable care that the item was free from any defect likely to cause death or injury. However, the judgment in this case went further than simply imposing a duty on manufacturers to take 'reasonable care' when distributing goods of a certain nature, i.e. those that could not be examined before consumption. Although not forming part of the *ratio* of the judgment, it has been suggested that Lord Atkin's speech on the 'neighbour principle' introduced to the law a general principle of 'good neighbourliness':[15]

> The rule that you are to love your neighbour becomes in law, you must not injure your neighbour…you must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure you neighbour. Who, then, in law is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called into question.[16]

Although the key 'injury' sustained by the claimant in the case of *Donoghue* was physical in nature (namely acute gastro-enteritis), evolution of case law has resulted in the current position whereby the duty to not cause psychiatric injury is seen as equally as important as the duty not to cause physical injury.[17] There are, however, certain preconditions that those wishing to recover damages for psychiatric illness must meet. First, the claimant's condition must be a recognisable psychiatric illness rather than a mere unpleasant emotion, and this will

[15] Lunney and Oliphant (n 9) 116.
[16] *Donoghue v Stevenson* (n 14) 580.
[17] *Page v Smith* [1996] AC 155. Although it should be noted that English law has recognised a cause of action for 'nervous shock' or psychiatric illness since the turn of the nineteenth century: *Dulieu v White & Sons* [1901] 2 KB 669.

usually be confirmed by the testimony of an expert witness. Thus, whilst the feelings of anxiety, fear and grief have been held as insufficient,[18] damages have been awarded by the courts for morbid depression,[19] post-traumatic stress disorder,[20] and chronic fatigue syndrome.[21] Second, the prohibited consequence must have been reasonably foreseeable. Third, the law has drawn a distinction between primary and secondary victims, prescribing only limited circumstances in which a party not directly involved in an incident will be permitted to bring an action in negligence for the onset of a psychiatric condition. In *Alcock v Chief Constable of South Yorkshire Police*[22] it was decided that, for a secondary victim to claim damages for psychiatric injury, he must demonstrate (1) a close tie of love and affection with the injured party, (2) physical proximity to the event or immediate aftermath, and (3) that he perceived the event with his own senses.

Any further discussion of these conditions is beyond the scope of this thesis. It is noteworthy, however, that in the case of *Hatton v Sutherland,*[23] the Court of Appeal stated that none of these 'special control mechanisms' applies to claims for psychiatric injury arising from the stress of doing work required by an employer. Lady Justice Hale went on to state that '…these claims require particular care in determination because they give rise to some difficult issues of foreseeability and causation and…a relevant breach of duty'.[24] It can therefore be concluded that the law relating to an *employer's* liability for psychiatric injury suffered at work has been slower to develop than the area of psychiatric illness in the tort of negligence generally.

[18] Law Commission, 'Liability for Psychiatric Illness' (Law Com No 249, 1998) [2.3]
[19] *Hinz v Berry* [1970] 2 QB 40.
[20] *Vernon v Bosley (No. 1)* [1997] 1 All ER 577 (CA).
[21] *Page v Smith* (n 17).
[22] [1992] 1 AC 310.
[23] [2002] EWCA Civ 76; [2002] 2 All ER 1 (CA).
[24] *Ibid* 624.

The first successful case brought against an employer for psychiatric illness induced by working conditions[25] was that of *Walker v Northumberland County Council.*[26] The claimant was employed by the respondent council as a social services officer, responsible for several teams of field workers engaged in child abuse cases. In 1986 the claimant suffered a nervous breakdown but returned to work in the following year on the condition that he would receive assistance in conducting his duties. Within one month of his return, this additional support was withdrawn and the claimant suffered a further breakdown. Following the principles laid down in the earlier case of *Petch v Customs and Excise Commissioners,* [27] it was decided that, although the council could not be held responsible for Mr Walker's first nervous breakdown, it was liable for the second on the basis that the it should have appreciated that the claimant was more vulnerable to psychiatric damage than his fellow workers. As stated by Coleman J, '…I have no doubt that it ought to have been foreseen…that if Mr Walker was again exposed to the same workload as he had been handling at the time of his [first] breakdown…there was a risk that he would once again succumb to mental illness'.[28] Thus, in the opinion of the Court, the claimant's first breakdown made his relapse reasonably foreseeable. The Court further suggested that, once a duty had been established on the part of the council, the performance of that duty required a 'reasonable response', taking into account the relationship with the claimant, the magnitude of the risk of injury, the seriousness of the consequences for Mr Walker and the cost and practicality of preventing the risk.[29] Despite the fact that provision of additional assistance to the claimant could have been expected to cause some disruption to normal working practice, the Court held that removal of this support equated to a breach of the council's duty.

[25] Namely the volume and character of the claimant's work.
[26] [1995] 1 All ER 737 (QBD).
[27] [1993] ICR 789 (CA).
[28] *Walker v Northumberland CC* (n 26) 756.
[29] *Ibid* 750.

Since *Walker,* a number of cases have been decided outlining the 'standard' that an employer must meet in order to fulfil its duty to prevent – or at least minimise – reasonably foreseeable psychiatric damage resulting from stress in the workplace. The case of *Hatton v Sutherland*[30] was one of four cases[31] heard by the Court of Appeal, all of which were related by their subject matter – namely employer's liability for psychiatric illness caused by stress at work. The appellants in all of the cases were employers, petitioning against damages awarded by the court of first instance to their employees for stress-related injuries. Three of the four appellants were successful, including the appellant in *Hatton*. The court laid down guidance as to when an employer would incur liability for the psychiatric illness of an employee, with the 'threshold question' being whether the harm caused by stress at work was reasonably foreseeable in the particular employee rather than the workforce generally. Although suggesting that foreseeability should be dependent on what the employer knew or ought to reasonably have known about his employee, Hale LJ stated that:

> Unless he knows of some particular problem or vulnerability, an employer is usually entitled to assume that his employee is up to the normal pressures of the job. It is only if there is something specific about the job or the employee or the combination of the two that he has to think harder.[32]

Hale LJ continued by stating that the employer need not make any 'searching or intrusive inquiries' regarding the status of his staff's health. Rather, the employer was entitled to accept what it was told by or on behalf of the employee at face value,[33] unless it had very

[30] *Hatton v Sutherland* (n 23).
[31] Hatton v Sutherland; Barber v Somerset County Council; Jones v Sandwell Metropolitan Borough Council; Bishop v Baker Refractories Ltd.
[32] *Hatton v Sutherland* (n 23) 15.
[33] A point that has since been confirmed in *Vahidi v Fairstead House School Trust Ltd* [2005] EWCA Civ 765; [2005] ELR 607 (CA).

good reason to consider otherwise. To trigger a duty to act, the signs of impending psychiatric decline had to be 'plain enough for any reasonable employer to realise that he should do something about it'.[34] Furthermore, an employer would be in breach of its duty only if he had failed to take steps that were considered reasonable in the circumstances, bearing in mind the factors discussed in *Walker*.[35] The court put forward sixteen practical propositions to assist litigants in cases involving stress at work claims, including the idea that an employer who offered a confidential advice service, with the possibility of referral to counselling or treatment, would be unlikely to be found in breach of his duty.[36] However, it should be noted that, in the recent case of *Daw v Intel Corporation UK Ltd*,[37] the Court of Appeal held that counselling services are not 'a panacea by which employers [can] discharge their duty of care in all cases'.[38] The claimant held an administrative position at the defendant organisation and, as a result of excessive demands at work, broke down. Managers asked her to write down her concerns and assured her that another employee would be recruited to assist her. In the event, this did not happen. The claimant was signed off from work with depression and attempted suicide. At trial the defendant company was found to be liable on the basis that it ought to have known that the demands on the claimant were unreasonable and therefore the risk of harm to her health was clear. Relying on the *Hatton* guidelines, the defendant company appealed on the basis that by providing a counselling service it had discharged its duty of care. Dismissing the appeal, the Court of Appeal commented that the serious managerial failures that had occurred could not have been

[34] *Hatton v Sutherland* (n 23) 15.
[35] *Walker v Northumberland CC* (n 26) 750.
[36] *Hatton v Sutherland* (n 23) 16, 20.
[37] [2007] EWCA Civ 70; [2007] 2 All ER 126 (CA).
[38] *Ibid.* 136.

prevented by counselling; at the very most, the provision of such a service to the claimant might have 'brought home to management that action was required'.[39]

The decision in *Hatton*[40] has been criticised on a number of counts, primarily due to the stringent foreseeability requirements laid down by the court which have been said to 'insulate' an employer from liability. This point seems particularly pertinent in relation to workers who are reluctant to disclose details of an impending illness to their employer, through fear of appearing unable to cope with the 'ordinary' pressures of work.[41] As argued by Walden, following the outcome in *Hatton*, 'employees were being held increasingly responsible for their own psychiatric wellbeing'.[42] There also seems to be internal inconsistencies in the judgment: Lady Justice Hale at first contends that, *unless there is something specific about the nature of the job in question*, an employer is entitled to presume that his staff can deal with the normal strains of the job. However, she later asserts that 'there are no occupations which should be regarded as intrinsically dangerous to mental health'.[43]

Despite the fact that subsequent cases have followed the *Hatton* guidelines closely,[44] the law has certainly not made it impossible for employees to bring successful claims for psychiatric injury against negligent employers. First, the Court of Appeal upheld the district judge's decision in the third case of the conjoined *Hatton* appeals (*Jones v Sandwell Metropolitan Borough Council*), arguing that the response of the appellant council to the complainant's

[39] *Ibid.*
[40] *Hatton v Sutherland* (n 23).
[41] Lunney and Oliphant, (n 9) 365.
[42] R Walden, 'Psychiatric Injury and Stress: The Employer's Duty of Care' (2004) 332 Health and Safety Bulletin 15, 16.
[43] *Hatton v Sutherland* (n 23) 19.
[44] *Pratley v Surrey County Council* [2003] EWCA Civ 1067, [2004] ICR 159 (CA); *Bonser v RJB Mining (UK) Ltd* [2003] EWCA Civ 1296, [2004] IRLR 164 (CA).

concerns of being overworked were unreasonable.[45] Second, it has been suggested that, after the decision in the later case of *Barber v Somerset County Council*[46] (another of the *Hatton* conjoined appeals that made it to the House of Lords), the Law Lords have placed responsibility for employees' mental health squarely back on the shoulders of employers. Mr Barber, an experienced maths teacher, retired on medical advice after a restructuring of staff duties at the school in which he worked. Before his departure he had taken a short leave of absence whilst suffering from depression which had been confirmed by his doctor. The Court of Appeal held that, upon his return to work, Barber's employer could not have reasonably foreseen the deterioration of his condition due to the speed at which matters had escalated, and also because of the lack of information provided by the complainant in relation to his symptoms. However, in allowing Barber's appeal, the House of Lords reasserted the words of Stanwick J in *Stokes v Guest, Keen and Nettlefield (Bolts and Nuts) Ltd*:[47]

> . . . the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of common sense or newer knowledge it is clearly bad; but, where there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it; and where he has in fact greater than average knowledge of the risks, he may be thereby obliged to take more than the average or standard precautions.[48]

[45] [2002] EWCA Civ 76; [2002] 2 All ER 1 (CA) 52.
[46] [2004] UKHL 13; [2004] 1 WLR 1089 (HL).
[47] [1968] 1 WLR 1776.
[48] *Ibid*. 1783.

Although Lord Walker accepted that the case was 'fairly close to the borderline' in terms of establishing liability he also stated that, having returned to work following his bout of depression, 'the school management team should have taken the initiative in making sympathetic inquiries about Mr Barber…and making some reduction in his workload…'[49]

Upon cursory inspection, it certainly seems as though *Barber*[50] has resulted in a situation where employees are now more likely to be successful in claiming for psychiatric injury caused by stress at work. However, Ross has argued that, far from creating any new principles, the House of Lords in *Barber* simply reaffirmed the guidance of Hale LJ in *Hatton*,[51] whilst at the same time highlighting that an employer's conduct must be reasonable, prudent, and led by up-to-date knowledge of health and safety issues.[52] This idea was given further credence by the Appeal Court in *Hartman v South Essex NHS Trust*.[53] Here it was decided that Lord Walker's speech in *Barber*, which described the *Hatton* guidelines as 'useful…[but]…lacking anything like statutory force',[54] was not an expression of disagreement with the principles themselves. Rather, it was merely a note of caution to suggest that 'no two cases were the same and that Hale LJ's words should not be applied as it were by rote regardless of the facts'.[55] Therefore, although the *Hatton* guidelines have been embraced by the courts as a valuable tool in making decisions regarding employer liability, 'stress at work' cases should apparently be decided on an individual basis. Moreover, judges may decide to depart from the guidelines where the circumstances of a given case dictate that it is necessary. It certainly seems as though the courts have attempted to strike a balance

[49] *Barber v Somerset CC* (n 46) 1111.
[50] *Barber v Somerset CC* (n 46).
[51] *Hatton v Sutherland* (n 23).
[52] M Ross, 'Stress: What can an employer do?' (2004) 9(11) Employment Law and Litigation 22.
[53] [2005] EWCA Civ 6; [2005] ICR 782 (CA).
[54] *Barber v Somerset CC* (n 46) 1109.
[55] *Hartman* (n 53) 791.

between the employee's right to work in a stress-free environment and the reasonableness of such a requirement, taking into account the resources at the disposal of the employer and the individual circumstances of the case.

III. CONTRACTUAL LIABILITY OF THE EMPLOYER

Although the principal cause of action regarding employers' liability for stress at work is through the tort of negligence, liability can equally be established through the law of contract.[56] The terms of a contract of employment may impose a higher standard of care on an employer than in negligence. Moreover, even if the contract permits the employer to impose conditions of stress on the employee, this is not to say that such terms will always be upheld in court. For example, in the case of *Johnstone v Bloomsbury Health Authority*[57] the claimant was required to work for up to 88 hours per week as a junior doctor. After a particularly busy period, during which he worked a 110-hour week, Mr Johnstone was involved in a car accident. He escaped uninjured but the incident resulted in his resignation. Mr Johnstone subsequently brought an action against the defendant health authority alleging breach of its duty as his employer to take reasonable care for his safety and well-being, and seeking a declaration that the he could not lawfully be required to work for so many hours in excess of the standard working week as would foreseeably injure his health. The question for the court was, therefore, whether being contractually obliged to work so many hours, it was reasonably foreseeable that such conditions would cause injury to health. It was held that section 2(1) of the Unfair Contract Terms Act 1977[58] would prevent the appellant health authority from relying on the express contractual term outlining the long working hours of the

[56] A Collender, A Buchan, and B Langstaff, 'Psychiatric Injury, Stress and Harassment', in J Hendy and M Ford (eds) *Munkman on Employers Liability* (13th edn Butterworths, London 2001).
[57] [1992] QB 333 (CA).
[58] This states that 'A person cannot by reference to any contract term…exclude or restrict his liability for death or personal injury resulting from negligence'.

claimant. In this case, the court declared that the term would be contrary to the *implied* duty to provide a safe system of work for employees,[59] as articulated in *Paris v Stepney Borough Council*.[60] Thus, it seems unlikely that the courts will uphold a clause in a contract of employment which potentially exposes the employee to working conditions that present a risk of injury. As pointed out by Collender *et al,* in deciding upon the validity of such clauses, 'the question, as always, is whether the employer has taken all those steps which are reasonable in the circumstances to protect the employee from reasonably foreseeable injury from the danger or stress'.[61]

This said, it has been stated that 'the rules to be applied when an employee brings an action against his employer for harm suffered at his workplace are the rules of tort' and that any duty incurred via contractual arrangement could not be wider in scope than the duty imposed by tort law.[62] Therefore, although employees have two avenues of redress, it will usually be through the tort of negligence that those who have suffered psychiatric injury from work-related stress will bring an action.

IV. CURRENT LEGISLATION

There is currently no legislation in force in the UK that places a responsibility on the part of employers to protect their staff from stressful working conditions. Indeed, the Law Commission has suggested that there is no need to for such legislation[63] for three key reasons: first, because the common law in this area is 'developing along the right lines'; second,

[59] Which has generally been held to include the provision and maintenance of proper premises and machinery, to select properly skilled and trained workers, and to establish a proper system of working. See *Wilsons and Clyde Coal Co Ltd v English* [1938] AC 57; *Vaughan v Ropner & Co* (1947) 80 LI L Rep 119 (CA).
[60] [1951] AC 367.
[61] Collender *et al* (n 56) 173.
[62] *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455, 497.
[63] Law Commission (n 18) [7.23]

because claims for psychiatric injury suffered at work will commonly involve complex evidentiary issues of foreseeability and causation which cannot be resolved by codification of the law; and third, because such cases should be dealt with by the courts via the tort of negligence and the general duty of care owed by an employer to his employees.[64]

There have, however, been attempts to address the more general problem of inadequate working conditions and practices. The first statute to deal with health and safety issues in the workplace was the Health and Safety at Work Act 1974. Born as a result of recommendations from the Robens committee, section 2(1) of the Act states that 'It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees'. This requires the employer to provide and maintain a safe environment and system of work and ensure that staff have access to any information, instruction, training and supervision necessary to guarantee their health and safety.[65] Employers are also required by the Act to provide a written policy statement regarding the health and safety of staff.[66] The Health and Safety at Work Act formed part of a much wider political agenda focusing on work characteristics and occupational health, with one of the primary aims of the then government being to 'improve working conditions and morale, rather than simply boost productivity'.[67] The 1970s was therefore a key era for workplace reform and improvements in health and safety generally, and marked the point at which the idea of stress at work was recognised as having a potential impact on the UK workforce.[68] The concept was further fuelled by the policies of Thatcher's Conservative Government, which included an erosion of

[64] *Ibid.* [7.22]
[65] Section 1(2) (a)-(e).
[66] Except in prescribed cases. See section 2(3).
[67] D Wainwright and M Calnan, *Work Stress: The Making of a Modern Epidemic* (Open University Press, Buckingham 2002) 42.
[68] B Gustavsen, 'Democratizing Occupational Health: The Scandinavian Experience of Work Reform' (1988) 18 International Journal of Health Services 675.

the employment laws that had acted to protect the interests of workers. According to some commentators this meant that, by the mid 1990s, British workers faced greater job insecurity, fewer rights at work, longer hours, and increased pressure to improve productivity.[69]

However, with the election of Blair's New Labour Government in 1997 came a renewed commitment to redressing the balance between employer and employee rights. The issue of health and safety at work – including work stress - has since permeated various areas of government policy. For instance, a Green Paper, entitled *Our Healthier Nation*,[70] set out the aims of improving the health of the population as a whole, particularly that of the 'worst-off' in society, in three key settings: schools, neighbourhoods, and - most significant for the purposes of this thesis - the workplace. The White Paper that followed reasserted these aims and highlighted the connection between coronary heart disease and jobs which make very high demands or provide little or no autonomy to the worker.[71] In an attempt to encourage employers to be proactive in tackling the issue of work stress and ill health, the White Paper declared that 'a healthy workplace will bring employers and employees improved productivity, lower rates of sickness absence, fewer accidents and less illness'.[72] Furthermore, it highlighted the launch of the 'Healthy Workplace Initiative'. Jointly sponsored by the Department of Health and the Health and Safety Executive, the aims of the Initiative are to identify and promote examples of good practice in handling workplace health issues and disseminate the results to employers; make available relevant and up to date information which reflects the available evidence on workplace health; provide better access to services and bridge the gap between prevention, treatment, and rehabilitation; and help to

[69] See Wainwright and Calnan, (n 67) 127.
[70] Secretary of State for Health, 'Our Healthier Nation: A Contract for Health' (Cm 3852, 1998).
[71] Secretary of State for Health, 'Saving Lives: Our Healthier Nation' (Cm 4386, 1999).
[72] *Ibid.* [4.26]

promote compliance with workplace legislation.[73] One-hundred thousand workplace organisations were contacted in early 1999 to encourage them to sign up to the initiative.[74] Members receive a free newsletter four times a year and become part of a national on-line community (via www.signupweb.net) which provides access to information and support services on occupational health.[75] In 2002, it was reported that 30,000 small and medium sized enterprises had joined the initiative.[76]

More recently, the Government has continued its efforts to improve the working environment for people employed in the UK. In its response to Dame Carol Black's Review of 'Britain's working age population',[77] the Government has set out its plans to address the recommendations of the report which include an occupational health helpline for smaller businesses and the Business HealthCheck tool, designed to enable employers to estimate the costs of sickness absence, turnover, worker ill-health, and injury.[78] The plans clearly rely on an inter-departmental approach and aim to bring together various government departments to tackle the issue of work stress, particularly the Health Service, the Department of Work and Pensions, and the Health and Safety Executive. The latter of these organisations has arguably played the most active role in improving workplace health over the past decade and, in 2004, launched its own management standards for work-related stress which, although lacking statutory force, supplement the existing law by defining the 'characteristics, or culture, of an organisation where stress is being managed effectively'.[79] The 'standards' achieve this by

[73] *Ibid.* [4.27].
[74] Hansard HC vol 328 col 183 (23 March 1999 WA).
[75] Hansard HC vol 379 col 1152W (7 February 2002).
[76] *Ibid.*
[77] Dame Carol Black, 'Working for a Healthier Tomorrow' (TSO, London 2008).
[78] Secretaries of State for the Department of Work and Pensions and Department of Health, 'Improving Health and Work: Changing Lives' (Cm 7492, 2008).
[79] Health and Safety Executive 'How to Tackle Work-Related Stress: A Guide for Employers on Making the Management Standards Work' (Information Leaflet) (October 2009) <http://www.hse.gov.uk/pubns/indg430.pdf> accessed 20 July 2009.

identifying six primary sources of workplace stress that have been associated with reduced productivity and sickness absence, namely demands; control; support; relationships; role; and organisational change. For each standard, a description of 'states to be achieved' is provided. These essentially indicate the minimum conditions that an organisation should realise to control work-related stress, and draw on the practical guidance given by the Court of Appeal in *Hatton*,[80] and the House of Lords in *Barber*[81]. Employers are encouraged to assess their existing performance by using a number of techniques, including a staff survey designed by the HSE.[82] It has been suggested that employers will be presumed to have a working knowledge of the HSE's guidance,[83] which will presumably be a factor that a court will take into account when deciding whether an organisation provided a 'reasonable response' when executing its established duty of care towards an employee.

Since the late 1980s, the European Community has also played a significant role in improving the state of health and safety in the workplace across all Member States. The overall aim of Community legislation has been to improve conditions for those in paid employment by encouraging harmonisation of the working environment. To this end, EC laws have laid down minimum health and safety requirements but they have, at the same time, allowed Member States the freedom to introduce a higher level of protection under domestic law should they wish to do so.[84] Since the Treaty of Nice of 2003, Articles 136 and 137 of the EC Treaty have formed the basis of Community efforts to protect workers' health and safety. Whilst Article 136 lays down the objective of promoting improved working conditions,

[80] *Hatton v Sutherland* (n 23).
[81] *Barber v Somerset CC* (n 46).
[82] See Health and Safety Executive (n 79) 4.
[83] See Walden (n 42) 18.
[84] Christa Kammerhofer, 'Common Policies: Social and Employment Policy; Health and Safety at Work' (Fact Sheet on the European Union 2008) <http://www.europarl.europa.eu/parliament/expert/displayFtu.do?language=en&id=74&ftuId=FTU_4.9.5.html> accessed 26 November 2009.

Article 137 states that the Council may – in order to achieve such an objective – adopt 'minimum requirements for gradual implementation' in relation to standards of health and safety in the workplace, without imposing 'administrative, financial and legal constraints which would hold back the creation and development of small and medium-sized undertakings'. One of the key stages in the development of Community policy on health and safety in the workplace came with Framework Directive 89/391/EEC.[85] This aimed to improve protection for workers from accidents at work and occupational diseases by outlining a range of preventative measures including plans for information sharing, consultation, and increased training for employees and employers. The Framework Directive provided the basis for 19 'daughter directives' covering various aspects of workplace health and safety.[86] According to the principles of EU law, these have subsequently been implemented into UK legislation. Indeed, in 1992 a number of statutory instruments (colloquially known as the 'six pack') were passed which brought into effect the most wide-ranging of the daughter directives.[87] Included in this bundle was the Management of Health and Safety at Work Regulations 1999,[88] which place a duty upon employers to conduct a 'suitable and sufficient' assessment of the health and safety risks (including risks to mental health) to which employees might be exposed whilst at work.

However, Community action has not been limited to legislation. For some time it has worked in partnership with other interested agencies, like the European Agency for Health and Safety

[85] Council Directive (EEC) 89/391 concerning the minimum safety and health requirements for the workplace [1989] OJ L 393/1.
[86] Kammerhofer (n 84).
[87] Namely, the Management of Health and Safety at Work Regulations 1999 (Directive 89/391) Safe Use of Work Equipment, Provision and Use of Work Equipment Regulations 1998 (Directive 89/655/EEC); Manual Handling Operations Regulations 1992 (Directive 90/269/EEC); Workplace (Health, Safety and Welfare) Regulations 1992 (Directive 89/654/EEC); Personal Protective Equipment at Work Regulations 1992 (Directive 89/656/EEC); Health and Safety (Display Screen Equipment) Regulations 1992 (Directive 90/270/EEC).
[88] The Management of Health and Safety at Work Regulations 1999 SI 1999/3242 (which revoked the Management of Health and Safety at Work Regulations 1992 SI 1992/2051).

at Work, which aims to share knowledge and information with governments, employers and workers to promote a culture of risk prevention.[89] Likewise, the European Commission has shown a commitment to cooperating with Trade Unions and Employer Organisations (the 'Social Partners') before taking action on employment-related issues and policy. Through this process, the Social Partners have reached a number of autonomous agreements in conjunction with the Commission.[90] Indeed, partners from a number of Member States - including the UK – recently signed up to a new framework agreement on work-related stress. The main aim of the agreement is for the Social Partners to increase the awareness and understanding of work stress among employers, their staff and representatives, so that problem symptoms can be identified and managed appropriately.[91] In June 2008, representatives of employers and employees from signatory states presented a report outlining how the objectives of the agreement had been reached. This highlighted the work of the HSE in developing the Management Standards, which is how the UK has complied with the objectives of the agreement.[92]

In 2007, the European Commission published its five-year strategy in relation to health and safety in the workplace, with a focus on reducing occupational accidents and diseases. The plan aims to do this by improving and simplifying existing legislation, enhancing its implementation in practice, and encouraging Member States to develop national strategies to meet the Commission's overall objectives.[93] This, along with the Social Partner agreement

[89] See <http://osha.europa.eu/en/about> accessed 21 July 2009.
[90] See <http://ec.europa.eu/social/main.jsp?catId=329&langId=en> accessed 21 July 2009.
[91] Health and Safety Executive, 'Work-related stress: A Guide' (Information Leaflet) (2005) <http://www.hse.gov.uk/stress/pdfs/eurostress.pdf> accessed 24 July 2009.
[92] European Social Partners, 'Implementation of the Autonomous Framework Agreement on Work-Related Stress' (Report) (18 June 2008) <http://www.etuc.org/IMG/pdf_Final_Implementation_report.pdf> accessed 22 November 2009.
[93] EU Strategy 2007 – 2012 for Health and Safety at Work <http://ec.europa.eu/social/main.jsp?catId=151&langId=en> accessed 26 November 2009.

discussed above, are both examples of how the Community has started to take specific action on the problem of stress at work and its commitment to a partnership approach with Member States. At a national level, progress has been more gradual. It can certainly be said that guidance for employers on ways to approach the problem of stress at work is now available; but statutory provisions outlining employers' duties in relation to preventing stress-related illness have been slower to emerge. Although the Health and Safety at Work Act, and the Management of Health and Safety at Work Regulations have established a number of broad expectations pertaining to the welfare of employees in the workplace – which have been interpreted to also include psychological health – neither make specific reference to stress-related ill-health attributable to working conditions. Overall, however, this is not necessarily something to be criticised in light of the fact that, in recent years, the courts have been happy to develop the common law in this area.

V. CONCLUSION

Like all employers, the Prison Service is under a statutory obligation to 'ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees'.[94] According to the Management of Health and Safety at Work Regulations 1999, it must also conduct a 'suitable and sufficient' assessment of the physical and psychological risks to which an employee might be exposed at work.[95] As there is currently no specific European legislation dealing with the issue of stress at work, these requirements seem to mark the extent of the Prison Service's statutory duty towards its employees regarding psychiatric injury. However, the scope of tort law, in particular negligence, extends these boundaries a little further. It has clearly been established through case law that an employer has a duty to

[94] Health and Safety at Work Act 1974, s 2(1).
[95] Management of Health and Safety at Work Regulations 1999 SI 1999/3242. reg 3.

protect his employees from reasonably foreseeable psychiatric injury caused by the work environment.[96] As decided by the court in *Hatton,*[97] what is reasonably foreseeable will depend on what an employer knows, or ought reasonably have known, about an individual employee, and will require a response that takes into account the magnitude of the risk of injury, the seriousness of the consequences, and the cost and practicality of preventing the risk.[98]

Although a number of the so-called 'stress at work' cases have involved claimants suffering a *second* breakdown at work – making the question of foreseeability easier to identify – it is clear that, if an employer has failed to take 'positive thought for the safety of his workers in the light of what [it] knows or ought to know',[99] it will be liable regardless of past events, providing that the injury was reasonably foreseeable and caused by the work environment. Therefore, although it will be unnecessary for Prison Service managers to make 'searching enquiries'[100] into the health of facilitators, once they become aware of any changes in the normal behaviour of an individual staff member, it would certainly be prudent to take action in order to reduce the likelihood of a claim for psychiatric injury. The form that such action should take will depend on the circumstances of each case. Furthermore, if an SOTP facilitator does require leave to recover from a stress related illness, the Prison establishment must ensure that, upon their return to work, adequate steps are taken to remedy the cause of stress (if it is work-related) and that additional support is provided.

[96] *Walker v Northumberland CC* (n 26).
[97] *Hatton v Sutherland* (n 23) 19.
[98] *Ibid.*
[99] *Stokes v Guest, Keen and Nettlefield* (n 47) 1783.
[100] *Hatton v Sutherland* (n 23) 19.

Prison Service policy states that those involved in delivering the SOTP must attend regular group supervision and a minimum of three counselling sessions provided by an independent professional. As discussed previously, the court in *Hatton*[101] laid down 16 guidelines for litigants in 'work stress' cases, one of which was related to the provision of counselling assistance. Hale LJ stated that any employer who 'offers a confidential advice service, with referral to appropriate counselling or treatment services, is unlikely to be found in breach of duty'.[102] Although this seemingly affords some protection to the Prison Service from claims of work-induced psychiatric injury, it will not be enough alone, especially given the Court of Appeal's recent decision in *Daw,*[103] where it was held that provision of a counselling service does not discharge the duty of care owed by an employer to his employees. Moreover, employers will now also be required to keep abreast of developments in health and safety theory and practice.[104] Therefore, it will be up to the Prison Service to keep up-to-date with relevant research to ensure that the debriefing, supervision and counselling services made available to facilitators remain effective.

[101] *Hatton v Sutherland* (n 23).
[102] *Ibid*. 20.
[103] *Daw v Intel Corporation (UK) Ltd* (n 37).
[104] *Stokes v Guest, Keen and Nettlefield* (n 47) 1783.

CHAPTER 5

METHODOLOGY OF THE EMPIRICAL STUDY

I. INTRODUCTION

The aim of the empirical part of this thesis is to provide a detailed account of the training and support needs of SOTP facilitators. The research examines the positive and negative effects of working with sexual offenders on facilitator health. The empirical data for the project was gathered by conducting interviews with a sample of trainee facilitators taken from the Core SOTP training course, held in January 2006. A number of these participants were subsequently followed up after one year's work as a facilitator. To supplement this data, a sample of SOTP treatment managers was interviewed and asked about various issues relating to SOTP training and support, including the positive and negative effects of the work. I also observed an SOTP treatment session and took part in week one of the Core SOTP training course.

II. RESEARCH AIMS

On the basis of the above, the aims of the research are to:

1. ascertain what motivates trainee facilitators to undertake work with sex offenders.
2. determine the positive and negative effects that trainee facilitators anticipate from working with sex offenders and to compare these responses to the effects they actually experienced during their first year working on the SOTP.
3. find out what trainee facilitators think of the two-week SOTP training course, and whether qualified facilitators feel it prepared them adequately for their role on the SOTP.

4. ascertain what types of support SOTP trainees feel they will need once qualified and compare these to the support mechanisms they have used during their first year's experience.
5. ascertain the opinions of qualified facilitators regarding the quality of the training, supervision and counselling they received during their first year working on the SOTP.

III. METHODOLOGY

1. Sources of Data and Research Methods

As briefly mentioned above, there were four sources of data utilised in the present study: interviews with SOTP facilitators, interviews with SOTP treatment managers, observation of/participation in the SOTP Core training course, and observation of an SOTP treatment session.

In-depth interviews were conducted with both facilitators and treatment managers on a face-to-face or telephone basis. This method was chosen to provide a rich quality of data and to gain a detailed insight into the training and support needs of SOTP facilitators. The use of a questionnaire was discounted due to the purely statistical information that emanates from closed survey questions and the low response rates that are generally yielded from self-completion tools.[1]

Interviews followed a structured format in that I asked primary questions in the same way each time. However, questions were rephrased and respondents probed for further information where necessary. This enabled me to explore points of interest in further detail,

[1] A Bryman, *Social Research Methods* (Oxford, OUP 2001).

whilst ensuring that all interviewees were asked the same questions to increase the reliability of the study.[2] Most questions were 'open' in nature although some used a Likert-type scale[3] to determine how important facilitators thought organisational and personal support mechanisms would be to them whilst working with sex offenders. In the present study, this scale of importance was a set of three numbered options (very important, important and not important) which were shown to interviewees on a cue card.

SOTP treatment managers were interviewed once, whereas facilitators were interviewed on two separate occasions: first, whilst completing week two of the SOTP Core training course and then after one year's experience working as a facilitator. This longitudinal approach was chosen in light of Clarke's criticism that 'all the published research into the impact of [the work of sex offender treatment providers] has been retrospective and based on "snapshot" methodology. Consequently, it is not possible to make reliable causal inferences regarding the nature of the reported symptoms...'.[4] Thus, collecting baseline data from trainees at their point of entry into the profession made it possible to explore how their views had changed after having actually worked on the programme and to assess the impact of organisational and personal means of support.

Stage one interviewees will be referred to as 'trainee facilitators' or 'trainees' throughout this thesis and stage two interviewees as 'qualified facilitators'.

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[2] Research is 'reliable' when data are repeatable, and is 'valid' when a concept is measured accurately, making the results 'true'. See N Gilbert, 'Research, Theory and Method' in N Gilbert (ed) *Researching Social Life* (2nd edn. Sage, London 2001).

[3] A scale devised to place interviewee responses on an attitude continuum. Traditionally, Likert scales are used to specify interviewees' level of agreement to a statement, with '1' denoting strong disagreement, and '5' showing strong agreement.

[4] J Clarke, 'The Psychosocial Impact on Facilitators of Working Therapeutically with Sex Offenders: An Experimental Study' (PhD thesis, University of York 2004) 43.

In terms of observation data, I attended, and participated in, the first week of the Core SOTP training in September 2005: the 'fundamental skills' week. This experience contributed to the development of the interview schedule, whilst also acting as a valuable source of information on the mechanics of the course and assessment procedures. I subsequently attended the second week of the Core SOTP training, held in January 2006. In this week, trainees worked through elements of the Core programme treatment manual, and practiced mock SOTP treatment sessions.[5] Attendance on this occasion was focused primarily on recruiting the study participants and data collection. However, attending the second week of the Core training programme proved useful as an observatory experience in itself, and allowed me to gain an insight into the structure of the course, its content, and delivery methods.

To gain a better insight into how a treatment session is managed, I attended a prison located in the north of England to observe a live SOTP treatment session. Initially, permission was sought from the Offending Behaviour Programme Unit (OBPU) to watch a video recorded session of the SOTP. For this, the consent of offenders due to participate in the session was required for ethical reasons. Fiona Ainsworth - a research psychologist at the OBPU - contacted all SOTP treatment managers, who then relayed the request to SOTP facilitators and group members. Perhaps unsurprisingly, many group members were suspicious and declined to give permission for the video to be viewed for research purposes, despite my assurances that only I would view the tape, and that it would be kept in a locked filing cabinet while unused. One treatment group, however, decided that they would allow me to observe a live session. This proved to be an invaluable experience, in terms of understanding the format and management of a group therapy session. It also proved to be more useful than watching a

[5] See chapter 3 for a full explanation of the SOTP training process.

pre-recorded meeting, as the offenders' interaction with each other, and with the group facilitators, could be observed in more detail. In addition, I was able to observe the post-treatment debrief with the group facilitators and their supervisor.

The observation data is discussed intermittently in the data analysis chapters, and briefly in chapter three of this thesis. However, the results of the empirical study are mostly based on the data gathered from interviews with trainees, qualified facilitators, and treatment managers.

2. Sampling

The sample of facilitators who took part in the empirical study of this thesis was taken from trainees attending week two of the Core SOTP training course. Access to these trainees was secured with the help of Ruth Mann, Head of Sex Offender Treatment Programmes at the OBPU. I attended the course and, on day one, gave a presentation on the aims and methods of the research in an attempt to recruit participants. A 'sign-up' sheet was then placed in the main training area for individuals to leave their contact details if they wished to participate. During the course of the day, a sample of 16 out of 30 trainees was collated,[6] and some interviews were conducted at the training course itself during break-times and at the end of each day. However, because of the number of individuals who wanted to take part and the fact that each interview took around 40 minutes, some were conducted shortly after the conclusion of the course, either by telephone or on a face to face basis at a location convenient to the participant. Nine participants were subsequently 'followed-up' after one year's experience of working as an SOTP facilitator. The remaining seven were either uncontactable or had not delivered a programme.

[6] For further details on the sample itself, see section IV of this chapter: 'Sample Populations'.

The sample of SOTP treatment managers was accessed by means of a contact list obtained from the OBPU. Of the 25 individuals named on the list, the 16 who managed the Core SOTP were contacted. Managers working at Young Offender Institutions[7] and establishments not offering the Core SOTP[8] were excluded, as the current study focuses on facilitators trained to deliver the Core programme to adult male offenders. Two emails were sent to the 16 potential interviewees, the first requesting that they participate in the research, and the second acting as a reminder. Seven managers responded and consented to take part in the study.

3. The Interview Schedules

Two interview schedules were developed; one for use with facilitators and the other for treatment managers.[9] Although questions differed slightly for each group, question 'themes' remained the same and were developed with a view to gleaning information relevant to the research aims. All interviewees were questioned on how they got into sex offender work; the positive and negative effects of working with sex offenders; and the training and support needs of SOTP facilitators. To construct certain questions, it was necessary to draw from the results of previous empirical work. For example, for questions relating to the positive and negative effects of working with sex offenders, I referred to earlier studies to find out what type of effects had been reported. This information was then used to build the questions for the schedule and create categories for discussion.[10]

[7] Aylesbury YOI; Hull YOI; and Swinfen Hall YOI.
[8] HMP Elmley; HMP Leyhill; HMP Littlehey; HMP Manchester; HMP Parc; HMP Shepton Mallet.
[9] See Appendix 2.
[10] For a detailed account of the studies that I consulted when constructing these categories, see chapter 6.

The interview schedule used for trainee facilitators and follow-up interviews remained largely the same in terms of the topics discussed. However, there were some alterations to the format and structure of the questionnaire (as discussed below) and, for obvious reasons, the phrasing of questions had to be altered slightly for follow-up interviews due to the retrospective nature of the responses sought. For example, trainee facilitators were asked 'what sort of negative emotional impact do you think working with sex offenders will have on you?', whereas qualified facilitators were asked 'what sort of negative impact, if any, has working with sex offenders had on you?' The schedule was piloted with six qualified SOTP facilitators (as discussed below) to test the wording, the order of questions and the time needed to complete an interview. Some of this data has been included in the analysis chapters. Feedback was also sought from Ruth Mann at the OBPU.

A small number of changes were made to the interview schedule used with SOTP facilitators throughout the duration of the project. Following the pilot interviews, it was decided that questions regarding past experience of sexual abuse and personal trauma should be moved to the end of the interview so that I would have a chance to establish a rapport with interviewees and thus encourage honest answers. Likewise, following the interviews with trainee facilitators, the categories of positive and negative effects of working with sex offenders were simplified for the benefit of the follow-up participants. Trainees were asked whether, as a result of working with sex offenders, they anticipated experiencing any of the positive and/or negative effects shown in Table 1 below:

Table 1: Categories of positive and negative effects included in the interview schedule for trainees

Negative Effects	Positive Effects
Physical	Professional
Emotional/Mental health	Personal
Feelings towards the Prison Service	Feelings towards the Prison Service
Feelings towards spouse or partner	Feelings towards spouse or partner
Feelings towards children	Feelings towards children
Other	Other

As can be seen, there was some disparity between the categories employed. Trainees were not questioned about the positive physical or emotional effects they thought they might experience, nor the negative personal or professional effects. This was because, after having examined the relevant literature, I found no empirical evidence of sex offender therapists experiencing negative professional effects, nor positive physical effects, and so such questions were deemed to unnecessary. Likewise, the category of 'positive personal effects' was designed to be the converse of 'negative emotional effects'. I thought that asking trainees about how they thought the programme would positively affect their personal life would also provide data on how they believed it would be of benefit to their mental and emotional health. With hindsight, this was not necessarily the case and was not clear to interviewees.

As a result, an identical set of categories of positive and negative effects were put to qualified facilitators at the follow-up stage, as shown in Table 2. My analysis of the data gathered from trainee and qualified facilitators was conducted in accordance with these categories. Readers are reminded of the changes made to the research instrument in the results section of chapter 6.

Table 2: Categories of positive and negative experiences discussed with qualified facilitators

Negative Effects Experienced	Positive Effects Experienced
← Emotional and/or mental health →	
← Physical health →	
← Personal life →	
← Professional life →	
← Feelings towards the Prison Service →	
← Feelings towards spouse or partner →	
← Feelings towards children →	
← Other →	

4. The Research Procedure

For interviews with trainees, qualified facilitators, and treatment managers, a brief description of the research was provided at the beginning of the interview and participants were required to sign a pre-prepared informed-consent document.[11] This outlined information on the purpose of the research and how participant information would be used. It also drew participants' attention to the fact that they were free to withdraw their consent at any time and could decline to answer any questions they preferred not to discuss.[12] Demographic details were recorded at this point, specifically name, age, ethnicity and sexuality. For ethnic classifications, I adopted the categories used by the *2001 National Census*.[13] For classifications of sexuality, however, no official scale could be found and so a simple sexuality scale was created, covering the categories of heterosexual, homosexual, bisexual

[11] See Appendix 3.
[12] Although none of the participants withdrew their consent for their data to be used as part of the study, one participant did ask for the tape recorder to be turned off when asked whether he had ever been the victim of sexual abuse and then declined to answer the question.
[13] Office for National Statistics, *Ethnic Group Statistics: A Guide for the Collection and Classification of Ethnicity Data* (HMSO, London 2003).

and ‘unsure’. For both ethnicity and sexuality scales, presentation cards were shown to participants listing the range of possible responses.

Interviews took around 40 minutes to complete and were tape-recorded. This was to improve the accuracy of the data at the writing-up stage of the project, although interviewees were reminded that the tape recorder could be turned off at their request during any part of the interview. Note taking was discounted from the outset due to the fact that it is a time consuming process which can have a negative impact on the interaction between the researcher and the interviewee. Also, note taking cannot guarantee that responses are recorded with word-for-word accuracy. Telephone interviews were conducted in a private room using the loud-speaker function, so that they too could be recorded.

The research was split into four stages:

Stage 1: Pilot interviews with qualified facilitators (December 2005)

Pilot interviewees were accessed with the help of Ruth Mann at the OBPU. All six volunteers were located within the same prison and interviews were conducted at that establishment.

Stage 2: Interviews with trainee facilitators at the SOTP Core training course (January 2006)

Interviews were conducted with trainees in the second week of the course because it was anticipated that a small number of participants would fail to meet the course requirements in the first week and so would not be invited to the second week of training. Such individuals

could not have been included in the follow-up study, thus reducing the number of potential follow-up interviewees.

Stage 2 interviews were conducted in a number of different locations as there was an inadequate amount of time to interview all volunteers at the training course itself. Interview locations were as follows:

- Six face-to-face interviews at the SOTP training venue;
- Seven face-to-face interviews conducted shortly after the SOTP training course - one at the University of Birmingham, and six at the respective prison establishments of interviewees;
- Three telephone interviews.

I attempted to conduct as many face-to-face interviews as possible in order to build a rapport with trainees, especially given the sensitive nature of some questions. It was also considered that establishing a good relationship with trainee facilitators would increase the likelihood of interviewees wanting to participate in the research at the 'follow-up' stage. This said, due to time and travel constraints, it was necessary to conduct three interviews over the telephone. Although certain disadvantages have been associated with telephone interviewing – for example, the fact that the interviewer is prevented from observing the body language of the participant[14] – it was decided that to exclude such interviews would decrease the validity of the study.

[14] R Simmons, 'Questionnaires' in N Gilbert (ed) *Researching Social Life* (2nd edn. Sage, London 2001).

Stage 3: Interviews with SOTP treatment managers by telephone (July 2006)

The treatment managers who agreed to take part in the study were located in various establishments across the country. Thus, in spite of the drawbacks associated with this method, telephone interviewing was used to save time and money.

Stage 4: Follow-up interviews with stage 2 trainees (January 2007)

These interviews were conducted approximately 12 months after trainees had completed the Core training course. Therefore, at this point, participants were fully qualified, with one year's experience of working on the SOTP. Facilitators were asked if they had experienced any positive or negative effects from working with sex offenders and about the training and support they had received, to see how (if at all) their views had changed since being a trainee. Six of the interviews were conducted on a face-to-face basis, and three via telephone due to the work commitments of interviewees.

IV. SAMPLE POPULATIONS

Sixteen out of 30 trainee SOTP facilitators agreed to participate in the study. No information was gathered on the 14 trainees who declined to participate. The participants came from a total of eight different prison establishments across England, Wales and Northern Ireland. Six of the 16 were male and ten female and they ranged in age from 22 to 59, with the average age being 32. Five were prison officers, four were probation officers, four were trainee psychologists, and three were psychological assistants. All said they were heterosexual and classified themselves as 'white' – 15 as 'white British', one as 'white Irish'. All were being trained to run the Core SOTP programme, although some had previously been involved in

facilitating other prison-run rehabilitation programmes (for example, the Enhanced Thinking Skills Programme).

Nine of the original 16 trainees were followed-up after one year's experience as an SOTP facilitator. The remaining seven were not interviewed because one had left her job, one had not delivered a programme, and five could not be contacted. This left a sample of four males and five females, ranged in age from 23 to 60, with the average age being 34. All had provided treatment on the SOTP since their previous interview, although not all had delivered the Core programme. This was because some participants had been trained to deliver the Adapted and Booster SOTP very soon after completing the Core training, and had therefore only delivered that programme at the time of follow up. Despite the fact that these participants had no experience of working on the Core SOTP I decided to include them in follow up study.

Of the 16 treatment managers who were contacted, seven agreed to participate in the study and all were interviewed by telephone. Five were female and two were male, with ages ranging from 27 to 41. All had between five and 14 years experience working for the Prison Service and, on average, participants had worked for five years before being appointed to the role of treatment manager (although this ranged from a few months, to 14 years). The length of time participants had been working in this role ranged between three months and six years. Four of the treatment managers interviewed were responsible for all SOTP programmes operating at their respective establishments, with one managing all rehabilitative programmes. The remaining three were responsible for specific SOTP programmes, namely Core; Core and Adapted; and Core and Extended.

V. ETHICAL ISSUES

According to Sieber, research ethics '…has to do with [the] application of a system of moral principles to prevent harming or wronging others, to promote the good, to be respectful, and to be fair'.[15] The main ethical issue affecting the current research related to the discussion of trainee facilitators' past experience of sexual abuse and other trauma. Past research has shown that between 21 and 33 per cent[16] of practising therapists have been sexually victimised at some point during their lifetime. Therefore, given that one of the aims of the research was 'to ascertain what motivates individuals to undertake work with sex offenders', it was decided that the subject should be raised with trainees to explore the possibility of such experiences having an effect upon their decision to work with sex offenders.

Sexual abuse has been identified as a 'sensitive' research topic,[17] requiring careful attention to be paid to the way in which it is integrated into a research interview. Some authors have argued that selected topics should be excluded from empirical research altogether because '…certain areas of personal and social life should be specially protected. Intimacy cannot exist where everything is disclosed, sanctuary cannot be sought where no place is inviolate, integrity cannot be seen to be maintained…without protection from illegitimate pressures'.[18] However, this raises the question of what exactly should be classed as 'sensitive' research. Indeed, Lee and Renzetti have stated that 'it is probably possible for *any* topic, depending on

[15] JE Sieber, 'The Ethics and Politics of Sensitive Research', in CM Renzetti and RM Lee (eds) *Researching Sensitive Topics* (Sage, London 1993) 14.
[16] See H Jackson and R Nuttall, 'Effects of Gender, Age, and History of Abuse on Social Workers' Judgements of Sexual Abuse Allegations' (1994) 18 Social Work Research 105, and KS Pope and S Feldman Summers, 'National Survey of Psychologists' Sexual and Physical Abuse History and their Evaluation of Training and Competence in this Area' (1992) 23 Professional Psychology: Research and Practice 353.
[17] RM Lee and CM Renzetti, 'The Problems of Researching Sensitive Topics', in RM Lee and CM Renzetti (eds) *Researching Sensitive Topics* (Sage, London 1993).
[18] A MacIntyre, 'Risk, Harm, and Benefit Assessment as Instruments of Moral Evaluation', in TL Beauchamp and others (eds) *Ethical Issues in Social Science Research* (Johns Hopkins University Press, Baltimore 1982) 188.

context, to be a sensitive one'.[19] It can also be contended that such an approach could lead to legitimate areas of research being ignored on the basis of their apparent sensitivity.

I decided to include some brief questions on sexual abuse and trainees' experience of other personal trauma. It was considered that such information might be of use to the Prison Service in terms of future recruitment strategies, as it has been tentatively suggested that victims of past sexual abuse may enter therapeutic work to resolve their own psychological trauma.[20] It was acknowledged from the outset, however, that discussing past sexual abuse or other personal trauma would be highly emotive for some trainees. I therefore approached the subject with the utmost caution and employed a number of measures to prevent, or at least minimise, any emotional distress to interviewees. Before interviews commenced, trainees were informed that, not only could they withdraw their consent to the interview at any time but they could also decline to answer specific questions and ask for the tape recorder to be switched off. The interview schedule was also split into distinct sections, with each focusing on a particular topic of discussion. At the beginning of each section, I gave a brief explanation of the subject matter of the questions to come. Therefore, trainees were forewarned that they were about to be asked questions of a sensitive nature and were given the opportunity to decline to continue with the interview. Questions regarding sexual abuse and experience of personal trauma were put to participants at the end of the interview so that I could establish trust with the interviewee and build rapport.

It has been suggested that those undertaking qualitative investigation into stressful life events could jeopardise their own emotional health either from the nature of the research data and

[19] Lee and Renzetti (n 17) 6.
[20] A Rushton, 'Stress Among Social Workers', in R Payne and J Firth Cozens (eds) *Stress in Health Professional* (John Wiley and Sons, Chichester 1987).

associated literature or from interview participants placing the researcher in a pseudo-therapist role.[21] This was guarded against in the current study by asking only closed questions about past sexual victimisation. The details of abuse experiences were not sought, thus minimising any emotional distress to interviewees and to me.

The other key ethical issue affecting the research was the fact that, at follow-up, qualified facilitators were asked about the quality of organisational support provided by HMPS. When designing the research instrument, it was acknowledged that interviewees might be reluctant to frankly express their feelings in relation to organisational culture, having been informed that such information would be available to prison managers upon completion of the thesis. As a result, confidentiality and anonymity were guaranteed from the outset. This also helped me to gain the trust of interviewees. All personal details of the research participants were stored in a locked filing cabinet, only accessible by me.

VI. DATA ANALYSIS

Following transcription, the responses of interviewees were analysed according to question number. Responses for each question were tabulated, which allowed for themes to be identified and categorised. Similar concepts were colour-coded and allocated appropriate category names. Data categories were generated mostly from the language used by interviewees which was made easier by the fact that interviews were tape-recorded. This also prevented me from altering the language used by interviewees. Because there was a relatively small number of participants in the study and because the sample was generally homogeneous

[21] G Lee-Treweek and S Linkogle, 'Putting Danger in the Frame', in G Lee-Treweek and S Linkogle (eds) *Danger in the Field – Risk and Ethics in Social Research* (Routledge, London 2000).

in terms of ethnicity and sexuality, I did not carry out any analysis of participant responses based on the gender, age, ethnicity and sexuality of the sample.

For certain questions, some participants provided more than one response. For example, when asked what positive effects they thought they would experience in terms of their professional life, some trainees thought they would get enhanced job satisfaction and improved skills and knowledge. Thus, as can be seen in the data analysis chapters of this thesis, the number of responses for some questions total more than 16. Wherever possible, however, I attempted to categorise the response of each interviewee to each question only once.

VII. LIMITATIONS OF THE RESEARCH

Although the research was designed in a way to ensure the best possible chance of the results being both reliable and valid,[22] there are some limitations to the data. The number of trainee facilitators and SOTP treatment managers who took part in the study was relatively small. I had access to 30 individuals participating in the Core SOTP training course held in January 2006, of whom 16 agreed to take part in the research. Ideally, I would have attended further training programmes to recruit a larger sample of participants but as courses are run only three times per year, time constraints prevented this. In relation to treatment managers, a sample of seven interviewees was eventually secured out of a possible 16 by emailing potential participants. Further efforts to enlist treatment managers could have been made – for example, by making telephone contact – but, again, time constraints meant that there was only a short period in which I could devote myself to recruitment strategies. The response rate for

[22] See note 2 for definitions of reliability and validity.

trainee facilitators and treatment managers was therefore 53.3 and 43.75 respectively. These figures are quite low – especially as it has been suggested that face to face 'interview surveys should aim to achieve about an 80 per cent response rate'.[23] This said, it is accepted that response rates to social research have been declining in recent years.[24] As such, it can be contended that a much higher proportion of empirical work in the future will be based on smaller sample sizes than research conducted in the 1960s and 1970s. Indeed, Maykut and Morehouse have noted that 'important sociological work is often based on relatively small samples…'.[25] Due to time constraints, it would have been extremely difficult for me to obtain a large, random sample of participants. Thus, to compensate for the small sample sizes, I focused on gathering good quality data by conducting detailed interviews with participants.

Participants were also self-selecting, rather than being chosen at random. This limited the extent to which the data was representative of the views of facilitators and treatment managers more generally. For example, trainees may have volunteered on the basis that they had a particular outlook on working with sex offenders or because they held critical views about the Prison Service. However, Arber has suggested that probability sampling – where each person in the population of interest has an equal chance of being part of the sample – may be 'unrealistic' for small-scale, qualitative research.[26] This view has been supported by Maykut and Morehouse who point out that 'traditional qualitative researchers concerned with complex

[23] S Arber, 'Designing Samples' in N Gilbert (ed) *Researching Social Life* (2nd edn, Sage, London 2001) 60.
[24] E Babbie, *The Practice of Social Research* (12th edn, Wadsworth, California 2010).
[25] Arber (n 23) 62.
[26] *Ibid.*

human phenomena rarely have the opportunity to select a truly random sample and often settle for approximations of randomness'.[27]

As has been explained, some of the interviews with trainee facilitators were conducted during the Core training programme, whilst the remainder were completed once the course had ended either by telephone, at the workplace of the interviewee or at Birmingham University. All 16 trainees in the sample successfully passed the course. However, it is possible that those who were interviewed during training responded differently from those who were interviewed after its completion. This is because those participants who were interviewed whilst the course was ongoing were unaware whether they had passed or failed whereas those who were interviewed afterwards knew of their success. This could have made them more positive about the training provided and the Prison Service generally. There is also a chance that the pressure of the course itself might have affected the responses of those interviewed during training.

In terms of the quality of interview material, facilitators and treatment managers may not have been entirely honest in their responses. This point seems particularly pertinent to the interviews with trainee facilitators who were asked about previous sexual abuse or traumatic experiences, and to follow-up interviewees who were asked to give their opinions on the quality of Prison Service support. Although interviewees were assured that their identities would remain anonymous, it was explained that results would be shared with the Prison Service and the Offending Behaviour Programme Unit. This may have inhibited some participants from expressing their true feelings. For example, one treatment manager hinted

[27] P Maykut and P Morehouse, *Beginning Qualitative Research* (Routledge/Falmer, London 1994) 56.

at certain problems with the support mechanisms in place at her establishment but felt unable to elucidate the details of her complaint through fear of being identified.[28]

Certain issues relating to the follow-up interviews may also have affected the final results. Although trainees were invited to participate in the research on the basis that they would be delivering the Core SOTP upon qualification, at the time of follow-up some had diversified and were facilitating on other SOTP courses, such as the Adapted and Booster programmes. The experience of delivering, for example, the Adapted SOTP is likely to be very different from delivering the Core programme in terms of the positive and negative effects experienced and the support and training provided. Likewise, some follow-up interviewees had delivered two programmes, and others only one - another factor that may have influenced participant responses. However, to exclude interviewees because they had not delivered a Core programme or because they had worked on more than one different group would have unduly reduced the sample size.

In spite of these limitations, a number of advantages can be identified from the methodology employed. The approach adopted utilised observational analysis as well as qualitative interviewing with two separate – but related - populations. This, along with the longitudinal element of the study, allowed me to gain an insight into the issues under investigation. Observing a group therapy session and the SOTP Core training also gave me a greater understanding of the programme and its management in practice. Overall, by using a combination of methodological techniques, I was able to gain a well-rounded knowledge of the SOTP, its theoretical groundings, and how it is delivered in practice.

[28] This also relates to Jupp's idea that 'individuals or groups of individuals may have an investment in the protection of interests of the "system" of which they see themselves as being a part'. See V Jupp, *Methods of Criminological Research* (Routledge, London 1989) 135.

CHAPTER 6

THE POSITIVE AND NEGATIVE EFFECTS OF WORKING WITH SEX OFFENDERS

I. INTRODUCTION

Recent research has suggested that individuals working therapeutically with sex offenders may experience positive life effects from their work. Amongst other things, Kadambi and Truscott have reported that sex offender therapists find reward from, amongst other things, the academic nature of the work, protecting potential victims, and seeing offenders change.[1] However, very little is known about why individuals choose to work with sexual offenders and there is a lack of academic literature in this area. Instead, research has focused on the negative health effects experienced by professionals in the field, particularly in terms of stress, burnout, and vicarious trauma.

For the empirical study of this thesis, I interviewed 16 trainee SOTP facilitators. Nine of this 16 were followed-up after working on the programme for one year. This chapter sets out findings from the empirical research regarding:

- Why SOTP trainees decided to work with sex offenders as a client group;
- The sort of positive and negative effects that SOTP trainees thought they would experience as a result of working with sex offenders;

[1] M Kadambi and D Truscott, 'Concept Mapping Professionals' Perceptions of Reward and Motive in Providing Sex Offender Treatment', (2006) 42 Journal of Offender Rehabilitation 37.

- The positive and negative effects actually experienced by the follow-up sample of nine qualified facilitators; and
- The sources of work-based stress affecting SOTP treatment managers, and the type of positive and negative effects they have seen facilitators experience whilst working under their supervision.

II. ENTRY INTO SEX OFFENDER WORK AND THE SOTP

Why individuals decide to work with sex offenders remains an important issue for the Prison Service in terms of attracting potential facilitators to the role. Indeed, this question has taken on even greater significance since the emergence of research suggesting that between 21 and 33[2] per cent of practicing therapists have been sexually victimised as a child. It is, therefore, possible that a significant minority of SOTP facilitators have, at some point, experienced sexual victimisation. This could present a problem in relation to the psychological health of facilitators if working on the SOTP leads to a recollection of past memories of abuse. Moreover it could result in a lower standard of care being provided to offenders if facilitators use their role merely as a way to resolve their own psychological trauma rather than focusing on the treatment needs of group members.

Searches of the literature have thus far failed to provide any empirical evidence supporting the proposition that the experience of sexual abuse hampers a victims' ability to perform effectively in the therapeutic role. However, Rushton has argued how those susceptible to depression might be drawn to careers in counselling and social work in an attempt to resolve

[2] See R Nuttal and H Jackson, 'Personal History of Childhood Abuse Among Clinicians' (1994) 18 Child Abuse and Neglect 455, and K S Pope and S Feldman-Summers, 'National Survey of Psychologists' Sexual and Physical Abuse History and their Evaluation of Training and Competence in these Areas' (1992) 23 Professional Psychology: Research and Practice 353.

their own emotional problems by helping others.[3] Little and Hamby have also shown how therapists who were abused during childhood – especially those with only partial recall of such events – found treating sexual abuse victims more difficult in terms of the 'interpersonal pulls' and 'emotional and cognitive arousal' they encountered during treatment sessions;[4] although no data was provided on whether this affected the standard of care provided. Clarke's research, on the other hand, has indicated that individuals who have been sexually victimised *during adulthood* are more likely to show high levels of Ruminative Vulnerability (i.e. emotional vulnerability due to a preoccupation with the distressing aspects of sex offender work) and Negative Reactivity to Offenders (i.e. feelings of anger, suspicion, cynicism, frustration and anxiety towards sex offenders, and sexual abuse generally).[5]

This said, examples of victim participation can be found throughout the criminal justice system. For instance, in May 2006, the then Home Secretary John Reid announced plans to employ victims of crime, and representatives of victim organisations on Parole Board panels.[6] In its response to these plans the Parole Board noted its support, but added that the 'victim experience' is already well represented by its current members. In a survey of 73 Parole Board members, 95 per cent claimed to have been a victim of crime, with 14 per cent having been the victim of a sexual assault or rape and a further 20 per cent having experienced gun or violent crime.[7]

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[3] A Rushton, 'Stress Among Social Workers', in R Payne and J Firth-Cozens (eds) *Stress in Health Professionals* (John Wiley and Sons, Chichester 1987).

[4] L Little and S L Hamby, 'Memory of Childhood Sexual Abuse Among Clinicians: Characteristics, Outcomes and Current Therapy Attitudes' (2001) 13 Sexual Abuse: A Journal of Research and Treatment 233, 245.

[5] J Clarke 'The Psychosocial Impact of Working Therapeutically with Sex Offenders: An Experimental Study' (PhD thesis, University of York 2004) 75.

[6] The Home Office has stated that perpetrators would not be placed before a Panel that included the victim of the crime that they committed. See http://press.homeoffice.gov.uk/Speeches/sp-annual-parole-board-05-06, accessed 25 January 2010.

[7] See http://www.paroleboard.gov.uk/news/parole_board_responds_to_home_secretary%E2%80%99s_proposals_for_reform/, accessed 25 January 2010.

To suggest that victims of sexual abuse cannot successfully treat sexual aggressors due to past emotional trauma would therefore be imprudent. However, it can still be argued that Parole Board members do not experience the sort of prolonged contact with offenders that SOTP facilitators are subjected to. They are also unlikely to hear first-hand offence accounts from perpetrators.

The primary aim of the following analysis is, therefore, to find out how many SOTP trainees have been the victim of sexual abuse - or any other personal trauma - and whether this experience had any impact on their decision to work with sex offenders. As a precursor to these very sensitive questions – and to provide further background information – trainees were asked when they had originally decided that they wanted to work with sexual offenders, if they had worked with such offenders before the SOTP, and why they wanted to do this type of work.

1. When did trainees decide they wanted to work on the SOTP and why?

Most of the 16 trainees had decided within the preceding year that they wanted to work on the SOTP. However, four had decided three years prior to training. Two said they had waited three years for training to be provided, another said that the job opportunity had only recently arisen, and another said that the recruitment process at her establishment was very slow. Eleven of the 16 trainees said that they had worked with sex offenders before training for the SOTP and a wide variety of roles were discussed, as shown in Table 1 below:

Table 1: Capacity in which trainees had previously worked with sexual offenders

Previous Work with Sexual Offenders	Number of Facilitators (n = 11)
One-to-one basis	5
HMPS Enhanced Thinking Skills Programme	4
Carrying out risk assessments	2
Escort for Group 4 Securicor (supervising sex offenders in court)	2
Drug treatment	1
Probation treatment programme	1
HMPS 'Personal Officer' scheme[8]	1
Note: Some of the trainees who answered this question provided multiple responses.	

Trainees were also asked why they had decided to work on the programme. Nine of the 16 trainees said that they had been drawn to sex offender work because of an interest in sexual offenders and forensic psychology[9]. For example, four commented that:

> *I think it's kind of an intriguing form of offending. I don't really know what it is specifically. Maybe it's less clear cut. If you take other forms of offending, like someone stealing from a shop to feed their drug habit, it's a bit more of a straightforward explanation, whereas I found sex offending more interesting because of the different explanations around it and all the contributing factors.*
>
> (Female Trainee Psychologist)

> *I knew I wanted to get into this type of work for quite a long time; maybe sort of the end of my GCSEs, end of A levels, I was thinking about what I wanted to do. I can't remember how it came about but it just fascinates me.*
>
> (Male Psychological Assistant)

[8] This scheme involves Prison Officers being partnered with a specific offender to provide help and advice.
[9] The psychological study of criminal behaviour.

> *I used to work in a mental health home with 16 – 25 year olds. I mean, these were severe learning difficulties and challenging behaviours. There was one student…he used to just pull his trousers down…and then he'd tap you on the shoulder. I used to think, why's he doing that? What's he doing it for? Is it attention? Is he just doing it to annoy you? Is he doing it because there's something wrong and he doesn't know how to explain it to you? That's when I think I decided I want to go to the Prison Service and work in this area. For some reason I thought, I'd like to work in that area; I'd like to understand more about why they do it.*
>
> (Male Prison Officer)

In light of the findings of Kadambi and Truscott's research (that helping to protect future victims was the most rewarding aspect of sex offender work identified by their sample of treatment providers)[10] it was surprising that only two trainees in the present study identified this as a reason why they were drawn to the idea of working on the SOTP. As put by one male prison officer:

> *…you've probably heard it before and you've probably read it before, and it does sound a bit corny but I do believe in it: if what we do prevents one victim, then you can't put a price on that and it's definitely worth it.*

In fact, a larger number of trainees had been drawn to the SOTP as a result of the perceived practical benefits of working on the programme. Five of the 16 trainees said that they waned to work on the SOTP to develop their existing skills, and three said that they enjoyed working with offenders in a group-work format, rather than on a one-to-one basis. As such, these trainees were attracted to the treatment methods applied as part of the SOTP:

[10] Kadambi and Truscott (n 1) 49.

I was doing quite a lot of work with ETS[11] *and just felt like a bit of a change really. I wanted to 'up' my style in a different way. And also,* [I've] *kind of worked using the Cognitive Behavioural Therapy model. I could see it was working within the group so I could see the benefits of it helping sex offenders.*

(Female Trainee Psychologist)

I've been involved in facilitating for about five years. I've run quite a number of ETS type programmes, and I felt I was getting a bit stale really; I was getting into a bit of rut with them. SOTP was a natural progression, and something that I hadn't done before.

(Male Prison Officer)

I liked the idea of having contact with an inmate over a lengthy period of time rather than seeing them for two hours for assessment and then never seeing them again.

(Female Probation Officer)

I like doing group work, so I wanted to continue that…just listening to what other people have said about SOTP and looking through the manuals and stuff, it seems more my style. It seemed more relaxed. And it was more of a discussion rather than talking to them and teaching them.

(Female Probation Officer)

Two of the 16 trainees had chosen to train for the SOTP purely because of job requirements. One of this two was a female trainee psychologist, who needed to diversify her experience for chartership[12] reasons and thus chose to work with sex offenders. The other was a male Prison Officer whose contract of employment required him to undertake an assessment for programme work. He opted to work on the SOTP rather than ETS as he thought it would

[11] Enhanced Thinking Skills Programme.

[12] 'Chartership' with the British Psychological Society (BPS) guarantees the proper training and qualifications of a psychologist. Individuals wanting to become chartered in forensic psychology must complete an undergraduate qualification in psychology, followed by the BPS Diploma in Forensic Psychology. This is composed of an academic stage and a vocational stage, whereby the candidate must demonstrate their ability in four core competencies.

encourage a more individual therapeutic style, allowing for personal input and creativity in group work sessions.

2. Past experiences of sexual abuse or personal trauma

Trainees were asked whether they had been a victim of sexual abuse, or experienced an event that they had found personally traumatic, and whether this had affected their decision to work with sex offenders. One trainee declined to answer this question, and therefore appears in the 'no trauma disclosed' category in Table 2 below. Interviewees were not asked about the details of their experiences, although three volunteered information. One talked about his divorce, another revealed that he had been held hostage by a group of inmates during a prison riot, and the other discussed the time when he found out that his cousin had been sexually abused by a family friend.

Table 2: Number of facilitators who had experienced past sexual abuse and/or other trauma

Type of trauma experienced	**Number of trainees**		**TOTAL**	**Experience affected trainee's decision to work with sex offenders?**	
	Males	**Females**		**Yes**	**No**
Victim of sexual abuse	0	3	**3**	1	2
Trauma arising from the sexual abuse of another person	1	0	**1**	1	0
Other trauma not related to sexual abuse	2	2	**4**	1	3
No trauma disclosed	3	5	**8**		
TOTAL	**6**	**10**	**16**	**3**	**5**

As can be seen from Table 2 above, three trainees who had experienced some form of trauma suggested that it had made them keen to work with sexual offenders. Moreover, two of this three discussed a traumatic experience that related to sexual abuse: one had been a victim of sexual abuse herself, and the other experienced distress after finding out that his cousin had been sexually abused. This interviewee chose to discuss in more detail why the experience had influenced his decision to work with sex offenders, saying:

> *I think I wanted to know why this had happened; and I wanted to know because I didn't want to see some other lad or girl or whoever it was, sitting in a corner quiet and all alone, and people just thinking they're a quiet person, and seeing them suffer like he must have done.*
>
> (Male Prison Officer)

The remaining two trainees did not offer any further details as to why their experiences had made them eager to work with sex offenders, and I felt that it would be inappropriate to probe for more information.

III. ANITICIPATED EFFECTS VS ACTUAL EFFECTS OF WORKING WITH SEX OFFENDERS

A growing body of research has, in the last ten years, explored the types of stressors faced by sex offender therapists. This has been accompanied more recently by evidence illustrating the positive effects experienced by individuals working with sex offenders.[13] The following data outline the responses of the 16 trainee facilitators interviewed regarding the positive and negative effects that they thought they would experience whilst working on the programme in terms of their:

[13] For a detailed account of the research literature discussing the positive and negative health effects of working with sex offenders, see Chapter 2.

- Personal life
- Professional life
- Physical health
- Emotional/mental health
- Feelings towards the Prison Service
- Feelings towards their spouse or partner, and
- Feelings towards children.

These categories were selected for a number of reasons. First, I consulted extensively with the Offending Behaviour Programme Unit (OBPU) – particularly Ruth Mann – in order to find out exactly what sort of information would be useful to the Prison Service in relation to the health effects experienced by staff working on the SOTP. The fact that the OBPU anticipated that the study would generate useable data also helped me to gain access to SOTP trainees and qualified facilitators. Second, my own review of the literature showed that these broad categories have been consistently used in empirical studies investigating the effects of working with sexual offenders. Third, the categories reflect those used by Clarke in her construction and validation of a scale to measure the psychological impact experienced by sex offender treatment providers.[14] To construct the scale, a total of 30 'scenarios' (generated from anecdotal information from experienced SOTP facilitators, the available literature, and Clarke's own experience of working with sex offenders) were put to research participants, who were then asked: 'What do you think?'; 'How do you feel?'; and 'What do you do?' These scenarios fell into 4 categories and were either: group work related (for example, 'at the end of a group, one group member who is still high risk insists he will never offend again');

[14] See Clarke (n 5) 52.

management related ('after a particularly draining session, your line manager asks you to undertake an urgent task right away'); personally related ('during an intimate moment with your partner, you start getting intrusive thoughts about an offender on your group'); and prison related ('you hear a rumour that the Governor is thinking of cutting SOTP from the regime').[15] Given that the Prison Service has drawn heavily on Clarke's work when devising training and selection programmes for SOTP facilitators, it made sense to rely on a similar range of categories in the present study.

The results of the following data analysis will be presented according to the bullet-point categories described above. For each category, the negative effects anticipated by trainee facilitators will be discussed and then compared to the actual effects experienced by the nine follow-up interviewees. Positive effects are then considered, following the same process of comparison.

1. Personal Life

Negative Effects

For reasons discussed in the chapter 5 of this thesis, trainees were not specifically asked whether they thought working on the SOTP would have a negative impact on their personal life.[16] However, during the interviews, a number of issues were discussed by nine of the 16 trainees that I felt could be described as negative effects on personal life. Five trainees said that they were concerned that they would become cynical towards other people's behaviour. For example:

[15] *Ibid.* 60 - 61.
[16] See Chapter 5, page 175.

> *I know you shouldn't but you can't help it. When you're walking down the street you tend to look at people and think, I'm unsure about you. You've got some of the traits that you would associate with some of the lads we've got here.*
>
> (Male Prison Officer)

> *I'm worried about not looking at things for what they are and always looking at the risk side. Say if I was around children, somebody might just be giving them some sweets and immediately I might think, what's all that about? Are they just giving them some sweets or is it part of something else?*
>
> (Female Trainee Psychologist)

Another concern of trainee facilitators (as discussed by three of the 16) was that they would 'take work home', and that this would have a negative effect on their family life. For instance, one female psychological assistant said: '*If you're unable to detach yourself* [from the job] *that's going to have an impact on your family integration'*. Another male prison officer said '*I'm worried sometimes, with what you listen to, it can make you tired and snappy and that I'm going to go home and upset my girlfriend. I don't want to do that'*. One trainee mentioned that she might become more concerned for her own personal safety as a result of working on the SOTP, and another commented that he might worry about particularly high risk offenders reoffending upon release into the community after completing the programme:

> *…if you have a certain offender, and there's just nothing you can do…and you know that they might still be a risk towards the public, but yet they have to be released because of their determinate sentence. That might be a negative thing in that you couldn't have done any more.*
>
> (Male Psychological Assistant)

When it came to the follow-up interviews, four of the nine qualified facilitators said that they had started to 'take their work home'. This was the only negative effect on personal life reported by trainees and, therefore, the range of effects that trainees thought they might experience had been narrowed after one year's experience on the SOTP. Two of the four said that they had found themselves thinking about the logistics of a forthcoming group session during 'family time', and how to plan a particular block of therapy. The other two emphasised difficulties in leaving the content of treatment sessions at work. For example, one female prison officer said:

> *I never used to take work home with me. No matter what happened on the wing I was very good at switching off. I'd say that I find it a lot harder to switch off than I thought I would, and I'll occasionally - just at random moments - have something go through my head about group or about a group member, and it's kind of hard to get rid of it once it's there.*

Positive Effects

Although positive effects on personal life have been less frequently reported, it has been shown that sex offender treatment providers experience a sense of 'mission' from their work, and feelings of personal accomplishment.[17] Nine of the 16 trainees in this study felt that they would experience improved personal skills. The key 'skills' discussed by trainees were: increased confidence, becoming more tolerant of other people, being more empathic, improved communication skills, and becoming less naïve about human behaviour:

[17] See KE Jackson *et al*, 'Working with Sex Offenders: The Impact on Practitioners' in S Bird Edmunds (ed) *Impact: Working with sexual abusers* (Safer Society Press, Vermont 1997); and R A Shelby, R M Stoddart, and K L Taylor, 'Factors Contributing to Levels of Burnout Among Sex Offender Treatment Providers' (2001) 16 Journal of Interpersonal Violence 1205.

I think I might learn a bit more about myself by doing the programme, and build my confidence really by using different skills.

(Female Trainee Psychologist)

I suppose it'll help me to understand people more. To look at the difficulties people are having in a more…empathic way.

(Female Probation Officer)

Hopefully it will make me a little wiser about things; a bit less naïve about what goes on. I think it might make me a better listener, because you have to spend a lot of time listening to [group members] *talking.*

(Female Probation Officer)

At follow-up, two out of the nine qualified facilitators thought that their personal skills (specifically enhanced communication skills and greater confidence) had improved as a result of working on the SOTP. Therefore, in comparison to what they had anticipated as trainees, a smaller proportion of qualified facilitators felt that their personal skills had been improved by working on the programme.

2. Professional Life

Negative Effects

As explained in chapter 5 of this thesis, trainees were not asked whether they anticipated experiencing any negative professional effect from working on the SOTP.[18] This was primarily because of the lack of research evidence currently available to support the existence of such an effect. However, following restructuring of the research questionnaire it was decided that qualified facilitators should be asked if they had experienced any negative impact

[18] See Chapter 5, page 175.

on their professional life. Only one qualified facilitator felt that this had occurred; in the form of conflict with other facilitators:

> *I don't know whether it's because we're working in a confined area, or it's the courses, but sometimes people just sort of build up and start niggling at each other…it has sorted itself out, but I'm always mindful that it could go back to that.*
>
> (Male Prison Officer)

Positive Effects

Given that research has shown that working with sex offenders can induce high levels of job satisfaction,[19] trainees were asked if they expected to derive some professional benefit from working on the SOTP. All 16 thought that they would do so, with many providing multiple reasons. The main benefit identified by trainees was 'career development', and 11 of the 16 interviewed anticipated that working on the SOTP would enhance their future promotion prospects. For trainee psychologists and psychological assistants, working on as a facilitator on the SOTP also meant a step towards chartership with the British Psychological Society:

> *I think it will be useful towards working with different client groups because I will be going towards chartership, so it will give me that varied experience across different prisoner groups.*
>
> (Female Trainee Psychologist)

> *It's another string to have to your bow. It's going to mean looking at more offence based things, and opening more doors in terms of my career.*
>
> (Male Trainee Psychologist)

[19] See Kadambi and Truscott (n 1) and Jackson *et al* (n 17).

It might help with career development, to get promoted, or a particular job that I want. Obviously being able to work with a difficult group of offenders could be quite useful.

(Female Probation Officer)

I suppose there aren't many prison officers that are trained to conduct this type of work, so I think it'll be good for my career.

(Male Prison Officer)

Another key positive effect that trainees thought they would experience was 'enhanced job satisfaction'. This was discussed by nine of the 16 trainees. In terms of why trainees thought that working with sex offenders would be so rewarding, most thought that they would get satisfaction from witnessing offender change and from helping to protect victims; although others mentioned having a genuine interest in this line of work, which would also make the job more satisfying:

I think I'll find it very rewarding to feel that I've actually contributed to helping [an offender] *realise that there are good aspects to them; and…to know that if they go out into the community, which is the objective – to rehabilitate these men - that their community will perhaps be a safer place as a result of your work.*

(Female Psychological Assistant)

I think from the different jobs I've done before I can see it will be fulfilling to see that you're getting up and going to work for an actual purpose, rather than just making money every day.

(Female Psychological Assistant)

Hopefully, I'll get more job satisfaction. I feel that I'll be doing something positive, and not just be turning a key…so that'll give me more satisfaction about what I'm doing.

(Female Prison Officer)

On a more practical level, seven trainees said that they anticipated that their skills and knowledge would improve as a result of working on the programme. The 'skills' referred to included tasks such as report writing, as well as personal skills such as organisational and communication skills:

> *I think it'll be really good for my professional skills. I think in terms of my knowledge about sex offending, that will be really useful to me, and also the reports you'll have to write, looking at risk and things like that.*
>
> (Female Trainee Psychologist)

> *You're more confident in talking to people on a one-to-one level, or in front of a group.*
>
> (Male Prison Officer)

At follow-up, all of the nine qualified facilitators felt that they had experienced some positive impact in terms of their professional life after working on the SOTP for one year. Some facilitators provided multiple responses; however, the benefits discussed fell into the same three categories identified by trainee facilitators; namely career development, enhanced job satisfaction, and improved skills and knowledge. The results are shown in Table 3 below, which also shows the responses of trainees in comparison:

Table 3: Comparison between trainee and qualified facilitator responses regarding positive impacts on professional life

Positive Impact on Professional Life?	**Number of Participants**	
	Trainees (16)	**Qualified Facilitators (9)**
Career Development	11	2
Enhanced Job Satisfaction	9	5
Improved Skills and Knowledge	7	5

As can be seen, a similar proportion of trainees who predicted that they would experience 'enhanced job satisfaction' actually did so whilst working on the SOTP. The same can be said about those who anticipated gaining 'improved skills and knowledge'. However, there was a significant difference between the number of trainees who thought they would develop their career in some way by working on the programme, and the number of qualified facilitators who thought their career had actually been so developed after one year's experience.

3. Physical Health

Negative Effects

It has been reported that individuals working with sex offenders can suffer from adverse physical effects, such as fatigue, and sleep disturbance.[20] Eight of the 16 trainees interviewed for the present study were concerned about experiencing negative physical symptoms after starting work on the SOTP, which are identified in Table 4 below:

Table 4: Negative physical effects anticipated by trainees

Negative physical effect	**Number of trainees**
Tiredness	4
Headaches	2
Sleeplessness	1
Reduced food intake and more exercise	1
TOTAL	**8**

[20] See M Erooga, 'Where the Professional Meets the Personal' in T Morrison, M Erooga and R C Beckett (eds) *Sexual Offending Against Children* (Routledge, Lorna 1994); S Bird Edmunds, 'The Personal Impact of Working with Sex Offenders' in S Bird Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997).

In comparison, only two of the nine qualified facilitators said that they had experienced negative physical effects. One reported feeling 'absolutely exhausted', whilst another said that he had experienced some mild sleeplessness:

> *…sometimes I lie awake at night thinking about the next day and what I'm going to do, making sure it's all planned in my head…It's usually before I go to bed and then probably in the morning when I first get up. So I wouldn't say I wake up in the middle of the night sweating and dreading going to work.*
>
> (Male Prison Officer)

Positive Effects

Trainees were not asked whether they anticipated experiencing any positive effect on their physical health whilst working on the SOTP. As explained in chapter 5, this was primarily because there is no research evidence to date that suggests those treating sexual offenders derive any physical benefit from the work.[21] However, following amendments to the research instrument, qualified facilitators were asked whether they had in fact noticed any positive effects on their physical health during the follow-up interviews. Indeed, three of the nine interviewees said that they had. One said that she took more care of herself since working on the programme, and would specifically 'take time out' to go and have a massage to 'unwind'. The remaining two (both male prison officers) said that they spent more time at the gym:

> *I usually go to the gym every day after I've run a session – even when I'm not running – because it just sort of takes my mind off it, and you just relax for an hour and a half…Courses do give you time to do that.*

[21] See Chapter 5, page 175.

4. Emotional/Mental Health

Negative Effects

Ten out of the 16 trainees expected some negative emotional impact as a result of working with sex offenders. Two thought that they might feel 'emotionally drained', and another said that she might feel 'withdrawn…and take things personally'. The remaining seven thought that they would find the work very upsetting:

> *…what springs to mind straight away are the things that you hear are so very unpleasant; so hearing about their offences and visualising what they've done could impact on my mental health I suppose.*
>
> (Female Probation Officer)

> *I'm worried that some of the information that I'm going to receive during that type of work might affect me emotionally. I might find it upsetting.*
>
> (Male Prison Officer)

A high proportion (seven out of nine) of the qualified facilitators interviewed at follow up reported experiencing a negative impact on their emotional/mental health. One female trainee psychologist said that she had had two dreams about sexual assault. The rest of the facilitators who responded to this question said that they had found the work emotionally draining, with some blaming this specifically on 'needy' group members. For example, one female probation officer commented that:

> *The group members tend to be a lot of people who have poor coping skills, inadequacies, and it's just constant I need you, I need you, I need you. So much so that you'd walk in and I wouldn't have got my coat off, I'd still be walking in with my bag on my shoulder and you'd meet at least three group members who just had to have 5 minutes of your time before group. And I think it's*

something about you've only just walked through the gate, you've only just left your children and family, and there are these people. And that I found really draining and annoying.

Two of the four facilitators who reported that they had found the work emotionally draining had been forced to take time off on grounds of ill health; one for six months, and the other for one month:

I was off work from March 6 until September 4 2006. At the end of September, about the third week, I went back to group after being assessed as ok to go back to group. I've been on Rolling programme since then…It was exhaustion. It was the demands of the probation role, as well as the demands of the SOTP, and not getting enough support; being asked to do too many programmes actually.

(Female Probation Officer)

I was actually off with stress and anxiety. I think part of it was work-related if I'm honest. Feedback from other people has told me that it probably was. I think I'm a bit more serious. I don't tend to laugh as much as I used to. I've spoken to other facilitators and it's something we kind of share I think.

(Female Prison Officer)

The facilitator who had taken one month off work was one of the three participants that said they had been a victim of sexual abuse. Although this is interesting, it is certainly not enough to show that victims of sexual abuse are more prone to the negative effects of sex offender work.

Positive Effects

Trainees were not asked whether they anticipated experiencing any positive effect on their emotional/mental health whilst working on the SOTP. This was primarily because – as explained in chapter 5[22] – I meant to capture such information by asking about the positive effects on trainees' personal lives. In hindsight, this made the data analysis more complicated, and so the 'categories' of effects discussed with participants were standardised for the follow-up interviews.

Thus, following restructuring of the research questionnaire, follow-up participants were asked if they had experienced any positive effects on their emotional/mental health as a result of working on the SOTP. One female probation officer said that, for the first time in her career, she felt able to leave work issues 'at work' rather than taking them home, and commented that '*now I can go in and do my job but when I come away that's not my responsibility*'. This particular facilitator had also reported experiencing a serious lack of support during the first programme that she worked on, and so it is possible that this negative experience encouraged her to draw a very clear dividing line between work and family life, and maybe even become a little obstinate in her view towards her work-related responsibilities.

A further three facilitators said that they had derived a personal benefit from working with the cognitive behavioural approach:

> *The material you deliver…is really useful so you can actually think, hang on a minute, I can use that as a coping strategy. In that respect it's been really helpful.*
>
> (Male Prison Officer)

[22] See page 175.

It's made me open my eyes to the way people think and other perspectives

(Male Prison Officer)

I'm able to weight things up better and…I'm much more patient. I'm able to look at the whole picture about a lot of things in life, and the skills I've learnt on the programme I use for myself. Some of the behavioural skills I find very, very useful, but also the therapeutic style...has definitely come into other parts of my life and other people have said that.

(Female Probation Officer)

5. Feelings towards the Prison Service

Negative Effects

Trainees were asked whether they thought working with sex offenders would have any negative effect on their feelings towards the Prison Service. In total, five out of the 16 said that this was a possibility, four of whom thought that this might happen if they received a lack of support from superiors:

If I don't get the support I need I think my feelings towards the Prison Service will rapidly decrease. I'm aware at our establishment we're a bit unstable at the moment because people have been leaving, so I'm kind of not too sure how that's going to pan-out.

(Female Trainee Psychologist)

I've already felt a lack of support at times, which I have brought up. But I think it needs to be said to upper management…It worries me and I was thinking of leaving.

(Female Probation Officer)

Indeed, at follow-up, three of the nine qualified facilitators said they had experienced negative feelings towards the Prison Service. All complaints related to the poor support that facilitators said they had received from supervisors and senior staff:

> [My co-facilitator and I] *had a very poor experience really. We were newly qualified, new out of training…and we were just left to get on with it…The supervision we had during that was pretty poor…It was just quite a bad experience.*
>
> (Female Probation Officer)

> *I don't feel that we got as much support as we should of on our first group and, as it was our first group, I think it was really important that we had that. At the time I was kind of aware of it but a bit swept away by just being in the group and stuff; so, it's not until now that I've started thinking how that was wrong really. So I think it was wrong that it was allowed to happen.*
>
> (Female Prison Officer)

> *There were issues with supervision which I wasn't very happy about. Things came to a head, and on one particular occasion it fell to me to go and give this one group member a final warning regarding his behaviour. So management wanted me to do that, they wanted me to see a counsellor, and they wanted to run group the next day. So the negative effect towards the Prison Service is that they say on the one hand they support facilitators, and that they do care for them, and they say to you "if you don't feel like running a group, you shouldn't run a group", but in reality it doesn't work like that.*
>
> (Male Prison Officer)

Positive Effects

Nine of the 16 trainees interviewed anticipated that their feelings towards the Prison Service would become more positive as a result of working on the SOTP. Four said that they already felt a sense of gratitude towards the Prison Service for providing them with an opportunity to

work on the programme. Another four said that they felt extremely positive about the SOTP itself, which they thought would subsequently increase their positive feelings towards the Prison Service as an organisation. For instance, one male psychological assistant said: '*by offering the SOTP* [the Prison Service] *is trying to prevent more victims*'. One trainee went further and anticipated that working on the SOTP would give her 'more faith' in the entire criminal justice system – not just the Prison Service.

In comparison, after one year of working on the SOTP one qualified facilitator said that he felt 'reassured' that prisons were taking rehabilitation for offenders seriously. Another three reported that they felt very positive towards the training and support provision provided by the Prison Service. For example, one male Prison Officer said:

> *I think of all the jobs I've done in the past, and the support you've got from management, or the opportunities I've had within that job, have been pretty poor. Then you come to the Prison Service, and whether you love it or hate it, for me - having previous experience of other stuff - you've got the facilities, you've got the training…I can't fault the Prison Service.*

In summary, therefore, whilst three qualified facilitators were very happy with the support and training they had received, three felt that the quality of support had been poor (as discussed above) which had engendered negative feelings towards the Prison Service. Of this latter group, not all were from the same prison[23] which illustrates that poor quality support is not a localised problem. However, cross tabulation showed that two of those who were happy with support, and two of those who were unhappy, were from the same establishment. There could be two reasons for this: it could show that, even in those establishments where there were

[23] Follow-up interviewees came from five different prisons across England and Wales. See Chapter 5 for further details on the demographics of the sample populations.

complaints about support provision, there is still good work going on in terms of efforts to support SOTP staff. Alternately, it could mean that there are widely different views held by facilitators on what exactly is good quality support, and what is not.

6. Feelings towards Spouse/Partner

Negative Feelings

Research has shown that how sex offender work can have an impact on social relationships and sex life.[24] Trainees were therefore asked if they thought that working with sex offenders would have a negative impact on their relationships with their spouse or partner. Nine of the sixteen thought that it would. Of this nine, five trainees anticipated that working on the programme would cause a change in the way that they interacted with their partner. Specifically, these trainees thought that they might experience difficulty in communicating with their partner after delivering a treatment session, and some were concerned that they would compare their partners' behaviour to that of the offenders with whom they were working:

> *I think the danger there is that you might start making comparisons between* [your partner's] *behaviour and the offender's behaviours; a lot of which is totally acceptable, and there's nothing wrong with it, but it's just carrying that over and comparing. That's something that you'd have to be very careful about.*
>
> (Female Psychological Assistant)

[24] D Guy and GP Liaboe, 'The Impact of Conducting Psychotherapy on Psychotherapists' Interpersonal Functioning' (1986) 17 Professional Psychology: Research and Practice 111; L Ellerby, 'Impact on Clinicians: Stressors and Providers of Sex Offender Treatment', in S. Bird-Edmunds (ed) *Impact: Working with Sexual Abusers* (Safer Society Press, Vermont 1997); K Garrison, *Working with Sex Offenders: A Practical Guide* (Social Work Monographs, Norwich 1992); and Jackson *et al* (n 17).

> *It's difficult to kind of explain to them how your day's gone…You can't really explain to them in too much detail, so it might limit communication a little bit sometimes.*
>
> (Female Probation Officer)

The remaining four trainees anticipated negative changes to their sex life, including sex becoming less pleasurable, experiencing flashbacks during sex, and feeling a disinclination to engage in sexual intercourse:

> *I suppose the obvious* [negative effect on a relationship] *would be your sex life because you're hearing very unpleasant things about what people have done to other people.*
>
> (Female Probation Officer)

> *I don't know whether this will be the case but people have said before that they've had flashbacks and stuff, during sex.*
>
> (Female Psychological Assistant)

Qualified facilitators generally reported that working on the SOTP had not impacted upon their intimate relationships to the extent that they had anticipated as trainees. Only two of the nine identified a negative impact relating to their spouse/partner, both of whom said that they had found it more difficult to talk with their partner – particularly about work related issues – since working on the programme:

> *You go home and* [my partner will] *ask, "what's up?" and you're just like "nothing"…You can't talk about things like that to the outside world because she wouldn't understand anyway.*
>
> (Male Prison Officer)

> *There's been some issues with the partner. Obviously, because of the nature of the work, sometimes you feel a bit withdrawn…It is possibly due to the nature of the work, and being new, and not used to this type of environment.*
>
> (Male Trainee Psychologist)

Positive feelings

Twelve of the 16 trainees said that they would expect some positive impact in terms of their feelings towards their spouse/partner after starting work on the SOTP, with some providing more than one response. Seven of the trainees thought that the skills they would use when delivering the programme would also make them better able to communicate with their partner:

> [SOTP] *might enable me to be more open and talk about things that, maybe a few years ago, I wouldn't have.*
>
> (Female Probation Officer)

> *Hopefully we'll be able to talk a lot better.* [My girlfriend is] *sometimes a bit insecure, and sometimes I'm just like "how many times have I got to tell you I love you?" And I know I shouldn't think like that but doing things like this I think hopefully I'll be able to sit back and think, you know what, she just wants to be told and that's fine.*
>
> (Male Prison Officer)

Four trainees also thought that working with sex offenders would make them better at understanding their partner. One said that she was 'already doing all that perspective taking' and thought that it would probably have a positive effect on her relationship. Perhaps more interestingly, another four trainees (all of whom were female) thought that working on the programme would make them more appreciate of their partners. Trainees generally drew a

comparison between their own 'normal' and 'loving' relationships, and the kind of highly deviant sexual behaviours that they would have to treat in men completing the SOTP:

> *I think it was the day we had the victim video. It was last week and everyone was just like "oh, I felt so sorry for her", and obviously I did have those feelings but…I felt happier almost to hear it because it was so far removed from my own situation that I was able to appreciate my own family and boyfriend a lot more.*
>
> (Female Psychological Assistant)

> *…you realise the good in people and you think thank heavens! I'm very, very lucky that I haven't met anybody with those kinds of distortions and those kinds of attitudes…and also acknowledging how much support your partner does give you when you work in a difficult area…you realise how lucky you are.*
>
> (Female Probation Officer)

The responses of the 16 follow-up interviewees generally reflected those of trainees: three thought that they were more appreciative of their partner since starting work on the programme, and two thought that they were better able to understand their partner. None of the qualified facilitators thought that the SOTP had made them better at communicating with their partner (as did seven trainees during the stage 1 interviews). Indeed, as discussed previously, 2 qualified facilitators said that they found it more difficult to talk to their partner after starting work on the SOTP.

7. Feelings towards Children

Negative Effects

It has been suggested that sex offender work can impact upon an individual's interaction with

children; particularly with male therapists, who have reported feeling concerned about the 'appropriateness' of their behaviour around young people.[25] Eleven of the 16 trainees interviewed thought that working with sex offenders would have a negative impact on their feelings towards children. Two of this eleven (both of whom were male prison officers) were interviewed after they had started work on the SOTP.[26] Both reported already feeling some concern over the appropriateness of playing with young relatives. One referred to the fact that he often had 'play fights' with his girlfriend's young brother, but said that sometimes he questioned whether he should be interacting in such a physical way with a young boy. The other male prison officer said that he had noticed a change in the way that he played with his niece, and commented that he was '*very mindful of the fact that I would like someone else to be there when I'm with her'*. The remaining nine trainees who thought that working on the SOTP would have a negative effect on their feelings towards children all said that they anticipated being much more vigilant around young people, and more protective of their own children:

> *I feel more aware that I want my son to be more secure…I've also started asking questions because my ex-wife's moved in with a new partner, and I'm very aware that I know nothing about this fella', and he's now living under the same roof as my son. I ask my son a certain set number of questions every week just to associate in my own mind that I can't see any signs happening.*
>
> (Male Prison Officer)

> *Since I've worked with sex offenders over the years…in assessment work, pre-sentence reports, that kind of thing, I think I am more protective of my own children than I would have been had I not done this kind of work. Certainly*

[25] RE Freeman-Longo, 'Introduction: A Personal and Professional Perspective on Burnout', in S. Bird Edmunds (ed) *Impact: Working with sexual abusers* (Safer Society Press, Vermont 1997).
[26] Seven of the 16 trainees were interviewed at their place of work, shortly after completing the SOTP training course. See page 178 for further details of data collection procedures.

> *things like if they want to go to somebody's house for tea I wouldn't feel comfortable unless I knew the people fairly well, and sleep-overs would be an absolute no-no unless I knew the people very well. So yes, I think it affects me as a parent.*
>
> (Female Probation Officer)

> *If I'm with children I think I'll always be looking around and seeing if people are potentially putting them at risk.*
>
> (Female Trainee Psychologist)

Being more protective towards children was the only negative effect discussed by five out of the nine qualified facilitators at follow up. All of the facilitators descried this heightened sense of vigilance in negative terms, but two of the five also thought that it could be viewed positively, in the sense that it made them more alert to identifying potentially 'risky' sexual behaviour:

> *I'd say working on the SOTP has had a negative impact* [on my feelings towards children*] but I don't know whether you'd class it as negative or not. Overprotective is how I'd put it. I find myself…if I see people outside of the jail, and there's young kids about. I think hmmm, I'm not quite sure about that.*
>
> (Male Prison Officer)

> *Possibly more protective. I don't know if that's negative though. It could be a positive. Sometimes* [I'm] *more aware around children.*
>
> (Female Prison Officer)

Positive Effects

Thirteen of the 16 trainees anticipated experiencing positive feelings towards children after working on the SOTP. Specifically, five thought that working on the programme would provide them with a greater understanding of children and their behaviour, and eight felt that

they would be more aware of child safety issues and the 'warning signs' of victimisation. A number of this eight trainees felt that this would assist them in protecting potential child victims from sexual abuse:

> *I guess having some knowledge would make you protective, and perhaps more able to look out for any warning signs.*
>
> (Female Probation Officer)

> *I'll be a lot more aware…of what's going on, and of what could happen and the type of people that are out there.*
>
> (Male Psychological Assistant)

> *Hopefully, if I can see some sort of change in the offenders I'm treating, then realising that more children are going to be protected. That's a positive.*
>
> (Female Prison Officer)

In comparison, only three of the nine qualified facilitators felt that working on the SOTP had engendered more positive feelings towards children. All three said that working with sex offenders had made them more protective of children generally. One of the three also said that, since starting work on the programme, he was more positive towards becoming a father himself:

> *…sometimes, when I hear what* [group members] *have done, I sort of feel a bit protective towards children…I have thoughts about wanting children of my own and protecting them; not from group members, but just being a good father and looking after them.*
>
> (Male Prison Officer)

IV. THE VIEWS OF SOTP TREATMENT MANAGERS

To add to the data gathered from SOTP trainees and qualified facilitators, and also to obtain a different perspective on the issues being evaluated, I conducted interviews with seven SOTP treatment managers. The following results outline the positive and negative effects treatment managers reported that they had seen SOTP facilitators experience after starting work on the programme. In addition, the results highlight the main causes of work-based stress to SOTP treatment managers, as identified by interviewees.

Only one research study has considered the impact of sex offender work on treatment managers of the SOTP. The work of Brown and Blount focuses wholly on occupational stress among SOTP treatment managers, and found that the stressors most frequently experienced were: when members of the treatment team did not 'pull their weight'; when facilitators failed to appreciate the importance of supervision; a lack of clear policy guidelines; a lack of understanding from governors; and a general lack of support.[27] The authors were able to categorise stressors into three distinct groups, and also link the years of experience spent working as a treatment manager to one of these groups. Thus, managers with less than two years' experience were found to be more concerned with stressors of a personal nature, such as heightened feelings of vulnerability. Managers with between two and five years' experience showed greater apprehension towards dealing with individuals outside of the treatment team, for example the governor; and managers with over five years' experience were most concerned about organisational and policy issues, such as having to cope with an

[27] J Brown and C Blount, 'Occupational Stress among Sex Offender Treatment Managers' (1997) 14 Journal of Managerial Psychology 108.

unequal share of the workload. This led the authors to conclude that 'experience does seem to play a role in the content of the stress reaction'.[28]

In the present study, all seven treatment managers were able to identify a number of positive effects that they had seen SOTP facilitators experience after starting work on the programme. Generally, treatment managers said that facilitators tended to have increased confidence, improved skills, and a high sense of job satisfaction as a result of working on the SOTP. It was also mentioned that facilitators learnt a lot more about themselves when delivering the programme. However, six of the seven interviewees also reported that they had, at some point during their career, seen facilitators experience some negative health or personal impact. Treatment managers reported facilitators experiencing negative emotional effects (such as becoming tearful and 'oversensitive') and problems in their personal relationships as a result of working on the SOTP. For instance, one treatment manager said that she knew a number of female facilitators who thought that their *'philosophy about men had become skewed because of the work they do'*. There was also some discussion about facilitators developing negative feelings towards the Prison Service. One treatment manager said that '*very often there becomes a "them" and an "us". "Us" are the people on the ground delivering programmes, and "them" are the management who don't understand anymore…and don't give us what we need'*. Thus, there was a definite acknowledgement by treatment managers that some facilitators feel that their efforts go unappreciated by higher management, which ultimately affects their feelings towards the Prison Service more generally. The most frequently discussed negative effect was facilitators becoming hyper-vigilant around children, and male facilitators questioning their own behaviour and interaction with children:

[28] *Ibid.* 115.

> *Male facilitators say that they feel their relationship, not only towards their own children, but a lot of the time towards other people's kids, has changed…You know, if they're at a party and a child comes and sits on their knee, they're very aware of it and they don't feel comfortable…That's definitely something that's been reported.*
>
> (Female Psychologist)

> *I've heard of people behaving in a way that they've never behaved before, like challenging men in the street who are with children who are crying. Actually feeling compelled to go up to the person and say, "what's going on here?", and then feel quite down about that afterwards.*
>
> (Female Psychologist)

Treatment managers were subsequently asked about their experiences of working on the SOTP. I felt that this was necessary for two reasons: first to see if the responses of treatment managers differed at all from those of SOTP facilitators, and second because of the paucity of research data currently available on the experiences of managers running rehabilitative programmes in the Prison Service. Interviewees were asked how many facilitators they were involved in managing or supervising in order to gauge the type of work-load that treatment managers had to deal with. This number ranged from five to 20 facilitators, with the average number being 14. All seven treatment managers still provided treatment on one or more of the SOTP programmes, including the Core, Adapted, Extended, and the Healthy Sexual Functioning programme. When asked whether they found their job 'stressful' all answered in the affirmative, although three added the caveat that the job was stressful 'at times'. Treatment managers' definitions of 'stress' are provided in Table 5 below:

Table 5: How treatment managers defined stress

Definition of stress	Number of participants
'Too much to do in too little time'	5
'Other people not doing their job properly'	1
'Getting wound up'	1
TOTAL	**7**

In terms of which aspects of their role they found most stressful, one treatment manager said that she found it difficult to cope when she could see that work colleagues failing to 'pull their weight'. However, the remaining six interviewees said that the most stressful part of the treatment manager role was the volume of work that they had to deal with. Two of this six also referred to the fact that, with such a high volume of work, they were sometimes forced to make important decisions about an offender's treatment in a very limited amount of time.

> *There's a lot of demands on my time, so when people come out of a group and say "this didn't go well", or "this prisoner shouldn't have been put on this group because he's too demanding", I feel a lot of pressure to try and fix everything…There's often a lot of people wanting to see me right now when I need to do something else, and I feel like I can't say no. And because of the nature of the work I am constantly thinking, if I don't see them now, am I damaging them? Or, am I letting them down?*
>
> (Female Psychologist)

> *It's having too many things that need doing and they're all equal priority, and therefore it's difficult trying to prioritise what I have to do…there's that much to do and they all need doing with imminent deadlines.*
>
> (Female Psychologist)

…while I enjoy making decisions when I've got time to make sure they're the right decisions, often I feel that you're making quite important decisions and have a limited amount of time to do that…

(Male Psychologist)

Finally, treatment managers were asked how their current role compared to other jobs they had done in the Prison Service. As some treatment managers had worked in various roles (for example, starting off as a psychological assistant, then moving on to be a trainee psychologist, as well as being a supervisor on the SOTP), a comparison was made between their current role, and their first job in the Prison Service. Table 6 shows the responses they gave:

Table 6: How treatment managers felt their role compared to their first job in the Prison Service

First job in the Prison Service?	**How the role of treatment manager compares to first job**			**TOTAL**
	Carries more responsibility	**More rewarding**	**More demanding**	
Psychological Assistant	1	0	1	**2**
Trainee Psychologist	1	1	0	**2**
Psychologist	1	0	0	**1**
Prison Officer	0	1	1	**2**
TOTAL	**3**	**2**	**2**	**7**

V. DISCUSSION

The results presented above describe the reasons why interviewees wanted to get involved in sex offender treatment provision; the positive and negative effects trainees expected to experience whilst working with sex offenders; the effects they actually experienced during their first year's work as a facilitator; the most frequently experienced effects of SOTP work,

as perceived by SOTP treatment managers; and the key sources of stress affecting treatment managers. The following discussion highlights some of the key findings, and their implications for SOTP facilitators, and the Prison Service.

1. Entry into Sex Offender Work and the SOTP

The results suggest that, for the most part, once interviewees had decided they wanted to work on the SOTP, the recruitment process was quick, subject to job vacancies on the programme. Three trainees had, however, waited three years to receive training, two of whom were from the same institution. Although this does not seem to have been a wide-spread problem, and none of the trainees expressed any negative feelings towards the Prison Service as a result, a delay of three years could ultimately dissuade skilled, experienced individuals from applying to work on the SOTP.

Most participants had previously worked with sex offenders before training for the SOTP. This perhaps explains why five trainees reported that they wanted to work on the programme to 'develop existing skills'. It also suggests that trainees see sex offender work as a means of honing their skills, and taking them to a 'higher level'. As one of the follow-up interviewees put it:

> *I think* [a] *positive point would be - not to use the word elite as in we are elite - but it's a stand alone department within the Prison Service, and it's seen as the higher echelons, so it's quite elite in that respect.*
>
> (Male Prison Officer)

Nine trainees also expressed an interest in sex offenders as a client group or in forensic psychology generally, which was one of the key areas of reward reported by the qualified

therapists partaking in Kadambi and Truscott's study.[29] The authors identified seven key areas in which sex offender therapists found reward from their work, namely: protection of potential victims; socially meaningful curiosity (a sense of being stimulated by the practical and academic nature of the work); enjoyment of counselling; professional benefits; relationship with colleagues; offender change and wellness; and offending specific change.[30] Protection of potential victims was reported to be the most rewarding aspect of sex offender work to treatment providers.[31]

In the current study, only two of the 16 trainees interviewed said that they wanted to work on the SOTP 'to prevent future victims of sexual abuse'. Comparing these findings to those of Kadambi and Truscott, it seems that protecting potential victims is something that contributes to job satisfaction upon qualification rather than something that initially draws people into the work. Indeed, five of the nine qualified facilitators who took part in the study said that one of the key professional benefits they had experienced was 'enhanced job satisfaction'. However, none of the five mentioned that they had felt a sense of reward specifically from the prospect of protecting potential victims.

Three of the 16 trainees (all female) reported that they had experienced previous sexual abuse and five (3 male, 2 female) reported some other form of personal trauma. Of the eight respondents, three said that their experience had influenced their decision to work on the SOTP. Two of this three reported experiences relating to sexual abuse: one female interviewee said that she had been sexually abused herself and the other male participant told me about the time he found out that his cousin had been sexually abused by a family friend.

[29] Kadambi and Truscott (n 1). See Chapter 2, page 96 for full details of the study.
[30] *Ibid.* 45.
[31] *Ibid.* 49.

In light of Clarke's suggestion that victims of adult sexual abuse might be more at risk of the negative impact of sex offender work,[32] this raises cause for concern in terms of the residual emotions such individuals might be taking into group sessions. It also raises the question of whether such facilitators are using the SOTP to overcome their own traumatic experiences. Greater attention therefore needs to be paid to such issues during the applicant selection procedure, perhaps to the extent that victims of sexual trauma are excluded from working with sex offenders. This is not to disparage the efforts of those currently working as SOTP facilitators who also have a history of sexual abuse, and there was no indication whatsoever that these participants were using the SOTP as a means of personal therapy; but if the Prison Service wishes to support its staff to the fullest extent, as well as to minimise the possibility of individuals taking legal action for stress experienced at work, then it must take proactive steps to achieve this. This type of approach should not lead to the complete exclusion from rehabilitative work of staff who have personally experienced sexual abuse; instead, such individuals should be encouraged to engage in one of the many other treatment programmes offered by HM Prison Service.

2. Effects of Working with Sexual Offenders

All 16 trainees thought that they would face positive and negative health effects as a result of working on the SOTP. Similarly, all nine qualified facilitators reported that they had experienced positive and negative impacts after starting work on the programme. Tables 7 and 8 provide a comparison between the effects anticipated by trainees, and those actually experienced by facilitators after working on the job for one year.

[32] Clarke (n 5) 84.

Table 7: Comparison between negative effects anticipated by trainees and negative effects experienced by qualified facilitators

Negative Effects	Number of trainees that anticipated this effect? (16)	Number of qualified facilitators that had experienced this effect? (9)
Personal life	9	4
Professional life	0	1
Physical health	8	2
Emotional/mental health	10	7
Feelings towards the Prison Service	4	3
Feelings towards spouse/partner	9	2
Feelings towards children	11	5
Note: Trainee facilitators were not asked if they thought they would experience a negative effect on their professional life, hence why zero responses were recorded for this category.		

Table 8: Comparison between positive effects anticipated by trainees and the positive effects experienced by qualified facilitators

Positive Effects	Number of trainees that anticipated this effect? (16)	Number of qualified facilitators that had experienced this effect? (9)
Personal life	9	2
Professional life	16	9
Physical health	0	3
Emotional/mental health	0	4
Feelings towards the Prison Service	9	4
Feelings towards spouse/partner	12	5
Feelings towards children	13	3
Note: Trainee facilitators were not asked if they thought they would experience a positive impact in terms of their physical health and emotional/mental health, hence why zero responses were recorded for this category.		

As can be seen above, there were some slight discrepancies between the effects anticipated by trainees and those actually experienced by qualified facilitators. For example, whilst 13 trainees thought that the SOTP would engender positive feelings towards children, only 3 qualified facilitators felt that this had actually occurred. Overall, the most frequently reported effects by qualified facilitators were:

- Negative effects on their emotional/mental health (7 facilitators); and
- Positive effects on their professional life (9 facilitators).

Negative effects on emotional and mental health have been reported in previous research. For example, in his sample of 28 American sex offender therapists, Farrenkoph found that over 40 per cent had experienced a 'hardening or dulling of emotions'.[33] In a much larger scale study involving 276 US sex offender treatment professionals, Bird Edmunds found that 29 per cent reported an increase in symptoms associated with burnout after commencing work with this particular offender group.[34] As highlighted in Table 7 above, seven of the nine qualified facilitators who took part in the current study said they had experienced a negative impact on their emotional and mental health. Two of these individuals had been forced to take time off work as a result of stress, one for one month, and one for six months. This raises obvious questions about the quality of support they received whilst delivering the SOTP – a matter that will be dealt with in chapter 8 of this thesis. It also raises concerns about how well informed these individuals were about the negative emotional effects that have been associated with sex offender work.

[33] T Farenkoph, ' What Happens to Therapists Who Work with Sex Offenders?' (1992) 18 Journal of Offender Rehabilitation, 217, 219.
[34] Bird Edmunds (n 20) 17.

Although the negative health effects associated with sex offender work are discussed intermittently throughout the SOTP training course, only a limited amount of time is devoted to any specific consideration of this issue. This is not to be critical of the course itself - given the amount of material to cover it is doubtful that tutors would be able to devote more time to the negative health effects of SOTP work. A new course – entitled 'Staying Strong' – is now being offered by the Prison Service which aims to develop the 'resilience' of SOTP facilitators to the more deleterious effects of working with sex offenders. However, what would be helpful is if facilitators could attend the two-week training course having already received some guidance on the type of positive and, more crucially, negative effects SOTP work can induce. As one treatment manager put it:

> *…for new facilitators there should be a review of how quickly people are put into this kind of work; and I also think there should be some consideration given to the aspects* [that research has identified as making some people] *potentially more vulnerable to this type of work than other people…*
>
> (Female Psychologist)

It is my opinion that there would be real value in providing a short awareness workshop for people wanting to facilitate on the SOTP. A similar idea has been proposed by Craig who argues that an 'intensive workshop may help to identify and select care staff suitable for further treatment facilitator training'.[35] Although Craig suggests that such a workshop might be held over two days, I believe that the Prison Service should implement a much shorter 'SOTP awareness' course – perhaps for half a day. This course would aim to provide individuals with information on the aims and content of the SOTP; research supporting the effectiveness of treatment; the effects of the work as discussed in the research literature; the

[35] L Craig, 'The Impact of Training on Attitudes towards Sex Offenders' (2005) 11 Journal of Sexual Aggression 197, 206.

available avenues of support; and the rewards associated with sex offender work, which have received much less attention than the identified disadvantages. It would also involve watching part of a video recorded session of the SOTP (subject to the relevant consents being obtained from SOTP group members). Instituting this type of workshop would enable staff interested in the programme to make a more informed decision about whether working on the SOTP is the right role for them.

In terms of positive effects, all qualified facilitators felt that working on the SOTP had led to a beneficial impact on their professional life. Within this category, five facilitators reported that they had improved their professional skills and knowledge, and five said they had experienced a sense of job satisfaction. Both of these effects were anticipated by trainees. However, 11 of the 16 trainees also thought that the SOTP would be beneficial to their career development prospects. This compared poorly to the data provided by qualified facilitators, with only two out of the nine reporting that the SOTP had provided them with greater career development opportunities. Although the sample size was too small to allow tests on statistical significance to be applied, this decrease in numbers warrants further consideration. Promotion prospects do exist on the programme, particularly for psychologists and probation officers who can progress to the position of supervisor or treatment manager with experience and satisfactory video monitoring reports.[36] However, it is recommended that prison officers should have a relevant mental health qualification before progressing to the grade of treatment manager. Funding has now been withdrawn by the Prison Service for such courses, making it necessary for the individual officer to pay for any further education he or she chooses to undertake.[37] This is perhaps something that should be made explicit at the start of the recruitment process

[36] Statement by Fiona Ainsworth of the Offending Behaviour Programme Unit (personal email correspondence 9 October 2006).
[37] *Ibid.*

given the number of participants who identified career development as a future goal. The issue was also discussed by one of the treatment managers who took part in the research:

> *There's no real promotion route…Facilitators are graded; they meet the grade of Prison Service administrative officer, so the promotion route is something called executive officer, which is basically an administrative managerial position. So they could be moving paperwork, or managing people moving paper work in the discipline office where's there's no prisoner contact. The only other thing they can do is become a trainee psychologist, but most of our facilitators don't have psychology degrees although they are very, very skilled.*
>
> (Male Psychologist)

It should be noted that, generally, treatment managers demonstrated a good understanding of the positive and negative effects that facilitators experience when working on the SOTP. However, the stressors that they identified as affecting their own role were very different from the negative effects discussed by facilitators and were mainly related to the volume of work that treatment managers have to contend with. This finding does not, therefore, correspond with the results of Brown and Blount who suggested that concerns about organisational issues (including workload) were most commonly associated with managers of over five years' experience.[38] Only one of the seven treatment managers interviewed for the current study had over five years' experience. The results of this thesis therefore imply that treatment managers of varying levels of experience (not just those with over 5 years) find organisational issues the most stressful part of their job.

[38] Brown and Blount (n 27) 117.

CHAPTER 7

THE TRAINING NEEDS OF SOTP FACILITATORS

I. INTRODUCTION

Staff training for those delivering therapy to patients and offenders aloke has been said to improve client outcomes, maintain staff performance, and allow the transfer of skills across client settings and programmes.[1] Thus far, only cursory evaluations of the Core SOTP training course have been conducted – usually by trainees writing down their thoughts after completing the two-week programme. Although the Offending Behaviour Programme Unit (OBPU) does respond to trainee feedback, there is no formal review of trainee comments about how the course might be improved in the future.[2] Likewise, changes to the course based on the feedback provided seem to occur on an ad hoc basis and where (in the opinion of the OBPU rather than trainees themselves) the benefits of change outweigh current practice. Sixteen trainee facilitators and, at follow-up, nine qualified facilitators were therefore asked for their thoughts on the Core SOTP training course. Specifically, trainees were asked what they thought about the quality of training; how they thought the course might be improved; and what training they expected to receive in the future from the Prison Service. Qualified facilitators were asked whether they thought the Core training had prepared them for their role; how they thought the course might be improved; and what further training they had received since completing the Core training. At the end of the chapter, the responses of SOTP treatment managers are presented regarding the type of training they had received for their role, allowing for a

[1] E Jahr, 'Current Issues in Staff Training' (1998) 19 Research in Developmental Disabilities 73.
[2] Statement of Christopher Dean (Personal email correspondence 8 May 2008).

comparison to be made between the training provided for senior staff and that provided for facilitators.

II. VIEWS ON THE CORE SOTP TRAINING COURSE

No systematic evaluation of the Core SOTP training course has ever been conducted. Appraising the course was not the sole focus of this research and so the following data outlines trainee responses regarding their opinion of the training, and how they thought it could be improved. This is followed by a consideration of the views of qualified facilitators who were asked if they thought the Core training had prepared them for their role and how – if at all – it could be developed.

Sixteen trainee facilitators were therefore asked, 'What is your opinion of the two-week Core training course so far?' Nine made positive comments about the course, using words such as 'enjoyable', 'excellent' and 'interesting' to describe their experience. There were criticisms, however, and 11 trainees made reference to one or more specific problems they had encountered on the course. The main criticism, as discussed by 4 trainees, was that the trainers delivering the court used far too much psychological jargon. Two of these trainees commented that:

> *I did feel like a fish out of water because I've not got a psychology background, so a lot of the stuff I was hearing, I was thinking, what?!! And you see a lot of heads nodding and you feel yourself getting smaller in your chair! To a great degree I did switch off for that bit.*
>
> (Male Prison Officer)

> *There's some terminology that's completely thrown me from time to time…That's a bit of a shame because you'll be really engrossed in something and you suddenly think, what am I thinking, I don't understand.*
>
> (Female Psychological Assistant)

Three trainees also thought that course tutors were disorganised and/or unsupportive:

> *I didn't really feel like some of the information was put across very well, and I felt that sometimes it was more like a grilling experience rather than something that was a bit more supportive. The tutors would demonstrate a role play in the main group, and I just felt that it wasn't clear what was expected from that role play. And the tutors even seemed to be getting slightly confused at times…So you'd go away to your syndicate group,*[3] *and you'd be left feeling a bit vulnerable, a bit unsure, and you'd be assessed on that.*
>
> (Female Prison Officer)

> *I thought…we had quite inexperienced trainers. We got contradictions between them. One of them even admitted that she was supposed to be on the course as refresher training, but then got made the tutor, so it was disconcerting straight away I think. The actual course itself was good, but I'm not sure about the actual trainers themselves. It may not be their fault. It may be that they'd not been trained properly.*
>
> (Female Trainee Psychologist)

In terms of the course content itself, three trainees thought the course was boring, and another two thought it too intensive. For instance, one male Prison Officer commented that: 'You'd do a role play and afterwards it'd be like 'you need to improve on this bit', and it's sort of like well, I

[3] 'Syndicate groups' are the small groups in which trainee facilitators practiced their skills during the Core training course. See chapter 3 for more details on the Core SOTP training course.

need to improve on a lot of it to be fair because I've had five minutes looking at it on a board and that's it, now you're qualified tutors'. Yet, in spite of this concern that trainees were essentially 'bombarded' with information, two still thought that not enough time had been spent looking at the Core treatment manual. One female Probation Officer commented that:

> *I came with the assumption that we would be taken through each block, and we're not...when I've looked at the manual of a night I'm kind of wondering well, how do I do that, and how do I do that?*

Having discussed their criticisms of the course, 10 trainees made recommendations as to how they thought it might be improved in the future, as shown in Table 1 below.

Table 1: Trainee's recommendations regarding how the Core SOTP training course could be improved

Recommendation	**Number of Trainees**
Course should be restructured so that it is less 'rushed'	3
Course content should be broadened	2
Course tutors should be more organised	2
More time devoted to the Core treatment manual	2
Glossary of terms of the more frequently used psychological terms to be provided to all participants	1
TOTAL	**10**

It was clear, however, that the vast majority of trainees did not view the Core training programme as the end of their training experience whilst working on the SOTP. Thirteen out of the 16 that took part said that they would expect further training, if necessary, to aid them in their work. Five of this 13 thought that such training might be provided in-house at their respective establishments, rather than externally. Trainees identified a number of Prison Service training courses (including role play training, primary facilitator training,[4] and training to deal with 'problem' scenarios during treatment) that they would like to do in the future, whether for reasons of professional development or for personal interest.

In terms of the views of qualified facilitators, nine of the original 16 trainees were asked – after one year's experience of working on the SOTP - whether they thought the Core training course had adequately prepared them for their role. Five thought that it had, and four said that it had not. All of this latter group said that the main problem was that the SOTP Core training had not highlighted the reality of actually delivering a treatment session:

> *I thought, before working on SOTP, I had a really good understanding of how stressful it would be. I thought that I was really well equipped because I'd worked with prisoners, so I thought it can't be any more difficult than that – but it really is. It's a lot more tiring than I think we were briefed about. I know* [the trainers] *don't want to put you off, but we only had a brief bit about the sort of effects on facilitators, and I think a bit more on that would get you a bit more equip…and make you think, well, I'm not crazy and it's actually normal to feel like this.*
>
> (Female Prison Officer)

[4] Primary facilitators (required only for the Rolling and Extended SOTP) are those considered to have a more advanced level of knowledge and skill in terms of delivering treatment. See chapter 3, page 125, for a more detailed explanation.

> *It doesn't prepare you for being in group with nine other people, two other facilitators and a camera and everything else that goes with it…You can't go into group and think right, I've got to do this, and do it like it says* [in the manual], *because everyone's different, and you have to model different things in different ways to people so they understand. I don't think it actually prepares you in any way for doing it for real.*
>
> (Male Prison Officer)

Six of the nine qualified facilitators made recommendations as to how the Core training course might be improved. Four said that training should be focused much more on showing the reality of delivering treatment in practice, including the negative effects that can be associated with delivering treatment. One of this four suggested that this might be achieved by allowing trainees to observe a recorded SOTP treatment session during the second week of training. The remaining two facilitators recommended that the course content should be broadened to include, respectively, more on the risk factors of sexual offending, and more on the administrative responsibilities of the job.

One male Prison Officer also mentioned that there should be a shorter time gap between completing training and delivering treatment on the programme. Indeed, one of the trainee facilitators who participated in the research was unable to volunteer for the follow up interviews as she had not been given the opportunity to deliver an SOTP course. Although this seems a relatively minor point it is, nonetheless, significant. If trainees are spending months after completing the Core training in their 'usual' role (perhaps, for example, working as a Prison Officer on the wings of a Prison) any knowledge gained from the course will be lost. It is

arguable that, in order to maximise the usefulness of the skills gained, those who successfully complete training should be given the opportunity to deliver a programme straight away. This would provide instant practical experience and highlight any emotional or coping difficulties, which may be suggestive of the fact that a facilitator is not suited to work on the SOTP.

For those who had delivered an SOTP programme it does seem, however, that the Prison Service had been effective in providing follow up training to supplement the skills developed on the Core SOTP course. After one year's experience, all nine qualified facilitators had participated in some further training, with four of the nine having been trained to deliver the Adapted SOTP almost immediately after completing the Core programme.

III. TRAINING FOR SOTP TREATMENT MANAGERS

In addition to interviewing SOTP trainees and qualified facilitators, seven SOTP treatment managers were asked about the type of training they had received for their role. Interviewee responses revealed that only one of the seven treatment managers had received any type of formal training. This related to the video monitoring of SOTP treatment sessions, and how to effectively evaluate facilitator performance from such recordings. Three others made reference to unofficial training provision, in the form of tripartite training[5], and informal training from supervisors.

[5] Each prison Programmes Department should have a 'tripartite' team. This is composed of: the treatment manager, who ensures that facilitators are receiving the right amount of supervision and counselling, and deals with issues encountered during treatment; the programmes manager, who provides operational support for treatment staff, such as making sure facilitators have the right resources to conduct a group therapy session; and the resettlement manager, who manages issues relating to the resettlement of offenders back into the community. Tripartite training involves the tripartite team reviewing their performance and progress in relation to audit criteria.

Two of the seven treatment managers interviewed felt that they would have benefited from Prison Service training; specifically, training on how to deal with particularly difficult treatment cases, and on how to properly apply SOTP audit requirements. However, the remaining five interviewees believed that they were suitably qualified to perform the duties of a treatment manager upon entering the role, and did not view their lack of formal training negatively:

> *I felt quite happy to just get on with it really. Anyway, I've always felt that if there was a training gap then the Prison Service is very good at filling it and there's always somebody who can support and guide you through it.*
>
> (Female Psychologist)

> *I consider that my training for the* [treatment manager] *role was ongoing from the day I started to the day I took the role on. So I didn't have any specific training, but I felt well and truly competent to take the role when I did.*
>
> (Female Psychologist)

IV. DISCUSSION

Just over half of the 16 trainee facilitators interviewed were pleased with the training they had received on the two-week Core training course. A similar proportion of qualified facilitators (five out of nine) also thought that it had prepared them adequately for their role on the SOTP. There were, however, some criticisms; for instance, four trainees complained that they were unfamiliar with some of the psychological terms used by course trainers. This should be of some concern to the Prison Service for two reasons: first, it could mean that some trainees are completing the two-week training course with a less than thorough understanding of its content; and second, use of language that is not understood by participants could result in a lack of interest

in the course. Indeed, three trainees said that they found the course boring. One trainee suggested that a glossary of the most frequently used psychological terms should be included in the course information pack distributed at the beginning of the first week. This would be a cheap and simple way of dealing with this particular problem, although tutors should also be encouraged to provide a relatively straightforward definition of key terms when delivering the course material and to avoid unnecessary jargon.

Three trainees also suggested that tutors should be more organised and said that, sometimes, trainers did not seem to be confident with the material they were delivering. In fact, it was alleged that one of the tutors should have been participating in the course herself, as refresher training, but was subsequently asked to stand in as a tutor instead. It seems obvious that, in order to be able to deliver effective training, course tutors must be wholly familiar with the Core treatment manual and Core training exercises. I was able to watch some sessions of the Core training between interviewing study participants and, from my point of view, course tutors seemed to be fairly organised. However, according to some trainees, this was not portrayed to be the case.

In terms of how the course could be improved, many of the recommendations made by interviewees (which are summarised at Table 2 below) related to the length of the course. Three trainees said that some elements of the course seemed rushed. Likewise, two wanted a 'broader' course content which, by implication, raises the issue as to whether the course needs to be longer. Two trainees specifically referred to the fact that, in their opinion, more time should have been devoted to looking at the Core treatment manual. This was also discussed in the pilot interviews,

where one participant described the Core training course as 'vastly insufficient'. As a result of not having time to cover all of the treatment blocks detailed in the Core treatment manual, she said:

> *You come to run a programme, and you are learning as you go on the manual, and I think that helps to create a lot of inconsistencies in the way that people run the programme…You just pick up the manual on the day you're doing it and you're like, "what are we going to do today?"…To an extent, you're flying by the seat of your pants every time you run a session if you haven't run it before.*
>
> (Female Probation Officer)

None of the 16 trainees or the nine qualified facilitators thought that the course should be longer. However, it is difficult to see how incorporating this additional content would be achievable without extending its duration. This leads to the question of whether the Core training course should be extended, and go beyond its current two weeks. In my opinion, the answer to this would be no for three reasons. First, even if the training course were extended considerably, it would be impossible to cover every aspect of the Core treatment manual due to its sheer length. The manual itself provides a detailed account of the content of each treatment session, of which there are 85 in total. This lack of time to cover every aspect of the manual was acknowledged by a number of interviewees, and some actually liked the idea of learning 'on the job'. Second, lengthening the duration of the course may well discourage potential candidates from entering sex offender work, particularly if they have practical considerations to think of, such as child care arrangements and family commitments. Third, the general feeling from participants at the end of the two-week course was that they were tired and were looking forward to going home to see their families. Indeed, three trainees criticised the course for being too intensive.

Table 2: Comparison of recommendations made by trainees and qualified facilitators regarding improvements to the Core training course

Recommendations of trainees	Recommendations of qualified facilitators
More time devoted to the Core treatment manual	Greater focus on the reality of delivering treatment in practice
Course content should be broadened	Course content should be broadened
Course tutors should be more organised	
Course should be restructured so that it is less 'rushed'	
Glossary of terms of the more frequently used psychological terms to all participants	

An alternative solution would be to restructure the course, so that more time is devoted to the areas on which facilitators feel they need to focus. However, this would potentially mean that some aspects of the course in its current format would need to be sacrificed. One way around this problem would be to require trainees to undertake some pre-course study, which would free up time on the two-week training programme. This was discussed by one trainee during his interview:

> *I would think that a lot of work could be done by the time you get here. There's a lot of other reading, other skills, that type of work, that could have been done in your establishment, so by the time you get here it'd be just a case of…more like when they put you into situations in groups, how to deal with certain things…more about the material of the group than the basic skills maybe.*
>
> (Male Psychological Assistant)

It is my opinion that trainees should be required to undertake a small amount of study before embarking on the Core training course. Such work should involve trainees:

- Attending the SOTP awareness training recommended in chapter 6, so that they are fully informed about the aims of the SOTP, research supporting its effectiveness, the format of a treatment session, and the positive and negative health effects associated with the work; and
- Undertaking some preliminary reading on the fundamental skills covered in week one of the Core training, and also some further reading on the aims and methods of the programme to supplement the knowledge gained on the SOTP awareness training. This would come in the form of a pre-course materials pack, which would also include a glossary of the most common psychological terms used on the Core training course.

Having said this, I do not feel that the first week of the Core training should begin with a consideration of the Core treatment manual to the exclusion of the fundamental skills altogether. Having done the fundamental skills training myself, it is clear how important it is for trainees to develop their ability - amongst other things - to use socratic questioning, challenge problematic attitudes, and work effectively with co-facilitators. However, having some knowledge of the fundamental skills required to facilitate on the SOTP *before* commencing training would inevitably leave additional time in which to practice such skills. Likewise, it may also allow for an earlier consideration (perhaps at the end of week 1 of the training) of the Core treatment manual, and other issues relating to sex offender treatment, which was recommended by a number of trainees and qualified facilitators alike. Providing trainees with some introduction to the SOTP, before allowing them to commence formal training, would also go some way to

satisfying a key recommendation of four of the nine qualified facilitators interviewed; namely that the Core training course did not go far enough in providing trainees with a clear idea of the reality of delivering the SOTP in practice. This is, of course, a difficult objective to achieve in a training environment; which is exactly why pre-course preparation seems even more vital.

It is equally as important that, having completed the Core training, newly qualified facilitators have good support structures to rely upon within their respective establishments, and access to further training if required. Further training for qualified facilitators seems to be in good supply and, by the time the follow-up interviews were concluded, all participants had completed some further SOTP training. As put by one male Prison Officer, a pilot interviewee:

> *There's lots of training there, and if I feel the need to, if I'm not feeling comfortable with something, I just say right, I need to go on some training, and it's sorted for me straight away.*

The same cannot be said for treatment managers, however, with only one out of seven receiving any type of formal training for their role. 'Training' for SOTP treatment managers seemed to be provided on a much more informal basis, generally coming from supervisors rather than structured courses. Most found this system unproblematic and, given that the most frequently reported source of stress for treatment managers related to the volume of work they have,[6] it is difficult to see how training could help with this particular problem. The more appropriate

[6] See chapter 6, page 223.

solution would seem to lie in ensuring that robust avenues of support are available for treatment managers, rather than increasing the training available to them.

CHAPTER 8

THE IMPACT OF SUPPORT ON SOTP FACILITATORS

I. INTRODUCTION

A wealth of literature now exists which suggests that social support can reduce stress and its associated symptoms.[1] However, in more recent times, a body of evidence has begun to develop that highlights the potentially negative effect that poor quality support can have upon users.[2] The present chapter outlines the responses of 16 trainee facilitators on the support that they thought they might need whilst working as an SOTP facilitator both from the Prison Service, and from sources outside of the workplace, such as family and friends. This data is then compared to information gathered from the nine follow-up participants, who were asked to identify the actual sources of support they used during their first year of working on the SOTP, and the quality of such support. Finally, the views of SOTP treatment managers are considered in relation to the support they provide to facilitators, its adequacy, and the support available to them as members of senior management.

In terms of organisational support, both trainees and qualified facilitators were asked only about their views on the supervision and counselling provided by the Prison Service. As discussed in Chapter 3 of this thesis, there are other means of support available to facilitators. However, I decided to focus on these two particular types of support as they offer the best

[1] See Chapter 3 for a review of the available literature.
[2] See for example RA Mayou, A Ehlers and M Hobbs, 'Psychological Debriefing for Road Traffic Accident Victims' (2000) 176 British Journal of Psychiatry 589; and IVE Carlier *et al*, 'Disaster-Related Post-Traumatic Stress in Police Officers: A Field Study of the Impact of Debriefing' (1998) 14 Stress Medicine 143.

opportunities for facilitators to explore their feelings in relation to their treatment experiences and offload any negative emotions.

II. ORGANISATIONAL SUPPORT

1. Opinions on Organisational Support Generally

Trainee facilitators were asked to rate how important they thought supervision and counselling would be to them once qualified using a grid that I prepared before the interviews. This grid was handed to participants, who then self-classified how important they thought each source of support would be by choosing from one of the following three categories:

- Very important
- Important
- Not important (including those who thought supervision/counselling would be neither important, nor unimportant).

All 16 trainees anticipated that both counselling and supervision would be either 'important' or 'very important' sources of organisational support. One trainee mistakenly believed that she would not be receiving counselling, and therefore only 15 responses were retrieved for this particular question. The results are shown in Table 1 below:

Table 1: Trainees' predictions of the importance of supervision and counselling

	Level of Importance			
	Very Important	**Important**	**Not Important**	**TOTAL**
Supervision	13	3	0	**16**
Counselling	11	4	0	**15**

A range of reasons were given for why these sources of support were deemed to be so crucial, including the sexually graphic nature of the material involved in the job, the possibility of problems with co-facilitators, and the need to monitor facilitator health:

> *There's no doubt about it - it's going to be very hard. It's a specialised job…And I think possibly a whole load of different things will crop up throughout that time: the way I think, the way I feel, the way my moods are; and to allow me to be able to do this job, I'm going to need support from, obviously,* [the Prison Service] *and people outside.*
>
> (Female Prison Officer)

> *I think* [supervision and counselling] *are going to be important because, at the end of the day, we're all just human. There may be a lot of material that we're exposed to that is quite shocking, and we need to absorb that rather than respond or react to it…That's going to have to come out some way.*
>
> (Female Psychological Assistant)

> *I think the nature of the material we're going to be looking at is going to be quite emotive, and I think I cope better when I talk things through with people. So I think* [supervision and counselling] *are going to be very important, especially if you have any problems with your co-facilitators. I think they need to be aired in a safe environment.*
>
> (Female Trainee Psychologist)

As explained in previous chapters, nine of the original 16 trainees were followed-up after one year's experience of working on the SOTP and were asked whether they had received the required amount of supervision and counselling, as stipulated in the audit document for the programme. Seven of the nine said that they had, and two said that they had not. Of these two facilitators, one had not attended all of the three mandatory counselling sessions, and both

had not received the requisite amount of supervision. One was forced to take one month off work due to stress related ill-health.

In addition, three of the seven facilitators that said they had been given the correct amount of support told me that they had not received any individual supervision until *after* the course they were working on had finished. Overall, therefore, five of the nine follow-up interviewees reported that they had either not received the right amount of supervision, or had received it at a seemingly inappropriate time. In spite of this, supervision was generally the preferred method of organisational support for facilitators. Six of the nine follow up interviewees said that supervision was the most helpful form of organisational support, compared to two facilitators who found counselling most helpful. One interviewee felt that supervision and counselling were equally as helpful. Table 2 illustrates how important facilitators felt each method of support was in helping them cope with the demands of SOTP work.

Table 2: Importance of supervision and counselling to qualified facilitators

Method of Support	**Level of Importance**			
	Very important	**Important**	**Not important**	**Total**
Supervision	6	3	0	**9**
Counselling	3	3	3	**9**

It is clear from Table 2 that, having experienced supervision, all facilitators found it important, and six of the nine said it was 'very important'. In comparison, facilitators found counselling slightly less helpful, with only three describing it as a very important source of support. Moreover, another three facilitators felt that counselling had not been important to them at all.

Overall, the results revealed that facilitators did not find organisational sources of support to be as important as they had anticipated as trainees. Table 3 shows a comparison between the views of follow up interviewees on how important they had found supervision and counselling, and the responses they gave as trainees on how important they anticipated these sources of support to be.

Table 3: Views of qualified facilitators on the importance of supervision and counselling compared to their views as trainees

		Level of Importance			
		Very Important	**Important**	**Not Important**	**TOTAL**
Supervision	**Trainee Facilitators**	9	0	0	**9**
	Qualified facilitators	6	3	0	**9**
Counselling	**Trainee Facilitators**	7	2	0	**9**
	Qualified Facilitators	3	3	3	**9**

Qualified facilitators were asked what they thought about the overall quality of organisational support. Although three of the nine described it as 'good', the remaining six said that there was definitely 'room for improvement'. There were no specific complaints about the quality of counselling provision; however, five interviewees reported that, during the first programme that they had run, their experience of supervision had been bad:

We had a very poor experience really. We were newly qualified, new out of training…and we were just left to get on with it…We didn't do a bad job, but we did stumble along. It was just quite a bad experience.

(Female Probation Officer)

I probably only had about two lots of supervision within 6 months, three at the most. I didn't have any individual supervision at all…looking back now I try not to be angry about it, but I'm a bit annoyed about it because I think we should have had that support, and we didn't.

(Female Prison Officer)

I don't think at times [supervision is] *very constructive. I think sometimes there's a lot of criticism, and it's not constructive. It doesn't really help you. Sometimes decisions are made and you're not even in on it; you don't even know until the last minute until it's too late and you think, well isn't that what supervision's for? To talk through things before decisions are made? But that didn't happen…We do get praise for the good things we do which is good…but that's just overshadowed by the sort of other things that get said.*

(Male Prison Officer)

Indeed, most facilitators were much more critical of supervision than they were of counselling. This was surprising given that interviewees generally found supervision to be a more helpful source of organisational support. The following sections consider in more detail trainee and facilitator views on supervision and counselling provision respectively.

2. Opinions on Supervision

Trainees were asked how they thought supervision would help them cope in their role upon qualification. Some gave multiple responses, but the main way in which they felt supervision

would help them deal with the more difficult aspects of SOTP work was by being a source of advice and feedback. This was discussed by 13 of the 16 trainees, who felt that supervisors would be helpful in terms of providing feedback on their professional performance. They also thought that supervision would be an appropriate forum in which to discuss the negative effects of SOTP work, and to seek reassurance that they were doing a good job:

> *I run ETS at the moment and I often come out of the sessions thinking that was rubbish! It was the worse session ever! And then you get feedback and it wasn't as bad as you thought it was. So it's telling you what the positives are, as well as giving you feedback on what you need to improve on.*
>
> (Female Probation Officer)

> *I think it'll help me to stay focused on what the aims* [of the programme] *are, to be able to highlight any difficulties I'm experiencing like… emotional stress. If they were arising I would say* [supervision] *is the place to bring them.*
>
> (Female Probation Officer)

> *Hopefully it'll make me clearer on what I need to do in treatment sessions, and if something does go wrong then I think supervision is there to reassure me it's not the first time it's gone wrong…and reassure me that it's alright, hopefully.*
>
> (Male Psychological Assistant)

> *I think it will help if you're not sure how to tackle something. For example, someone says something in group and you're sat there thinking, I want to challenge that but how do I do it? You can have a chat with your supervisor and they might say "I think this is the alley you should go down" or "this might be a good idea".*
>
> (Male Prison Officer)

Four trainees felt that supervision would help to increase their skills and knowledge, both in terms of the theoretical grounding of sex offender treatment, and the practical delivery of

treatment. For instances, one male prison officer said that supervision would help him to '*question and probe, because in the programme there's so much questioning to elicit information, thoughts and feelings and what's been going on in that offender's life*'. Another three trainees felt that supervision would assist them in sustaining their focus and motivation. This was summed up in the words of a female trainee psychologist, who said '*I think* [supervision] *will kind of make me feel more supported and valued, and kind of give me more motivation really to continue working with sex offenders'*.

At follow up, all nine of the qualified facilitators reported that the key way in which supervision had helped them to cope was as a source of advice and feedback. None of the nine said that supervision had helped them to sustain their focus and motivation, nor that it had helped in increasing their skills and knowledge (although this could have been an indirect result of taking on board the 'advice and feedback' of supervisors). Interviewees spoke about supervisors being able to give a 'breath of fresh air' on issues they had encountered during treatment, which allowed them to tackle problems from a fresh perspective. Interviewees also appreciated being reassured that their technique, and the questions they put to offenders, were sound. As explained by one male Prison Officer:

> *You might be thinking along the lines of crikey! This is not one of my strong points! But then you have supervision, and your supervisor comes back saying you're really good at doing that. It makes you think you're not so bad at things after all.*

Qualified facilitators were also asked if they had any criticisms of the supervision that they had received, and if they thought it could be improved in any way. Three of the nine qualified facilitators had no complaints about supervision. However, the remaining six were fairly

critical, and some identified more than one problem that they had encountered. Four facilitators said that the level of supervision that they had received had been inconsistent or badly timed. For instance, one female probation officer said '*We were newly qualified, new out of training, and we were just left to get on with it…The supervision we had was pretty poor*'. Another male prison officer explained how he had not received all of his individual supervision until after the course he was delivering had finished:

> *…you had to have had a minimum of three supervised sessions and feedback later on. I've had one and I brought it up* [with my supervisor] *and he said "oh don't worry, we'll sort that out and make sure you get your full quota"....The course is finished now, and I've had one session out of three…How can you get a sense of how good or bad you are from one session?*

Two facilitators said that they felt that supervisors had shown a general disregard for facilitator support needs. One male prison officer suggested that supervisors 'pay lip service' to the idea of the importance of support but that, in practice, facilitators were not always given the support they needed. For example, he said that supervisors often told facilitators that if they did not feel up to running a group session then, in the interests of maintaining treatment standards and facilitator health, they should not engage in delivering treatment. However, this facilitator told me that the reality of the situation was very different and that, due to staffing limits, newly qualified facilitators were essentially 'thrown in at the deep end' without always having adequate sources of organisational support upon which to rely on.

Two facilitators also felt that supervisors failed to listen to facilitator ideas during group supervision sessions. For example, one female trainee psychologist reported that '*one of the supervisors was very kind of rigid in her views, and would kind of almost dismiss what our*

thoughts were and give us a long list of aims to achieve…which didn't really work for any of us'. On a related point, another facilitators felt that too much negative feedback was provided by supervisors, which was not constructive.

In light of these problems, three of the nine follow-up interviewees thought that supervision could be improved simply by being provided on a regular basis and at appropriate times throughout the duration of the programme. Two other facilitators also said that supervision could be more constructive, one of whom went as far as suggesting that some supervisors used the experience – whether intentionally or not – to 'put people down'. One male Prison Officer mentioned that very few facilitators would consider making a complaint about their supervisor because of the bad feeling it would cause within the team, and the negative effect it might have on a facilitator's professional development prospects.

3. Opinions on Counselling

The majority of trainees (13 of the 16) thought that counselling would help them cope by providing a forum to 'offload' any work-related or personal issues. Six of this 13 also highlighted the importance of counselling being sourced from an independent provider, which they thought was vital in terms of making the service a useful means of support:

> *Sitting in the group every day, and what you listen to, it's not nice. People say it's what you're trained to do - it's part of being a facilitator; yeah it is, and I accept that, but it's still not easy…I'm glad that I've got the counselling here because it does have an emotional impact on you and sometimes you need that one-to-one; just that quiet time, just to get it off your chest.*
>
> (Male Prison Officer)

> *I'll be able to say exactly how I feel and…just to get it off my chest. Sometimes you don't even need an answer to what you're saying; it's just being able to physically say it to someone else.*
>
> (Female Psychological Assistant)

> *The counselling I think is important because I think there might be some issues that are more personal that you wouldn't want to talk about in front of your co-tutors and your supervisor, through fear of feeling that you might be judged because you're quite inexperienced. And I think by having an independent counsellor you can do that without fear of repercussions.*
>
> (Female Trainee Psychologist)

Of the three remaining trainees, one thought that counselling would help her devise coping strategies to deal with the negative effects of sex offender work, another was unsure of how counselling would help her cope whilst working as a facilitator, and the third was under the mistaken impression that she would not be receiving counselling.

These responses were subsequently compared to those of the nine qualified facilitators who took part in the follow up study. One of this nine said that counselling had had no impact at all on her ability to cope with SOTP work. However, all of the remaining eight interviewees were able to find something positive to say about it. One felt that counselling had allowed her to explore her feelings about sex offender work (and thus improve as a facilitator), and another thought it had provided an opportunity to develop techniques to 'switch off' from work. All of the remaining six facilitators said that counselling had provided an opportunity to offload work and/or personal issues:

It was an opportunity to offload…It's confidential and a chance to go forward in everything you're experiencing. And getting things off your chest really helps as opposed to just going on with it.

(Male Trainee Psychologist)

I'd just come out of a relationship last year so I was able to talk abut that with the counsellor, and she gave me different perspectives on things which I found really useful.

(Female Trainee Psychologist)

In terms of how counselling could be improved, four facilitators could think of no problems with the service that they had received. Of the remaining five, the main criticisms that emerged were that too much 'psychological jargon' was used by counsellors (as discussed by two facilitators), and that the service should be more 'person focused', rather than centring primarily on meeting the requirements of the SOTP audit criteria (also discussed by two facilitators). These respective issues were described as follows:

Sometimes…I don't understand what she's saying. I struggle with the whole there's a child, an adult and a parent inside you…I'm not a psychologist and I don't understand sometimes what she's trying to say.

(Male Prison Officer)

I found it a bit unhelpful when the programme manager was saying "you've got to go to counselling on such and such a time" to tick the boxes for audit requirements. I thought counselling was for me.

(Female Probation Officer)

Another female probation officer raised an important point about the administrative difficulties she had experienced in booking counselling appointments, which had led to her not receiving all three of the compulsory sessions. At her establishment, all available

counselling appointments were published on a list, and facilitators booked appointments by 'signing up' to a time and date that was most convenient to them. She explained that, whilst the psychology team and prison staff shared an office, probation staff were housed in a separate part of the prison. The counselling sign up sheet was located near to the office of the prison and psychology staff. As such, this facilitator explained that, by the time she had managed to get to the list to book a session, there would regularly be only one appointment left (which would often be at a time or date that was inconvenient to her). She said that this issue was linked to much broader problems with communication in the prison programmes department, and that probation officers involved in delivering the SOTP were not always kept fully up to date in respect of the administrative aspects of the programme.

In spite of these criticisms, the majority of qualified facilitators were happy with the counselling service provided, and only three made recommendations about how it could be enhanced. The improvements that were suggested by facilitators were that there should be an improved system for booking counselling appointments, provision for alternative therapies during counselling (such as massage and aromatherapy) and that the number of compulsory sessions should be increased to four or five counselling appointments per SOTP programme. This latter point has been the subject of some discussion in recent years, especially by Prison Service management. Some have questioned whether, given the current debate surrounding the effectiveness of counselling in the workplace,[3] the Prison Service should continue to make SOTP facilitators attend counselling on a mandatory basis. Three follow-up participants reported that they had found counselling neither important nor unimportant, therefore qualified facilitators were also asked: 'Should attendance at counselling be retained

[3] See for example, J McLeod and M Henderson, 'Does Workplace Counselling Work?' (2003) 182 British Journal of Psychiatry 103.

as a compulsory requirement of working on the SOTP?' Two of the nine were unsure but the remaining seven thought that it should be. The main reason offered for this was that the provision of an optional service would result in a decline in its use leading, potentially, to an increase in health problems for facilitators:

> *I think it's better mandatory. If it's not mandatory, there's this idea amongst some people that…if I go and see a counsellor that means I'm not coping, so I think some people - particularly some officers who have been in the job for years and years - don't like to admit they can't do it, and I've witnessed that. I think myself I'd feel like that as well. I'd think, well I can't go and see her too much because people will think I'm not coping; so I think if it's mandatory people expect that you'll go, which is much better.*
>
> (Female Prison Officer)

Despite the fact that the majority of interviewees believed that qualified facilitators should be compelled to attend counselling, one female Probation Officer openly admitted that she had not attended all mandatory sessions. Likewise, one male Prison Officer questioned whether facilitators should be expected to go three sessions over the course of an SOTP programme:

> *For me, I'd be much more comfortable if I didn't have to go three times. Last time I went I didn't particularly need to go…so we spent half an hour talking about my bad back! I suppose it is a waste of a counselling session sat there talking about bad backs because we haven't got anything constructive to say.*

It was clear from facilitator responses that there were mixed feelings about how important counselling was to each individual facilitator. For example, whilst the Prison Officer quoted above felt the number of compulsory counselling sessions should be cut down, another facilitator - when asked how she thought the service could be improved – said she would have

liked more counselling. However, overall, the majority of follow-up interviewees felt that counselling should remain a compulsory requirement of practicing on the SOTP.

4. Other Forms of Organisational Support: Co-Workers and Co-Facilitators

Trainees were asked if they could name any other forms of organisational support that they thought would be helpful to them in their role as an SOTP facilitator. Twelve of the 16 trainees identified co-workers as an additional source of support. A number of reasons were given for this, including the fact that respondents could learn from the experience of other facilitators, and call on them for advice on treatment issues and impromptu training.

Seven of this 12 made specific reference to the importance of co-*facilitators* during their time on the SOTP, highlighting their experience and their backup function during group sessions as significant to support. As put by one trainee:

> *I think* [co-facilitators are] *very important to me because they offer different points of view… It's like when you're in a group, you can be asking a question and get stuck, and then they come in and they help you out. You all help each other. You can't do this on your own, you need other people there…*
>
> (Male Prison Officer)

This viewpoint was reflected by the qualified facilitators who were interviewed at follow-up, with six out of nine highlighting the importance of their co-facilitators, or other facilitators, in providing support to them in the workplace. One male trainee psychologist reported that 'the people who I was working with were particularly useful. Possibly no more so than the supervision, but possibly more so than the counselling'. The main reason given for this by interviewees was that other facilitators could relate entirely to the treatment situation, and

therefore be truly empathic about stressful experiences. Although, in terms of organisational support, the current study focused primarily on the provision of supervision and counselling, support from co-facilitators is clearly another avenue of support relied upon by those providing treatment on the SOTP. It seems important, therefore, that the Prison Service strives to ensure that good working relationships are maintained within facilitator 'teams'.

III. PERSONAL SUPPORT

Trainees were asked to identify what forms of 'external or personal support' would be available to them whilst working as an SOTP facilitator. All trainees identified at least one personal source of support that they thought they might rely on, with most participants identifying more than one possibility. Three separate categories emerged (as shown in Table 4 below), namely 'spouse/partner', 'other family members' and 'friends'.

Trainees also rated how important they felt their personal sources of support would be in terms of helping them to cope with the demands of the SOTP (see Table 4). The same scale was used here as in the questions concerning organisational support.

Table 4: Importance of personal sources of support as anticipated by trainees

Source of Support	**Number of Facilitators (n=16)**			
	Very Important	**Important**	**Not Important**	**TOTAL**
Spouse/Partner	7	3	0	**10**
Other Family	6	5	2	**13**
Friends	7	3	2	**12**

Note: Most participants identified more than one source of personal support. This table therefore contains multiple responses.

The main way in which trainees thought that family and friends would be able to provide support was by listening to problems that they felt they would be unable to discuss at work. Four trainees also thought that friends and family would provide a sense of normality in what could be a very stressful and emotionally draining job:

> *To me it's just about going home and having a laugh and forgetting about work. Just living a normal every-day life. I just go round* [to my parent's house] *every Saturday, watch TV, have a Chinese…it's just that normality that's important to me. I come to work on a Monday morning having not thought about work for the weekend and I'm happy.*
>
> (Male Prison Officer)

> *It'll just be nice to have mates around me to just get out of work and just go and do normal things…Just going out and having a good laugh.*
>
> (Male Psychological Assistant)

However, it was interesting to note that, even at this early stage in their SOTP careers, six trainees said that they would rather rely on organisational sources of support than personal sources. Generally, interviewees thought that their supervisor and counsellor would have a greater understanding of the impact of the work, and would therefore be more useful to them. Likewise, trainees felt that they did not want to burden family and friends with the sometimes distressing details of their work.

Trainees were also asked – hypothetically – about the sort of things that family and friends might say or do that they would find unsupportive in relation to their role. Three trainees were unable to think of any examples. Of the remaining 13, two said that family and friends had already made disparaging remarks about the nature of SOTP work because of the

particular offenders involved, and these trainees had found this unhelpful. However, trainees were most concerned that family and friends would (1) show an unwillingness to listen to them if they wanted to 'offload' at the end of the day, and (2) show a lack of empathy and understanding of the demands of SOTP work.

After one year's experience of working on the SOTP, the nine qualified facilitators who took part in the follow-up study were asked to identify what forms of 'personal support' they had relied on during their first year as an SOTP facilitator. The same sources were identified (namely spouse/partner, friends, and other family members), although 'friends' turned out to be the most popular choice. Two of the nine qualified facilitators said that they had not relied on personal sources of support at all during their first year working on the SOTP. Cross tabulation of the data showed that both of these participants had, as trainees, reported that they intended to rely on family and friends for support.

Thus, personal sources of support were clearly not as important to these facilitators as they initially anticipated. Indeed, as a general rule, qualified facilitators did not find family and friends as important as they thought they would be as trainees. This is illustrated in Table 5 below, which shows a comparison between the views of the nine follow-up interviewees, and the responses they gave as trainees. Even of the six qualified facilitators who reported that they had relied on friends for support, four said that these friends also worked in the criminal justice system themselves. Thus, overall, most qualified facilitators preferred to rely on organisational sources of support, or at least personal sources of support who had some pre-existing knowledge of the field.

Table 5: Views of qualified facilitators on the importance of personal sources of support compared to their views as trainees

		Level of Importance			
		Very Important	**Important**	**Not Important**	**TOTAL**
Spouse/Partner	**Trainees**	4	1	0	**5**
	Qualified Facilitators	2	3	0	**5**
Other Family	**Trainees**	4	4	0	**8**
	Qualified Facilitators	0	2	0	**2**
Friends	**Trainees**	3	3	0	**6**
	Qualified Facilitators	2	4	0	**6**

As with trainees, qualified facilitators were also asked if family or friends had said or done anything that they had found unhelpful in terms of supporting them in their role. Four said that they could not think of anything done by family and friends that had made them feel unsupported (although this was not necessarily surprising given that qualified facilitators generally did not like discussing the SOTP with people unconnected to their work). The remaining five had all encountered hostility towards sex offenders as a group – including from other prison staff - which they found very unsupportive:

> *When people ask you what you do the response is usually quite negative. It's usually like "Oh God, how can you do that?...Why do you waste your time?" That can be quite negative really because it's hard to try and keep yourself upbeat in this job, and when people say that it's not productive at all…*
>
> (Female Prison Officer)

The only people that I would say grumble about anything we do are wing staff… you can get snubbed, or there's certain officers that will go out of their way to disrupt what you're doing. There are some group rooms over on the new side, and officers were using them as rest rooms at night. We set up some of the prisoners work up there, and there's hundreds and hundreds of pounds of equipment. The camera went missing one day, TVs turned back to front, everything unplugged, group work turned upside down, chairs flung about…and you just think, we're both wearing the same uniform; we're both doing the same job. What's the need to do that? So that's most unhelpful.

(Male Prison Officer)

In terms of *how* qualified facilitators felt that family and friends supported them in their role, two of the seven said that they had helped by listening and being empathic. Another facilitator said that his family had helped him by 'providing a sense of normality' and said that '*they're just good at bringing you back to the normal king of thinking after the experience you've been through'*. The remaining four facilitators all said that, in terms of personal sources of support, they had relied mainly on friends working in the field and that, as such, they had found their professional advice and guidance an extremely helpful source of support:

I don't particularly talk to my family…it's more difficult when you're not working in an establishment. It's very difficult to go through the whole process of explaining what you do and all that, so I've kind of used friends who are more in the job really.

(Female Trainee Psychologist)

I've got a good friend who works in programmes…We talk a lot and we spend time outside of work...I find that useful because we know what we're talking about. You don't have to dumb it down or talk it up, you just talk and he will understand and you just get it out in the open.

(Male Prison Officer)

IV. THE VIEWS OF SOTP TREATMENT MANAGERS

To supplement the data gathered from the 16 trainees and nine qualified facilitators, seven SOTP treatment managers were also questioned on the forms of support available to people working on the programme. The key questions put to treatment managers focused on what they thought about the quality of support services for SOTP facilitators and how, if at all, they could be improved in the future. Participants were also asked about the sources of support available to them in their role as managers.

Treatment managers were first asked about the types of support they themselves were involved in providing to facilitators. All seven made reference to supervision (both group and individual), and one or more of the following: debriefing; monthly facilitator meetings; the facilitator health review; and informal supervision and training. This final category was of particular importance to treatment managers, and all said that they had an 'open-door policy':

> *An awful lot of informal supervision goes on as well; people coming in after groups and wanting to talk things through, or wanting advice, or just wanting to debrief, and I think that's quite important because, although it doesn't get written down anywhere as having happened, I think that allows people to make sense of things as they occur.*
>
> (Male Psychologist)

> *Even though I'm not always in my office, I say I've got an open door. They can call me, email me, come and see me anytime and I'll get back to them. So I like to think I'm as visible as I can be, and I always say to facilitators if they're going home mentally thinking about things then they need to stop and talk about it at work the next day.*
>
> (Female Psychologist)

When asked whether they thought that the support they provided was effective in terms of preventing or minimising the negative effects of SOTP work, all treatment managers seemed to agree that they were. However, some added a caveat to this. For example, one manager said that support sources could only be truly effective for those facilitators who were willing to take advantage of them. Another said:

> *I don't think on their own they're worth much…They're only good as an 'add-on' to…efficient programme management; so having the right amount of time to prepare and write things up afterwards.*
>
> (Female Psychologist)

This point regarding preparation time highlights a wider point that was discussed by over half of the treatment managers interviewed; namely that the level of support provided to SOTP facilitators can depend very much on the regime of the individual prison, and the attitudes of the governor and other senior management towards treatment.

As for counselling, all treatment managers thought it was an 'important' source of support, with four believing it to be very important. However, a number commented that nothing could *prevent* negative outcomes, and that counselling could only identify 'problem areas' in the emotional health of a facilitator. As such, treatment managers generally thought that facilitators should take some personal responsibility for their own health and well-being by employing effective coping strategies, developed in conjunction with their counsellor or supervisor. One treatment manager also commented that she did not believe counselling was necessary for all facilitators, and that some could cope perfectly well without having to attend all three compulsory sessions. None, however, went as far as to say it should be an optional, rather than a mandatory, form of support.

Given the particular emotional strains that have been identified as being associated with sex offender work, treatment managers were asked if there were any 'special' support measures available to newly qualified SOTP facilitators. Most made reference to the extra support mechanisms specified in the SOTP audit document, namely extra individual supervision if needed, and the requirement that new facilitators be grouped with experienced facilitators when delivering their first treatment programme. In addition, some establishments seemed to have adopted individual strategies for supporting newly qualified facilitators. One interviewee reported that she had set up mock treatment sessions for new facilitators to practice their techniques. Another treatment manager talked about a mentoring scheme that had recently been trialled in the Prison where she worked:

> *We had recently started talking about having a mentoring system, so that new facilitators can come back to the establishment and be 'buddied' up with somebody who's really experienced. We tried that last year with two new psych' assistants who we buddied up with our longest running officer…The problem that we've encountered with that is that the supervisor sometimes feels they're loosing their grip on the group because they are just too many people hovering around…so that there's not clear guidance and clear leadership...It didn't cause problems, but you could certainly see there was the potential to if there were different personalities involved. So we've tried to put that in for new facilitators, but I'm not sure we've hit the right formula yet.*
>
> (Female Psychologist)

In addition to the types of support offered by the Prison Service, treatment managers were also asked about the implementation of support mechanisms and, specifically, if they had ever experienced any difficulty in providing support to SOTP facilitators. The main problems discussed were that, first, treatment managers felt that there was not always enough time to provide good quality support to facilitators in their team; second, some facilitators were

resistant to support and were unwilling to accept changes in SOTP practice; and third, some facilitators were unable to get along together due to a 'clash of personalities'. Treatment managers said that, sometimes, this made it more difficult to provide support.

In light of these problems, treatment managers were subsequently asked how they thought support services could be improved for facilitators. This question generated a lot of discussion and one participant offered two ideas on how she thought the working environment could be enhanced (hence why eight responses are outlined below). Two treatment managers said that there should be greater recognition by higher management of the work done by SOTP staff, and that this could be reflected in higher wages for facilitators. One of this two said '*you tend to see the governor when there's a problem, not when you're doing a good job. I think it would be nice every now and again to have somebody of importance acknowledge our day-to-day life'*. Another two treatment managers said that there should be more time available for supervisors and other members of the management team to provide help, advice and information to facilitators:

> *I think it's time. It's proper supervision…It's time from the more experienced members of the team…to make sure people are properly supported…Not in terms of supervisors being in the groups with them, but in terms of the supervisors being around to prepare with them, the supervisors being around to debrief, the supervisors being around to offer impromptu training when facilitators think "oh God, I don't know what I'm doing here". If there's a particularly difficult group member I feel like we never have time to properly train our staff to manage them.*
>
> (Female Psychologist)

Three treatment managers felt that there should be greater efforts made by the Prison Service to ensure that individuals were emotionally 'ready' for working on the SOTP, and that facilitator health reviews should be held more frequently. As one female psychologist put it:

> *I think…for new facilitators there should be a review of how quickly people are put into this kind of work, and I also think there should be some consideration given to the aspects* [that research has identified as making people] *potentially more vulnerable to this type of work than other people…Also I think the health review should probably be more regular, especially for people who have some of those vulnerabilities.*

In contrast to this, one treatment manager said that the Prison Service needed to employ more facilitators to deliver the programme in order for managers to meet Key Performance Targets, and that this needed to be done quickly. Although this treatment manager commented that '*obviously you'd never force people to be facilitators…because it wouldn't ever work'*, she concluded by saying that the Prison Service needed to train more facilitators, and hire more psychologists, to assess offenders for the programme and to subsequently deliver it. This highlights a conflict between the needs of those individuals considering a career working on the SOTP, and the need of the Prison Service to meet the targets set in respect of programme completion rates. Whilst it was clear that a significant proportion of treatment managers felt that more time should be devoted to assessing individuals' suitability to work on the programme, it is also apparent that - in order to meet Key Performance Targets set by the Prison Service - a larger number of facilitators are required to deliver the SOTP. It is difficult to see how these two issues can be reconciled.

V. DISCUSSION

Overall, trainees expected organisational support to be more crucial than personal sources of support in terms of helping them deal with the negative effects of sex offender work. This was echoed by pilot interviewees and qualified facilitators who generally preferred to rely on work-based sources of support. Even those follow-up participants who said that they had used friends for support had mostly relied on people who had some familiarity with sex offender work or the criminal justice system more generally.

The main ways in which qualified facilitators felt supervision and counselling had helped them cope with SOTP work were very similar to the responses they had provided as trainees. However, qualified facilitators did not think organisational sources of support had been as helpful as they had initially anticipated after one year's experience on the programme. It is probable that this was due to the problems facilitators had experienced with the means of support offered by the Prison Service.

In comparison to supervision, there were very few criticisms about the quality of counselling which is provided by an independent supplier (external to the Prison Service) to maintain confidentiality and encourage attendance. There were, however, some complaints regarding the practicalities of attending compulsory counselling sessions, and one facilitator openly admitted that she had not attended all of her required appointments. This was primarily because she had not had proper access to the counselling 'sign-up' sheet which, she said, was indicative of wider communication problems throughout her establishment. This facilitator had not been approached by her superiors to establish why she had not attended all three of the compulsory sessions and this suggests that managers were either unaware of her non-

compliance (thus lending credence to the facilitator's point about communication problems) or were unconcerned about it. In recent years, the benefits of compulsory counselling and debriefing have been questioned, with some research going as far as saying that it may be damaging to force an individual to engage in the therapeutic process.[4] Nevertheless, seven of the nine follow-up interviewees thought that attendance at counselling should remain a pre-requisite of working on the SOTP, and I would agree. If future research shows mandatory counselling to be damaging to the health of facilitators, then the Prison Service should obviously withdraw it as a means of support. However, up until that point – especially in light of current case law in the area of stress at work[5] – it would seem rash for counselling to be removed or even provided on a non-mandatory basis. In the meantime, as discussed by Batt, it would be prudent for the Offending Behaviour Programme Unit to 'regularly review literature in this area for its applicability to HM Prison Service'.[6]

Turning to supervision, follow-up interviewees generally reported supervision to be more useful than counselling in terms of protecting them from the negative effects of sex offender work. However, as a means of organisational support, supervision attracted many more criticisms than counselling. Two of the nine qualified facilitators interviewed had not received the right amount of supervision during the first course that they delivered; one of whom had been forced to take a month off work due to stress-related ill health. Overall, six facilitators were critical of the quality of supervision.

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[4] See for example B Raphael and JP Wilson, 'Introduction and Overview: Key Issues in the Conceptualization of Debriefing', in B Raphael and JP Wilson (eds) *Psychological Debriefing: Theory, Practice and Evidence* (Cambridge University Press, Cambridge 2000). See Chapter 3 for a full discussion of the available research.

[5] Particularly *Hatton v Sutherland* [2002] EWCA Civ 76; [2002] 2 All ER 1 (CA), where Hale LJ stated that any employer who provided a confidential counselling service would be unlikely to be found in breach of its duty of care towards the employee. However, this statement must now be read in light of the later decision in *Daw v Intel Corporation (UK) Ltd* [2007] EWCA Civ 70; [2007] 2 All ER 126 (CA). See Chapter 4 for a full discussion of the relevant case law.

[6] E Batt, 'Application of Psychological Debriefing Principles and Techniques to Sex Offender Treatment Facilitators in HM Prison Service' (Internal, Prison Service, 2006) 9.

Facilitators suggested that the main way in which supervision could be improved was by being more constructive in terms of the feedback provided and being more regular. For example, three participants reported that they were going to receive most of their allotted individual supervision *after* their course had finished. Time constraints may well make it difficult to schedule individual supervision evenly throughout the duration of a course. Indeed, the overwhelming feeling from treatment managers was that more time should be available to provide quality support to facilitators, and one openly admitted that 'new facilitators are just chucked in at the deep end'. Nevertheless, prompt and strategically timed supervision is essential if facilitators are able to use feedback constructively and report any problems they might be experiencing during treatment. As a result, the Prison Service should endeavour to ensure that facilitators receive all of their required supervision *before* the end of a programme. Since the Core SOTP takes around six months to complete, and facilitators should receive at least 12 hours of group supervision, it is my opinion that facilitators should receive around two hours' group supervision per month, per programme. In terms of individual supervision (of which facilitators are entitled to two hours per programme), it would seem sensible that staff working on the SOTP receive at least half of their allotted individual supervision at the half way point of a programme. It would also make sense for newly qualified facilitators to receive at least 30 minutes of individual supervision within their first month of working on the SOTP so that their capacity to deal with the negative effects of sex offender work can be assessed.

Another reason why supervision provided at the end of a programme is of no value is that staff are not guaranteed the opportunity to run consecutive SOTP courses, with some being sent back to the wings or other prison departments after delivering only one or two

programmes. This was seen by some interviewees as grossly unfair. One trainee psychologist reported that she had been 'rolled off' the SOTP sooner than she had expected and that her motivation to facilitate had consequently waned. The position was summed up well by a male Prison Officer:

> *One of my mates, he's only done two Adapted, and he's going back on the wings. There's been people in that department 10 years that have never gone back on the wings, so how do they work that out?...I think that's really unfair. If they want to introduce a policy to give new people the option of going into SOTP then great, but let's have a fair system so that everyone gets a turn…*

This same issue was mentioned by one of the treatment managers interviewed who also reported that the nature of the prison regime can interfere with the preparation of treatment sessions when staff are reallocated to cover work in different areas of the prison. Several other treatment managers also commented that support provision for facilitators can depend very much on factors beyond their control, such as the attitude of the prison governor to treatment:

> *We've got a new governor now who's great and seems very understanding of the pressures we're under…That hasn't always been the case, and there have been times where* [we] *have felt that we've got these very high targets and we're expected to meet them regardless. People have been quite ill. People have been off with stress…we've seen people close to breaking point. I think that goes too far then. You need to be able to feel supported by your line manager and ultimately by the governor.*
>
> (Female Psychologist)

This view was supported by three of the six facilitators who took part in the pilot interviews of this study, who suggested that the senior management team generally had a poor understanding of the specific pressures of SOTP work and the time needed to prepare for sessions:

> *I don't think the senior management team really recognises our efforts…We're always being taken away from what we do to go and do something else…It can be frustrating…when you've got to practice, get your role plays sorted out…Say if you allow yourself an afternoon to do that, and then you find you've got to go on escort. So I don't think the Prison Service per se is very supportive.*
>
> (Female Prison Officer)

Although the SOTP audit document provides that 'the residential environment [of the prison] should support the aims and values of the treatment programme in order that staff and prisoners feel fully supported in their work',[7] it seems that this is not always the case. Whilst a number of SOTP facilitators in the current study were undoubtedly unhappy with the support they had received, treatment managers are also under pressure to provide constant support – sometimes in difficult circumstances – whilst also adhering to the audit criteria. In addition to the means of support outlined in the audit document, treatment managers reported several ways in which they were attempting to support newly qualified facilitators, including ad hoc training, mock treatment sessions, 'buddy' schemes, and having an 'open door' policy to encourage individuals to discuss any problems they might be having on the programme.

[7] HM Prison Service, *Combined Accredited Offending Behaviour Programmes Audit Document* (Internal, Offending Behaviour Programme Unit, London 2005) 16.

However, it can be argued that, until the entire prison system embraces the value of treatment for sexual offenders, the full benefit of such individual efforts to support facilitators will be wasted. One suggestion might be to improve links between prison departments to educate fellow staff about the content of the SOTP, its aims, and the results of evaluation studies. This might also improve the negative attitudes towards sex offenders displayed by other Prison Service staff, as described by five of the follow-up interviewees and three of the pilot interviewees. In fact, one of the participants from the pilot study reported that some prison officers working at her establishment applied the same slang names that they used to describe sexual offenders when talking about staff working on the SOTP:

> *The sort of terminology used in here spoken about sex offenders, you get the same used towards you because you associate with them. You know like, 'you must be a sex offender yourself'; things like that. It's because they don't understand what you do. They have this idea that you sit on your arse all day drinking coffee…Because the* [offenders] *only come out for two hours,* [other prison officers] *see that as the only time you work. They don't see the amount of prep you have to do before hand.*
>
> (Male Prison Officer)

One of the prisons that I visited had initiated a training scheme for newly recruited prison officers and those working on the vulnerable prisoner unit to educate them about the aims and purpose of the SOTP. The problem with this approach is that, once new officers start work on the wings, they are inevitably exposed to the entrenched views of experienced officers about sex offenders, which would ultimately undermine the value of such training. It would seem more sensible to offer this type of programme to all staff across the entire prison system, subject to a pilot project testing its effectiveness in changing attitudes towards sex offenders.

Another way in which treatment managers suggested that support for SOTP facilitators could be improved is by instituting more thorough facilitator selection methods. Three of the seven managers interviewed said that some individuals should simply not be allowed to work on the programme because of their potential vulnerability to the negative effects of working with sex offenders. As put by one: 'it would be better for everyone if [the Prison Service] learned to say no to certain people'; i.e. those who show, upon their return from training or during the training course itself, that they might suffer detrimental health effects as a result of the work. A number of treatment managers also discussed instances where individuals successfully 'passed' the Core SOTP training course but then failed to meet the requisite treatment standards upon their return to the prison environment. As one put it:

> *We had someone who came back off training and, although they hadn't failed it, the feedback provided didn't really suggest they'd passed. So we spent quite a lot of time making sure they developed experience in other groups before they entered SOTP…*
>
> (Male Psychologist)

If individuals are being accepted as competent to work on the SOTP, but then demonstrate unsuitable traits or inadequate skills upon their return to the prison environment, the task of providing support will be much more difficult. This prompted some treatment managers to suggest that there should be more pre-training advice to individuals contemplating a career on the SOTP, which supports the idea of establishing an awareness workshop – as discussed in Chapter 6. In light of the data gathered from treatment managers, it is my recommendation that the Prison Service should reconsider the timing of facilitator health reviews for qualified staff. At present, such reviews are conducted every four years. However, in my opinion, there would be more value in providing a formal, scheduled health-check after the first year of

facilitating on the programme, and every two years thereafter. As one experienced treatment manager put it:

> *I think the health review should probably be more regular…and that's feedback that I've had from facilitators here who've kind of said they've been working for four years say, and now, at this stage, when they're having their review they are quite a bit older, they're more settled, they've been in the service quite a while. But a lot of them have said "Actually, I would have really liked a review when I first started, when I was only 23 and I didn't have a partner and I didn't know all about this".*
>
> (Female Psychologist)

Moving the facilitator health review forward would have two main benefits: first, it would provide a greater level of support to newly qualified staff which may have an impact upon the quality of treatment; and second, it would act as a potential line of defence to the Prison Service should a claim for stress at work reach the courts.

In conclusion, the results show that facilitators rely to a much greater extent on organisational forms of support than they do on family and friends. As a result, it is crucial that the Prison Service provide high quality support services for SOTP staff. Although it is not contended that the overall quality of support to facilitators was poor, in some cases support was of a substandard level and the data gathered from follow-up interviews in general suggests that certain aspects of organisational support requires further attention. This is reflected by the fact that six out of nine qualified facilitators said there was 'room for improvement' in terms of the quality of support provided by the Prison Service.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

I. INTRODUCTION

The current research had five key objectives, namely:

1. To ascertain what motivates trainee facilitators to undertake work with sex offenders.
2. To determine the positive and negative effects trainee facilitators anticipate from working with sex offenders, and to compare these responses to the effects they actually experienced during their first year working on the SOTP.
3. To find out what trainee facilitators think of the two-week SOTP training course, and to find out whether qualified facilitators feel it prepared them adequately for their role on the SOTP.
4. To ascertain what types of support SOTP trainees feel they will need once qualified, and compare these to the support mechanisms they have used during their first year's experience.
5. To ascertain the opinions of qualified facilitators regarding the quality of any training, supervision and counselling they received during their first year working on the SOTP.

With these aims in mind, the following chapter outlines the further work that I feel the Prison Service now needs to undertake in respect of improving training and support for those individuals entering a career on the SOTP, and qualified facilitators.

II. TRAINEE MOTIVATIONS TO WORK WITH SEXUAL OFFENDERS

The main reasons that trainees wanted to work on the SOTP were to pursue their interest in sex offenders as a group, and to develop existing skills. However, previous research has found that the key benefit of working with sexual offenders, as reported by therapists in the field, is the sense that they are helping to prevent future victims.[1] In the current study, only two of the 16 trainees mentioned this as a factor influencing their decision to work on the SOTP. It is therefore possible that protecting potential victims is something that contributes to job satisfaction upon qualification, rather than something that initially draws people into the work.

I also wanted to investigate the impact of previous trauma and, particularly, past experiences of sexual abuse on trainees' decision to work with sex offenders. Overall, the results of this research did not suggest that interviewees who reported past sexual abuse or other trauma experienced any greater negative impact as a result of working on the SOTP. However, one of the female interviewees who disclosed that she had been the victim of sexual abuse, and also said that this experience had impacted on her decision to work on the programme, subsequently reported at follow up that she had been forced to take one month off work with stress and anxiety.

As the small sample size of the study prevented any analysis of the statistical significance of this result, it seems reasonable to suggest that greater attention needs to be given to such issues during the applicant selection procedure. Indeed, it is my opinion that victims of sexual trauma should be excluded from working on the SOTP for two reasons: first, as a

[1] MA Kadambi and D Truscott, 'Concept Mapping Professionals' Perceptions of Reward and Motive in Providing Sex Offender Treatement' (2006) 42 Journal of Offender Rehabilitation 37.

preventative measure, to protect the emotional health of such individuals; and second, to minimise the possibility of the Prison Service being found liable should a past victim decide to bring legal action for work induced stress. As explained in Chapter 4, the threshold criterion in this type of case is whether the harm caused by stress at work was reasonably foreseeable in the particular employee. Furthmore, in the case of *Hatton v Sutherland* Hale LJ asserted that, 'unless he knows of some particular problem or vulnerability, an employer is usually entitled to assume that his employee is up to the normal pressures of the job'.[2] Herein lies the problem: during the recruitment procedure, trainee facilitators are required to disclose the details of any previous sexual abuse. The Prison Service are, therefore, very much aware of the 'particular vulnerabilities' of these individuals before they enter the programme.

Although this approach may seem unfair to past victims who want the opportunity to work on the SOTP, it makes sense in terms of protecting the emotional welfare of facilitators and the legal position of the Prison Service. As an alternative, such staff should be encouraged to engage in one of the many other treatment programmes offered by HM Prison Service.

RECOMMENDATION 1: Individuals who have a previous history of sexual abuse should be excluded from working on the SOTP.

III. THE POSITIVE AND NEGATIVE EFFECTS OF SOTP WORK

The most frequently reported negative effect, as discussed by qualified facilitators, related to their emotional/mental health, and two facilitators had been forced to take time off due to stress experienced in the work place. This raised two obvious questions: first, about the

[2] [2002] EWCA Civ 76; [2002] 2 All ER 1 (CA), 15.

quality of support being given to newly qualified facilitators by front line supervisors and counsellors (a point that will be dealt with later in this Chapter); and second, about the quality of information provided to trainees on the positive and negative effects that have been associated with working with sex offenders. It is arguable that more time should be devoted to such issues during the SOTP training course. However, given the vast amount of material that tutors already have to cover during this two-week course, it is difficult to see how this would be possible. Given the grave impact that sex offender work has been shown to have on the lives of some therapists, it would seem sensible if individuals could attend SOTP training having already received some guidance on the type of effects this work can induce.

Thus, it is my opinion that there would be real value in providing a short awareness workshop for people wanting to facilitate on the SOTP. Although one of the key aims of this course would be to provide individuals with a good basic knowledge of the negative effects associated with sex offender work, it could also be used to a broader effect; namely to disseminate information on the aims and content of the SOTP, the available avenues of support to facilitators, and the rewards associated with the work, which have received much less attention from academics writing in this area. In addition, it would ideally involve participants watching part of a video recorded session of the SOTP (subject to the relevant consents being obtained from SOTP group members). This would enable staff interested in working on the programme to make a more informed decision about whether working with sex offenders is the right choice for them.

The most frequently reported positive effect discussed by qualified facilitators related to their professional life, and facilitators felt that their professional skills and knowledge had

developed substantially since starting work on the programme. This 'effect' was also anticipated by trainees; however, a high proportion of trainees (11 of the 16) also anticipated that the SOTP would be beneficial to their career development prospects. This compared to only two of the nine qualified facilitators when the issue was discussed at follow up. There was therefore a discrepancy between the number of trainees who felt that their career would be enhanced by working on the Programme, and the number of qualified facilitators who thought that their career prospects had been so benefitted.

Promotion prospects do exist on the programme, although these are primarily reserved for psychologists and probation officers. On the other hand, it is recommended by the Prison Service that prison officers obtain a relevant mental health qualification before progressing to higher level positions, such as treatment manager. Regrettably, the Prison Service no longer funds such courses, meaning that officers must self-finance any further education they choose to undertake. Given the high number of trainees that felt working on the SOTP would improve their career prospects, this is something that should be made explicit at the start of the recruitment process. The above mentioned SOTP awareness workshop would seem the ideal place to do this.

RECOMMENDATION 2: The Prison Service should ensure that all staff interested in working on the SOTP first attend a compulsory awareness workshop, designed to provide information on the aims and content of the Programme, the positive and negative effects associated with SOTP work, and the available avenues of support. The workshop would also involve participants watching part of a video recorded SOTP treatment session.

RECOMMENDATION 3: The Prison Service should make greater efforts to inform staff interested in working on the SOTP – particularly Prison Officers – of the promotion prospects available.

IV. TRAINING

Just over half of the trainees who were interviewed for the current study were pleased with the training they received on the two-week SOTP Core training course. In terms of how the course could be improved both trainees and qualified facilitators said that certain key issues that they felt should have been covered on the course were excluded, simply because there wasn't enough time to include them into skills practice exercises and group discussions. Having said this, none of the interviewees – neither trainees nor qualified staff – thought that the course should be extended. This reflects my own opinion in that it would be impossible to study all facets of the job – and particularly the entire Core treatment manual – in any reasonable length of time.

I agree with the recommendations of the sample of qualified facilitators that took part in the current study, namely that SOTP training should have a greater focus on the reality of delivering treatment and, specifically, should spend a greater amount of time looking at the Core treatment manual and the content of the various treatment sessions that facilitators are expected to deliver. However, rather than make the course longer in order to accommodate such plans, it is my opinion that trainees should be required to undertake some pre-course study, which would 'free up' time on the two-week training programme. This pre-course preparation would involve trainees attending SOTP awareness training (recommended above), and undertaking some preliminary reading on the fundamental skills covered in week one of

the Core training, and also some further reading on the aims and methods of the programme, and research supporting its effectiveness. This would come in the form of a pre-course materials pack, which would also include a glossary of the psychological terms most commonly used on the Core training course to prevent trainees from becoming overwhelmed with terminology with which they are unfamiliar. This type of study would supplement the already practical nature of the SOTP training course with a more robust academic grounding, providing candidates with a greater knowledge about the reasons behind treating sex offenders, and success rates in risk reduction. Given that a large proportion of trainees reported that they had entered sex offender work because of their interest in the client group and forensic psychology, some pre-course study would also serve to nurture this attraction to the subject area.

As a final point, the researcher would also recommend that the Prison Service make greater efforts to ensure that, once trained, facilitators are provided with the opportunity to deliver the SOTP straight away. If trainees are spending months after finishing the Core training in their 'usual' role, any knowledge gained from the course will start to deteriorate. Nor does this approach seem sensible in terms of a cost-benefit analysis: given that the Prison Service are spending thousands on training SOTP facilitators, it makes no economic sense if such individuals are not then employed in the role for which they have been educated. It is, therefore, my opinion that those who successfully complete the SOTP Core training should be given the opportunity to deliver a programme straight away. This would provide instant practical experience and highlight any emotional or coping difficulties which may be suggestive of the fact that a facilitator is not suited to work on the SOTP.

RECOMMENDATION 4: Trainee facilitators should be required to undertake some preliminary study before attending the SOTP Core training course. This would involve compulsory attendance at an SOTP awareness workshop, and some introductory reading on the aims of the SOTP, treatment methods, research supporting its effectiveness, and the fundamental skills covered in week one of SOTP training. The programme of preliminary study would come in the form of a pre-course information pack, which would also include a glossary of the most frequently used psychological terms on the training course itself.

RECOMMENDATION 5: The Prison Service should evaluate the length of time that newly qualified facilitators have to wait between completing training and delivering a programme.

V. SUPPORT

The present study aimed to investigate the types of support used by trainee and qualified facilitators, how these means of support helped them to cope with the demands of SOTP work, and how important they felt each type of support had been.

In terms of 'type' of support, participants were asked about personal sources of support (i.e. family and friends), and organisational means of support – specifically supervision and counselling. Two key findings emerged: first, qualified facilitators felt that organisational means of support had been more helpful than personal sources of support; and second, qualified facilitators found supervision more important in terms of supporting them in their role than the counselling they had received.

In spite of these results, qualified facilitators had very few complaints about the counselling service, and seven of the nine said that they thought it should remain a compulsory requirement of working on the SOTP. Although a selection of empirical papers have, more recently, placed a firm question mark over the benefits of compelling an individual to enter into the therapeutic process,[3] I would agree with the idea that, at present, counselling should retain its mandatory status. If future research shows compulsory counselling to be damaging to the health of facilitators then the Prison Service should, of course, withdraw it as a means of support. However, up until that point – especially in light of the decision in *Hatton*,[4] where it was decided that an organisation offering a confidential advice service would be unlikely to be found in breach of its duty to prevent reasonably foreseeable psychiatric damage – it would seem rash for counselling to be removed.

Qualified facilitators identified supervision as the most important source of support available to them, yet it was also heavily criticised. Some facilitators had not received the correct amount of supervision and others had received their allotted hours of individual supervision after they had completed the programme on which they were working. One of the main ways in which facilitators felt supervision could be improved was by being more regular and more constructive in terms of the feedback provided. Prompt and strategically timed supervision is clearly essential if facilitators are to be able to use feedback constructively and report any problems they might be experiencing during treatment. Therefore, the Prison Service should endeavour to ensure that facilitators receive all of their required supervision *before* the end of a programme. Given that the Core SOTP takes around six months to complete, and that

[3] RA Mayou, A Ehlers and M Hobbs, 'Psychological Debriefing for Road Traffic Accident Victims' (2000) 176 British Journal of Psychiatry 589; I V E Carlier *et al*, 'Disaster-Related Post-Traumatic Stress in Police Officers: A Field Study of the Impact of Debriefing' (1998) 14 Stress Medicine 143.
[4] *Hatton v Sutherland* [2002] EWCA Civ 76; [2002] 2 All ER 1 (CA).

facilitators should receive at least 12 hours of group supervision and two hours of individual supervision per programme, supervisors should have a duty to make certain that facilitators receive at least two hours of group supervision per month, per programme, and that they receive at least one hour of individual supervision at the half way point of a programme. This individual supervision need not necessarily be delivered in one-hour sessions. Indeed, I would recommend that newly qualified facilitators receive 30 minutes of individual supervision within their first month of working on the SOTP. This would provide an opportunity to assess how well new facilitators are coping with the demands of working with sex offenders in a therapeutic capacity. At the half way point of a programme, appropriate times could be agreed between the supervisor and the facilitator to conduct the remaining hour of individual supervision, based on an assessment of how the facilitator is progressing in their new role.

It is my view that the timing of the facilitator health review should also be brought forward. At present, the review is conducted every four years. However, in terms of protecting the health of newly qualified facilitators, I feel that there would be more value in providing a formal, scheduled health-check after the first year of facilitating on the programme, and every two years thereafter.

A number of the treatment managers interviewed for this study discussed that support for staff working on the SOTP can depend on factors beyond their control; for example, the attitude of the governor towards rehabilitative treatments, and the nature of the prison regime, which will sometimes require facilitators – especially prison officers – to cover other, more pressing duties within the prison. In addition, some of the qualified facilitators that took part in the

follow-up study discussed how the negative attitude of other prison staff towards sex offenders, and towards the SOTP itself, can have a detrimental impact on how 'supported' facilitators feel. In order to optimise the level of support for those working on the SOTP, a much broader, prison-wide approach is required. One way in which this could be achieved would be to improve links between prison departments in order to educate fellow staff about the content of SOTP, its aims, and the results of evaluation studies. Indeed, one of the prisons I visited had already initiated this type of training scheme for newly recruited prison officers and everyone working on the vulnerable prisoner unit. This is certainly a step in the right direction; nevertheless, a more sensible approach would be to offer such training to all prison staff rather than selected groups. It is my opinion that this would aid in breaking down the preconceptions that some Prison Service employees (including those in managerial positions) hold about the nature and effectiveness of treatment for sex offenders and the work of SOTP facilitators. It is accepted, however, that such a wide-scale project would be resource intensive. Thus, in terms of ways in which the Prison Service can improve the support available to SOTP facilitators, this type of prison-wide approach would need to be part of a long-term strategy, rather than something that could be implemented immediately.

RECOMMENDATION 6: The Prison Service should continue to provide an independent counselling service for SOTP facilitators. Attendance at three counselling sessions per SOTP programme should continue to be a compulsory requirement of working as a facilitator.

RECOMMENDATION 7: **S**upervisors working on the SOTP should be under a duty to ensure that facilitators receive the requisite amount of supervision (as stipulated in the audit document) before the conclusion of a programme. Such supervision should be delivered

evenly throughout a programme. Facilitators should receive at least two hours of group supervision per month, per programme, and at least one hour of individual supervision at the half way point of a programme. Newly qualified facilitators should receive 30 minutes of their allotted two hours of individual supervision within the first month of starting work on the SOTP.

RECOMMENDATION 8: The timing of the facilitator health review should be revised. Instead of being every four years, a formal health-check should be conducted after the first year of facilitating on the programme, and every two years thereafter.

APPENDIX 1: PRISONS DELIVERING THE SOTP

						SOTP Programme	
Prison	**Category**	**Core**	**Adapted**	**Extended**	**Rolling**	**Better Life Booster**	**Adapted Better Life Booster**
Frankland	High	✓	✓	✓			
Full Sutton	High	✓	✓	✓	✓		
Manchester	High		✓				
Wakefield	High	✓	✓	✓		✓	✓
Albany	B	✓		✓			
Bullingdon	Local	✓	✓	✓		✓	
Elmley	Local B				✓		
Parc	Local B				✓		
Rye Hill	B	✓	✓				
Wandsworth	Local	✓		✓	✓		
Aklington	C	✓	✓		✓	✓	
Channings Wood	C	✓		✓			
Hull	C/YOI	✓			✓		
Littlehey	C				✓		
Maidstone	C	✓		✓		✓	
Risley	C	✓			✓	✓	
Shepton Mallet	C			✓		✓	
Stafford	C	✓			✓		
Usk	C	✓	✓	✓		✓	
Wayland	C	✓			✓	✓	
Whatton	C	✓	✓		✓	✓	✓
Wymott	C	✓	✓			✓	
Leyhill	Open D					✓	
Aylesbury	YOI	✓					
Hull	YOI	✓			✓		
Swinfen Hall	YOI	✓	✓	✓		✓	

APPENDIX 2: INTERVIEW SCHEDULES

Interview Guide for Pilot Interviewees

Complete informed consent documentation.
Record interviewee's name, gender, prison establishment and interview reference number.
Test tape-recorder.

Introduction
My name is Laura Brampton, and I'm carrying out some independent research at Birmingham University regarding the training and support needs of SOTP facilitators.

As you know, there is no obligation to take part, but I would very much appreciate your views about your experiences as a facilitator. You are free to decline to answer any questions that you do not feel entirely comfortable with.

The interview will be tape-recorded, but I can assure you that whatever you tell me will not be used in any way that would identify you personally in my final report.

A. Questions about the positive and negative aspects of working with sex offenders

I would first like to ask you about the positive and negative aspects that you can identify about your work with sex offenders.

1. What sort of negative impact do you think working with sex offenders has had on you in terms of:

    i. Your physical health
    ii. Your emotional health
    iii. Your feelings towards the prison service generally
    iv. Your feelings towards your spouse/partner
    v. Your feelings towards children (whether your own or other people's)
    vi. Any other negative impact

2. Now looking at the opposite side of the previous question, what sort of positive impact have you experienced as a result of working with sex offenders in terms of:
    i. Personal impact
    ii. Professional impact
    iii. Your feelings towards the prison service generally
    iv. Your feelings towards your spouse/partner
    v. Your feelings towards children (whether your own or other people's)
    vi. Any other positive impact

B. Questions regarding training

Thank you. I would now like to ask you some questions about the two-week training course you completed to become a facilitator, and the training you have received since working on the SOTP.

3. What was your opinion of the two-week training course? (*Prompt: Were there any areas that you feel could be improved?*)

4. Other than the two-week training course you completed before becoming a facilitator, what additional training have you received to help you in your role as an SOTP facilitator?

5. How was this training relevant to your role? (*Prompt: For example, what specific aspect of your work was it targeted to enhance?)*

6. Do you feel it enhanced your performance as an SOTP facilitator? (*Prompt: Why? Why not?*)

C. Questions about support

I now want to ask you about the support your have received both internally from your institution (for example, supervision); and externally from sources outside of the workplace (for example, from family and friends).

Organisational support

7. What types of behaviour from your work colleagues, supervisor, and other prison staff, do you find supportive in your role as an SOTP facilitator?

8. What is it about these types of behaviour that assist you in your work as a facilitator?

9. Alternately, can you identify any types of behaviour from your work colleagues, supervisor, or any other prison staff, that you find unhelpful in your role as an SOTP facilitator? (*Prompt: How are these behaviours unhelpful? How do they have a negative impact on your work?*)

10. What official organisational support mechanisms are available to you as an SOTP facilitator? (*Prompt: For example, supervision and counselling*)

11. How important are each of these support mechanisms to you as a facilitator? (*Show card*)

Very important	1
Important	2
Neutral	3
Not important	4

(*Prompt: Can you explain why? Why is X more helpful than Y? How do organisational support mechanisms help you cope in your role as a facilitator?*)

12. Can you think of any other type of support that you would like to see the prison service provide in the future for you in your role as an SOTP facilitator?

Personal support

13. As well as organisational support mechanisms, can you identify any people external to the prison service, particularly family and friends, that help you cope with your work as an SOTP facilitator?

14. What types of behaviour from these individuals do you find assist you in relation to your work as an SOTP facilitator?

15. What is it about these types of behaviour that your find supportive when you arrive home from work?

16. How important are (each) of these support mechanisms to you as a facilitator? (*Show card*)

Very important	1
Important	2
Neutral	3
Not important	4

(*Prompt: Can you explain a little further? How do these forms of support help you cope?)*

17. Can you identify any types of behaviour from these personal sources of support that you find unhelpful? (*Prompt: How are they unhelpful? How do they have a negative impact on you work?*)

D. Questions about events that might be related to your involvement in SOTP

I would now like to ask you some questions about why you decided to get involved in sex offender work. Some of the questions are sensitive in nature and require very personal information, so please feel free to take your time.

18. How long have you been a facilitator?

19. When did you decide to become an SOTP facilitator?

20. Why did you decide to become an SOTP facilitator?

21. Had you ever worked with sex offenders before working on the SOTP? (*Prompts: In what capacity? What were your responsibilities?*)

    If yes: How was this different from the SOTP?
    If no: Go to question 22

22. Have you ever been the victim of sexual abuse?

23. Have you ever been involved in any other situation that you found personally traumatic?

If yes to Q22 and/or 23: Continue to question 24.
If no to Q22 and/or 23: Continue to next section.

24. Do you think this experience/experiences had an impact on your decision to become an SOTP facilitator?

If yes: Which experience in particular? In what way did you think it had an impact?
If no: Continue to next section

F. Personal information

The interview is now over. I just need to ask you some personal information regarding your age, race, and sexuality.

25. How old are you?

26. I'm going to show you a card. This is how the National Census asks people to classify their race. Could you tell me which number best describes you. (*Show card*)

White	
British	1
Irish	2
Any other white background – please specify	3
Mixed	
White and Black Caribbean	4
White and Black African	5
White and Asian	6
Any other mixed background – please specify	7
Asian or Asian British	
Indian	8
Pakistani	9
Bangladeshi	10
Any other Asian background – please specify	11
Black or Black British	
Caribbean	12
African	13
Any other Black background - please specify	14
Chinese or other ethic group	
Chinese	15
Other ethnic group – please specificy	16

27. How would you describe your sexuality? (*Show card*)

Heterosexual	1
Homosexual	2
Bisexual	3
Asexual	4
Unsure	5
Other – please state	6

Thank you very much for your time.

Switch tape recorder off.

Interview Guide for Trainee Facilitators

Complete informed consent documentation.
Record interviewee's name, gender, prison establishment and interview reference number.
Test tape-recorder.

Introduction
My name is Laura Brampton, and I'm carrying out some independent research at Birmingham University regarding the training and support needs of SOTP facilitators.

As you know, there is no obligation to take part, but I would very much appreciate your views about your experiences as a facilitator. If it's ok with you, I'd also like to speak with you again in about a year's time, to see how your opinions have changed.

The interview will be tape-recorded, but I can assure you that whatever you tell me will not be used in any way that would identify you personally in my final report. However I will have to take your name, and a few other details, so as I can follow you up in one year's time.

A. Questions about your entry into sex offender work

I first need to ask you some questions about why you decided to get involved in sex offender work. Some of the questions are sensitive in nature and require very personal information, so please feel free to take your time.

7. When did you decide to become an SOTP facilitator?

8. Why did you decide to become an SOTP facilitator?

9. Had you ever worked with sex offenders before working on the SOTP? (*Prompts: In what capacity? What were your responsibilities?*)

   If yes: How was this different from the SOTP?
   If no: Go to question 4

10. Have you ever been the victim of sexual abuse?

    If yes: Did this experience have an impact on your decision to become an SOTP facilitator?
    If no: Continue to next section

B. Questions about the positive and negative aspects of working with sex offenders

Thank you. I now need to ask you about the positive and negative aspects that you think you might experience whilst working with sex offenders on the SOTP.

11. What sort of negative impact do you think working with sex offenders might have on you in terms of:

    vii. Your physical health
    viii. Your emotional/mental health
    ix. Your feelings towards the Prison Service
    x. Your feelings towards your spouse/partner
    xi. Your feelings towards children
    xii. Any other negative impact

12. Now looking at the opposite side of the previous question, what sort of positive impact do you think working with sex offenders might have on you in terms of:

    vii. Personal impact
    viii. Professional impact
    ix. Your feelings towards the Prison Service
    x. Your feelings towards your spouse/partner
    xi. Your feelings towards children
    xii. Any other positive impact

C. Questions regarding training

I would now like to ask you some questions about the two-week training course you are currently involved in, and the training that you will receive in the future to aid you in your role as a facilitator.

13. What is your opinion of the two-week training course so far? *(Prompt: Are there any areas that you feel could be improved?*)

14. Other than the two-week training course that you're currently involved in, would you expect further training to be provided in the future to aid you in your role as an SOTP facilitator?

    If yes: What sort of further training would you like to be provided? (*Prompt: For example, are there any particular areas of sex offender work that you feel you might need further guidance on?)*

    If no: Continue to Section D

D. Questions about support

I now want to ask you about the support you think you will need whilst working as an SOTP facilitator both internally from your institution (for example, supervision); and externally from sources outside of the workplace (for example, from family and friends).

15. I understand that, as a facilitator, you will receive formal supervision and a number of independent counselling sessions. Looking at the following options, how important do you think each of these support mechanisms will be to you as a facilitator?

Very important	1
Important	2
Not important	3

(*Prompt: Can you explain why? Why do you think X will be more important than Y?*)

16. What will you expect from supervision? (*Prompt: What do you think will be discussed? What format do you think supervision will take?*)

17. What will you expect from the independent counselling sessions? (*Prompt: What do you think will be discussed? How will the counselling differ from supervision sessions?*)

18. Are there any other forms of organisational support that you are aware of that might help you cope in your role as a facilitator?

19. What other forms of *external* or *personal* support will be available to you? (*Prompt: Family, friends, therapist)*

20. Again, looking at the following card, how important do you think (each) of these support mechanisms to you as a facilitator?

Very important	1
Quite important	2
Neutral	3
Not important	4

(*Prompt: Can you explain a little further? How do you think these forms of support will help you cope? Why do you think X will be more important than Y?)*

21. Generally speaking, how do you think poor support from family and friends would affect you in your role?

F. **Personal information**

The interview is now over. I just need to ask you some personal information regarding your age, race, and sexuality.

22. How old are you?

23. I'm going to show you a card. This is how the National Census asks people to classify their race. Could you tell me which number best describes you.

White	
British	1
Irish	2
Any other white background – please specify	3
Mixed	
White and Black Caribbean	4
White and Black African	5
White and Asian	6
Any other mixed background – please specify	7
Asian or Asian British	
Indian	8
Pakistani	9
Bangladeshi	10
Any other Asian background – please specify	11
Black or Black British	
Caribbean	12
African	13
Any other Black background - please specify	14
Chinese or other ethic group	
Chinese	15
Other ethnic group – please specificy	16

24. How would you describe your sexuality?

Heterosexual	1
Homosexual	2
Bisexual	3
Unsure	4

Thank you very much for your time.

Turn tape recorder off.

Interview Guide for Follow-Up Interviews

Complete informed consent documentation.
Record interviewee's name, gender, prison establishment and interview reference number.
Test tape-recorder.

Introduction

My name is Laura Brampton and, as you already know, I'm carrying out some independent research at Birmingham University regarding the training and support needs of SOTP facilitators.

As you know, there is no obligation to take part, but I would very much appreciate you views about your experiences as a facilitator since we met last year.

The interview will be tape-recorded, but I can assure you that whatever you tell me will not be used in any way that will identify you personally in my final report.

1. Have you provided treatment on the SOTP since we last spoke?

   If yes: Can you provide details? How long have you been working on SOTP?
   If no: Terminate interview

A. Questions about the positive and negative aspects of working with sex offenders

I first need to ask you about the positive and negative aspects of working with sex offenders that you have experienced in the last year whilst working on the SOTP.

Negative impacts

2. Has working on SOTP had any negative effect in terms of your:

   xiii. Emotional/mental health
   xiv. Physical health
   xv. Personal life
   xvi. Professional life
   xvii. Feelings towards the Prison Service
   xviii. Feelings towards your spouse/partner
   xix. Feelings towards children
   xx. Any other negative impact

(Prompt: Ask interviewee to provide examples of each)

Positive impacts

3. Has working on SOTP has any positive effect in terms of your:

   i. Emotional/mental health
   ii. Physical health
   iii. Personal life
   iv. Professional life
   v. Feelings towards the Prison Service
   vi. Feelings towards your spouse/partner
   vii. Feelings towards children
   viii. Any other positive impact

(Prompt: Ask interviewee to provide examples of each)

B. Questions regarding training

Thank you. I would now like to ask you some questions about the two-week training course you completed last year, and any training you have received since then.

4. Having worked as an SOTP facilitators for a year now, do you think the two week training course prepared you adequately for your role on the SOTP?

5. Is there any way that you think the course might be improved, after one year's experience? Please provide examples.

6. Other than the two-week training course, have you received any further training from the Prison Service to aid you in your role as an SOTP facilitator? If yes, what further training have you received?

7. Is there any further training that you would like to take part in? If so, what training are you interested in completing?

C. Questions about support

I would now like to ask you about the type of support you have received whilst working as an SOTP facilitator, both internally from your institution (namely supervision and counselling), and externally from sources outside of the workplace (for example, family and friends).

Organisational support

8. I understand that, as a facilitator, you should have received formal supervision and at least 3 independent counselling sessions. Is this correct?

   If yes: How much supervision have you received?
   If no: What have you not received? How has this impacted upon you in your role?

9. Can you comment on how important each of these sources of support have been in terms of aiding you in your role as a facilitator?

10. What aspects of supervision have you found to be particularly helpful or unhelpful in terms of supporting you in your role?
11. What aspects of counselling have you found to be particularly helpful or unhelpful in terms of supporting you in your role?

12. Should attendance at counselling be retained as a compulsory requirement of working on the SOTP?

13. Do you think one form of support (i.e. supervision or counselling) has been more important than the other in terms of aiding you in your role?

14. Are there any areas regarding the provision and/or quality of supervision and/or counselling that you feel could be improved?

    If yes: Which areas specifically? How do you think such issues might be improved?
    If no: Continue to question 15.

15. What is your overall opinion on the quality of internal support provided by the Prison Service?

Personal support

16. Have you made use of any personal forms of support since starting work on the SOTP (for example, talking to family and friends)?

    If yes: Which particular individuals have you sought support from?
    If no: Why not? Continue to question 17.

17. What was it that these people did that you found to be helpful in terms of supporting you in your role as an SOTP facilitator?

18. Did they do anything that you found to be unhelpful in terms of supporting you in your role?

19. Overall, has any person, external to the working environment, done anything that you have found unhelpful in terms of supporting you in your role?

Thank you for your time.

Turn tape recorder off and provide interviewee with your contact details.

Interview Guide for Treatment Managers

Complete informed consent documentation.
Record interviewee's name, gender, prison establishment and interview reference number.
Test tape-recorder.

Introduction
My name is Laura Brampton, and I'm carrying out some independent research at Birmingham University regarding the training and support needs of SOTP facilitators. As a result, I would very much appreciate you views about your experiences as a Treatment Manager to supplement my research on SOTP facilitators.

As you know, there is no obligation to take part and you are free to decline to answer any questions that you do not feel entirely comfortable with.

With your permission I would like to tape-record the interview, but I can assure you that whatever you tell me will not be used in any way that would identify you personally in my final report.

A. Questions about your career

I would first like to ask you a few questions about your career, and how you became involved in the Sex Offender Treatment Programme

1. When did you start working for the prison service and in what capacity?

2. When did you first get involved in the SOTP?

3. Can you describe your involvement, both as a facilitator and as a Treatment Manager?

4. Had you done any work with sex offenders before you started working on the SOTP?

   If yes: In what capacity? How was it different to SOTP?
   If no: Continue to question 5

5. Have you worked on any other prison-run rehabilitation programmes?

   If yes: Which programme/s? What was your role? Did you deliver supervision?
   If no: Continue to question 6

B. Questions about your experiences as a treatment manager

I would now like to ask you specifically about your experiences of being a Treatment Manager.

6. When did you first become a Treatment Manager on SOTP?

7. Why did you decide to become a Treatment Manager? *(Prompt: Was it a natural progression in your career, or was it recommended that you should apply?)*

8. Do you feel that you were supported fully during the Treatment Manager training course, and given details about the nature of the position and the responsibilities you were expected to undertake?

9. How many people working on the SOTP are you involved in managing and supervising?

10. Have you been a Treatment Manager on any other rehabilitative programme run by the prison service?

    If yes: How did that experience compare to your current role?
    If no: Continue to question 11

11. Do you still provide hands-on treatment on the SOTP as well as working in a managerial role?

    If yes: In what capacity?
    If no: Continue to question 12

12. Do you find your job as a Treatment Manager 'stressful'?

    If yes: Continue to question 13
    If no: Continue to question 15

13. How would you define 'stress'?

14. In what ways do you find your job as a Treatment Manager 'stressful'? *(Prompt: Why do you find this stressful? Are there any other aspects of your job that you find stressful?)*

15. What means of support, provided by the prison service, are available to you as a Treatment Manager to cope with any stress you might experience?

16. Looking at the following scale, how helpful do you find these sources of support?

Very helpful	1
Helpful	2
Unhelpful	3
Very unhelpful	4

17. How does you job as a Treatment Manager compare to other jobs you have done in the prison service?

C. Questions about the support provided to SOTP facilitators

Thank you. I now need to ask you some questions about the support you are able to provide to the SOTP facilitators that you manage.

Support that you provide

18. What forms of support are you involved in providing to SOTP facilitators? Please provide examples. *(Prompt: This might include supervisory activities, but not necessarily)*

19. How effective do you think these are in supporting SOTP facilitators in your team?

20. Are there any special support measure offered to newly qualified facilitators?

21. Have you ever experienced any difficulties in supporting the SOTP facilitators in your team? *(Prompt: For example, facilitators being resistant to supervision, or other staff being uncooperative in terms of time schedules)*

    If yes: Please provide examples, and continue to question 22
    If no: Continue to question 24

22. How often has this recurred? Please give examples.

23. How did you overcome these difficulties? Please give examples. *(Prompt: For example, by a one-to-one discussion)*

Other sources of support

24. What other sources of support are provided by the prison service to SOTP facilitators?

25. How important do you think providing external counselling to support SOTP facilitators is in terms of preventing/minimising any negative effects of working with sex offenders?

Very important	1
Important	2
Unimportant	3

26. Is there anything else that you think should be done by the prison service to provide further support to SOTP facilitators?

D. Questions about the positive and negative effects of working with sex offenders

I now want to ask you some questions about the most commonly experienced effects you might have witnessed in SOTP facilitators you have supervised/supported.

27. Have you ever come across any negative behavioural or emotional effects occurring in SOTP facilitators in your team as a result of their work?

    If yes: What sort of effect/s? Was this something that was brought up by the facilitator during discussion, or was it something you identified yourself?
    If no: Continue to question 28

    If respondent does not cover any of the following areas when discussing negative effect, prompt:

    i. Physical health
    ii. Emotional health
    iii. Feelings towards the prison service
    iv. Feelings towards their spouse/partner
    v. Feelings towards children
    vi. Any other negative effect

28. Now looking at the opposite side of the question, can you think of any positive effects occurring in the SOTP facilitators in your team as a result of their work?

    If yes: What sort of effect/s? How have you identified such effects?
    If no: Finish interview

    If respondent does not cover any of the following areas when discussing positive effect, prompt:

    i. Personal impact
    ii. Professional impact
    iii. Feelings towards the prison service
    iv. Feelings towards their spouse/partner
    v. Feelings towards children
    vi. Any other positive impact

Thank you very much for your time.

Provide interviewee with your contact details and switch tape recorder off.

APPENDIX 3: INFORMED CONSENT DOCUMENTATION

Informed Consent: An Information Guide for Research Participants

What is informed consent?
The concept of informed consent essentially provides that persons who participate in research activities should be free to choose to take part or refuse, having been given the fullest information possible about the nature and purpose of the research in question.

What sort of questions will I be asked?
The interview will mostly relate to the training and support needs you have as an SOTP facilitator, and the positive and negative aspects of working with sex offenders. There will also be some questions relating to events that might have impacted upon your involvement in sex offender work. Some of the questions in this particular section are very personal in nature; however, as explained below, you may request that the tape recorder be turned off at any time, and you are free to refuse to answer any questions you are not entirely comfortable with.

How will the information I provide be used?
The information you provide will be used as part of a doctoral thesis looking into the training and support needs of SOTP facilitators. It is hoped that the findings of the thesis will go some way towards informing future policy relating to the support and training of SOTP facilitators.

Will the information I provide remain anonymous?
Yes. Although the interviewer will have to take some personal details for reasons relating to informed consent, all personal information will be kept entirely confidential. Each interviewee will be given a reference number, which relates to their personal details. Only the interviewer will have access to this information.

How long will my information be kept for?
The information you provide will be kept for the time it takes for the research to be completed. It is anticipated that the thesis will be finished in 2009.

Where will the information be stored?
The information you provide will be stored in a locked filing cabinet when not in use.

Can I give consent to some questions but not others?
You may find that you are willing to answer certain questions in the interview, but are uncomfortable in answering others. This is fine, and will not affect your ability to participate in the research. Please inform the interviewer if there are any questions that you would prefer not to answer.

Can I withdraw my consent at a later date?
You can withdraw your consent to participate in the research at any time.

Why is the interview being recorded?
The interview is being tape recorded to ensure that the interviewer has an accurate account of the discussion, and so that the information you provide cannot be misconstrued.

Can I request that the tape recorder be turned off?
You may request that the tape recorder be turned off at any point during the interview.

Consent Form for Research Participants

Interviewee reference number:……

I understand that I am consenting to:

- Being interviewed for the purpose of research being conducted into the training and support needs of SOTP facilitators
- Recording equipment being used for the interview
- The information I provide being used to inform the research, but with the understanding that my data will remain anonymous.

	Yes	**No**
• I have received and been given time to read an information guide about consent.	☐	☐
• *Telephone interviews:* I have had (or been given the opportunity to have) an information guide about consent read to me.	☐	☐
• I have been given the opportunity to ask all the questions I want to. Those questions have been answered fully and to my satisfaction.	☐	☐
• I understand that I can withdraw my consent at any time.	☐	☐
• I understand that I can request that the tape recorder be turned off at any time.	☐	☐

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