

**'I've changed my life': Understanding what helps  
Offenders with a Learning Disability to Avoid Reoffending**

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## Note to Reader

This thesis comprises three papers: a literature review, a research paper and a reflective paper. The proposed journals for publication of these papers: the Journal of Forensic Practice (paper 1) Journal of Intellectual Disabilities (paper 2) and the Clinical Psychology Forum (paper 3) are peer reviewed and known to publish papers relating to the subject of this thesis. Paper 1 has an upper limit word count of 7500 inclusive of references, tables and figures, but exclusive of a 250-word abstract; paper 2 has an ideal word limit of 8000 exclusive of a 150-word abstract and paper 3 has a word limit of 2500 with a 40-word summary. Due to academic requirements, some of these word limits are surpassed and so papers will be edited prior to submission to journals. An accessible version of the research paper is planned and will be submitted for publication to the British Journal of Learning Disabilities. The proposed journals provide differing style guidance (see Appendices A, B and C) and so for consistency the written style of the thesis and referencing is in accordance with American Psychological Association guidance (APA 6<sup>TH</sup> Edition), alterations will take place later for submission to journals. Alterations include writing out abbreviations in full, changes to the referencing style and the removal of references to appendices. The appendix is not required for journal submission. Consistent with academic requirements, the papers are typed in Arial 12 point font, with 1.5 line spacing. Left hand margins are set at 40mm to allow for binding. Papers include a 'Key Practitioner Message' and keywords. To aid the reader, tables and figures appear within the text. Note that throughout the thesis all identifiable information is omitted or altered to protect anonymity.

Throughout the papers, the term 'Learning Disability' is used in place of 'Intellectual Disability'. Notably the latter is the current status quo in the academic environment. However, participants in the research presented in Paper 2 identify with the term Learning Disability and so this is preferred. The term will be altered for submission to journals.

The overall word count for the thesis is 16,831, excluding the contents page, references and appendices.

## Thesis Abstract

This thesis aims to add to the evidence base regarding offenders with a Learning Disability (LD) living in UK communities. The thesis also aims to enhance the reader's understanding about why offenders with a LD avoid reoffending. The first paper reviews the current literature on the community-based treatment and support of offenders with a LD. In line with social policy, effective treatment reduces reoffending. Current developments show that effective treatments are long-term Cognitive Behavioural Therapy programmes, innovative treatment components that enhance empathy and skills to problem solve, and community integration. The review highlights issues with a small sample size in the quantitative evaluations of treatment efficacy, which researchers address by stating other measures of change (e.g. community engagement and reductions in support). Throughout the literature, these measures are inconsistent and informal. Therefore, the review outlines a need to use consistent and robust methods to evaluate treatment efficacy, which could include qualitative research. The second paper employs narrative methodology to explore the reasons why, offenders with a LD do and do not reoffend. The research involves interviews with six male offenders living in the community. Analysis and interpretation suggest that offenders with a LD need to have the ability or support to make decisions to avoid reoffending. Offenders with a LD must also have meaningful relationships and engagement in the community, which they fear losing if they reoffend. The outcomes endorse community-based treatments and improving community opportunities for offenders with a LD. The third paper offers a reflective commentary focused on overcoming the barriers to completing a thesis. The barriers relate to the conduct of the literature review and the research. Overall, the thesis provides an insight into what helps offenders with a LD to avoid reoffending, with reference to the evidence base and regard to individual stories.

**Paper 1: Literature Review**

**Community-based treatment of Offenders with a Learning Disability**

**Word count: 7820 (Inclusive of References)**

## Abstract

Offenders with a learning disability increasingly receive community based treatment and support to address their offending behaviour. Social policy makers are interested in what is effective and reduces reoffending. This paper reviews what treatment or support takes place in the UK community with appraisal of its proposed efficacy. Electronic searches using EBSCOHost identified nine post 2010 papers for review. In adherence with Critical Appraisal Skills Programme frameworks (CASP; Public Health Resource Unit, 2006) and guidelines from Aveyard (2010) the papers were critically appraised and analysed thematically. The thematic analysis highlighted long-term Cognitive Behavioural Therapy, community integration and innovative treatment components to enhance problem solving skills and empathy, as effective treatments. A small sample size was highlighted in four of the studies because it hindered establishing treatment effectiveness. In response to difficulties establishing efficacy, community engagement and reduced support are considered as measures of positive change. However, these measures are inconsistently and informally recorded throughout the papers. Despite being limited to nine papers, the review highlights a need to use other methods to establish treatment efficacy and complement quantitative outcomes, including consistent records of community engagement and robust qualitative measures. This is a wider consideration in the context of social policy and service development.

*Keywords: Community, Learning Disability, Intellectual Disability, Offenders, Offending Behaviour, Treatment.*

## **Key Practitioner Message**

- Long-term Cognitive Behavioural Therapy is an effective community based treatment for offenders with a Learning Disability.
- Community Integration is an effective community based treatment for offenders with a Learning Disability.
- To assess the outcomes of long-term treatment with long-term follow up periods, clinicians should routinely collect data for research, service evaluation and audit.
- Community Engagement should be routinely and formally recorded, pre, during and post treatment.
- Qualitative methods and other measures of treatment efficacy are due consideration where small sample sizes may confound quantitative analysis.

## **Introduction**

In 2011 there were an estimated 1.5 million people living with a Learning Disability (LD) in the UK and up to 1.2 million people in England (Emerson et al., 2012). In the UK a LD diagnosis constitutes an Intelligence Quotient below 70 (below 74 incorporates the appropriate standard deviation); concurrent deficits in social and adaptive abilities; with difficulties present since childhood (British Psychological Society; BPS, 2001). Only a few decades ago many individuals with a LD lived in institutions and long-stay hospitals. However, since the 1970s, deinstitutionalisation has led to an increased presence and engagement of people with LD in UK communities. The community is also where the treatment and on-going support of these individuals now takes place. Generic and specialist community services aim to respond effectively to the needs of people with a LD, including those of offenders. Treatment for offenders with a LD is primarily concerned with reducing offending behaviour. For these individuals, exposure to the Criminal Justice System (CJS) for illegal behaviours means they may receive treatment from community services rather than custodial sentences. Reasons for this are well documented (Wheeler et al., 2009). Whether it is not in the public interest to prosecute or due to limited availability of appropriate treatment in prison services, it remains that community services provide care for some offenders with LD. This paper utilises a systematic approach to review recent developments in community-based treatment for adult offenders with a LD.

### **Offending Behaviour**

For this paper, offending behaviour is defined as conduct that breaks the UK law. Breaking the law means that an individual may have contact with the CJS.

### **Offenders with a Learning Disability**

The exact number of offenders with a LD is difficult to establish. Recent attempts show between 2% and 10% of all offenders live with a LD (Lindsay, 2011). Attempts to establish accurate figures may be affected by different assessments; differing definitions of a LD in other countries and different inclusion criteria in treatment and research (Lindsay, Michie & Lambrick, 2010). Also, criteria might not specify inclusion of offenders with 'Borderline' ability (IQ between 71 and 84). While these individuals do not meet LD diagnostic criteria, some have

similar deficits and need more support (e.g. problems with learning; Zetlin & Murtaugh, 1990). Unsurprisingly, many of these individuals benefit from treatment adapted for people with a LD (e.g. longer-term; Craig, Stringer & Sanders, 2012).

In the community, other issues may confound attempts to establish numbers. First, LD services may not record offences as such, describing offending behaviour as risky, anti-social, aggressive and/or challenging (Wheeler et al., 2009). Second, offending behaviour managed in the community may avoid contact with the CJS. Third, services might not consider the presence of a LD in treatment: if an individual is able to engage in treatment without adaptations (e.g. methadone treatment for drug addiction) then assessing a LD may not be relevant. Therefore, the overall number of offenders with a LD could be higher than estimates. Nonetheless, the numbers are considered significant and those individuals require support and treatment (Lindsay, 2011). This is particularly the case for people who commit sexual offences, because people with a LD are considered overrepresented in this population (Taylor & Lindsay, 2010).

## **Treatment**

Social policy is concerned with effective treatment that reduces offending, the risk of offending or harm caused by the offending behaviour (Lindsay et al., 2010). Therefore, addressing offending involves, in part, the treatment of criminogenic need: dynamic factors correlated with offending that when treated reduce the offending behaviour (Bonta, 2002). To illustrate, if anger positively correlates with violent offences (when a person is angry, they behave violently), then anger management treatment may reduce violent behaviour. Lindsay et al. (2013), note that for LD offenders there is evidence for effective treatments of criminogenic needs: anger, substance (drug and alcohol) misuse and inappropriate sexual interests. Generally, this endorses group-based Cognitive Behavioural Therapy (CBT): a systematic psychological approach that aims to address maladaptive behaviours, dysfunctional emotions and cognitive processes (Beck, 2011). Lindsay, Jahoda, Willner and Taylor (2013) suggest that psychological therapies including CBT should be adapted or designed for people with a LD. Adaptations include supplementary modules to enhance understanding of emotions, the use of visual aids, role-play and other creative techniques (e.g. Baim, Brookes and Mountford, 2000). An increased length of time for CBT/treatment should also be in place (Lindsay & Smith, 1998).

Group-based adapted CBT is usually a part of a wider treatment programme (e.g. Sex Offender Treatment Services Collaborative – Intellectual Disability; SOTSEC-ID programme, Murphy & Sinclair, 2009). In addition to affecting change in behaviours, emotions and cognitive processes, programmes seek to address other factors linked with offending. These may include sexual knowledge, education, relationships, antisocial attitudes, social circle, unemployment and static (unchangeable) factors including sexual abuse history. Where CBT is not appropriate to meet the needs associated with some of these factors (e.g. poor sexual knowledge), other methods like psycho-education are used. Given many factors relate to offending, meeting treatment needs is a multidisciplinary concern. In addition to input from social workers, nurses, psychiatrists, police and support workers, both forensic and clinical psychologists (CP) work to reduce offending behaviour. All professionals can be trained to provide therapy like CBT. However, given the complex and challenging nature of work with offenders, professionals require support (Mosher, 2010). Therefore, psychologists can also provide supervision and consultation to other workers (Whitton, Collinson & Adams, 2013).

### **Treatment Efficacy**

Social policy is concerned with effective treatments that reduce offending behaviour. Reviewing systems and recommending bodies, namely the Cochrane Collaboration and NICE (National Institute for Clinical Excellence), consider effective treatment 'gold standard' if tested in a Randomised Control Trial (RCT). Similarly, Sherman et al. (1997) who outlined the 'What Works' reviewing system for the United States criminal justice services, shares this view. In offender treatment, the consensus is that RCTs are problematic to achieve due to the ethical implications of a controlled non-treatment group. It is possible to compare a treatment group to a 'waiting list' control group. However, it remains unethical for a number of reasons, including public protection and risk, to not treat sex offenders or allow them to wait for treatment. In response, there is 'controlled trials' (without control groups and randomization) of sex offender treatment and in this context these are the current 'best' evidence (e.g. Murphy et al., 2010). For the most part these include CBT interventions. Recommendations of CBT may reflect a trend for using CBT based interventions in the UK, because it is perceived by some, a

shorter-term and therefore lower cost alternative to other psychological therapies (e.g. psychodynamic; McQueen, 2009).

For services that deliver therapy, feedback on the process and outcomes is essential. In the National Health Service (NHS), patient experience informs quality improvement of services. Moreover, if a person has a positive experience of treatment then this may contribute to positive outcomes (DoH, 2010). Therefore, it is important to consider the impact of the intervention for the individual/s receiving it, including people with a LD (Raitasuo, Taiminem & Salocangas, 1999).

Macdonald, Sinason and Hollins (2003) suggest that using qualitative methods to access these experiences could complement quantitative methods in the analysis of treatment efficacy. For offenders with a LD, a positive treatment experience could potentially promote reductions in reoffending. In addition, community-based interventions may enhance this experience.

### **Community-based Treatment**

Community-based treatments for offenders with a LD are provided in the context of policy (e.g. 'The Mansell Report', DoH, 1993; 'The Reed Report', DoH & Home Office, 1992; 'Valuing People Now', DoH 2009). These outline that, where possible, treatment should take place in the community, close to home and with qualified support in any contact with the CJS. This echoes the principles of deinstitutionalisation and recognises the importance of proficient community-based support in enhancing quality of life. Where community treatment for some offenders with a LD is not possible because of risk or other factors, including severe mental illness, the overall aim following secure treatment is community reintegration. In these instances, multi-agency collaboration is imperative given that the community will provide on-going support or top-up treatment. Therefore, ideally, secure-based treatments should take place as close to the home of the offender as possible. However, McBrien, Newton and Banks (2010) state that unfortunately some offenders with a LD continue to receive secure treatment miles away from home. They suggest that this is due to a lack of appropriate treatment in local communities despite policy, supporting evidence and the considerably higher cost of out-of-county placements.

In the community, specialist and generic services provide treatment to offenders with a LD (Wheeler et al., 2009). Specialist community services work specifically to meet the needs of offenders with a LD, with staff trained to do so.

These services may employ staff with forensic, health and social care backgrounds. Conversely, generic services known as Community Learning Disability Teams (CLDTs) work to meet the needs of the local LD population. This includes offenders if specialist services are unavailable. Based on local need these services employ multi-disciplinary staff with health and social care backgrounds and sometimes employ staff with specialist forensic training and experience.

## Theories

Community-based treatment rationale stems from theories of the development of offending behaviour. Cohen (1955) proposed that young boys from poorer communities identify with a delinquent subculture and lack opportunities to develop pro-social skills, thus going on to present with offending behaviour. This theory suggests increased pro-social opportunities that encourage pro-social behaviours could mean less crime. Pro-social behaviours are actions that benefit others and society; these may be encouraged by engagement with education, an occupation and so on. Since the 1950's, research into offending behaviour has supported aspects of Cohen's theory. Particularly that, anti-social family interaction (e.g. confrontational), negative developmental experiences, and the lack of opportunity to learn skills to problem solve in a pro-social way link with anti-social behaviours (Patterson, Reid & Dishion, 1992).

Pro-social skills are an important element to Hirschi's Control Theory (CT; 1969). Hirschi suggests people behave pro-socially through pro-social learning and self-control, and that four factors enable this: *attachment* to the values of society; *commitment* to society with an understanding of the loss one would experience due to arrest or imprisonment; *involvement* in communities through work, education and so on; and *belief* in the laws of society to promote community cohesion. In essence, if an individual is less engaged with society on these premises, then they are likely to present with anti-social behaviour. To summarise, both theories suggest that modelled and reinforced pro-social behaviours, positive engagement with the community, and self-control are likely to mean less offending behaviours. Lindsay (2005) proposes that pro-social opportunities and integration in the community could be as important as the treatment provided for offenders with a LD. The Good Lives Model for the treatment of sex offenders with a LD (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) resonates with this:

construction of a balanced, pro-social, positive identity for a sex offender is integral to treatment.

### **Rationale for Review**

A review of developments directs future research and provides foundations for service development (Aveyard, 2010). As offenders with a LD have become more prevalent in UK communities, research into community treatment has increased (Taylor & Lindsay, 2010). However, the research area is relatively small compared with secure environments. Therefore, community-based treatments may be innovative and because of this, it is important to review these and their efficacy. A review is also important due to public spending cuts in the UK. Cuts to health, social and forensic services ensued in May 2010, when the new government (Conservative/Liberal Democrat coalition) aimed to rectify a long-standing financial deficit. Multi-agency work is a necessity to address the needs of offenders, but services may be required to do more with less in the context of cuts (Senior & Shaw, 2011). It is not within the scope of this research to evaluate treatment costs, but community services could be in increasing favour, due to the often-higher costs of more specialist services. In light of this, the review is limited to developments in UK communities because the social welfare, health and forensic systems might vary considerably internationally (e.g. In the UK the NHS is free at the point of access).

### **Aim**

The literature review will focus on community-based treatment of adult offenders with a LD in the UK, with attention to recent developments. The review will appraise research validity, reliability, applicability and the proposed treatment efficacy. First, the review methodology will be described and decisions regarding the methods will be outlined with reference to epistemology. Then the results will be presented. Finally, the findings will be discussed in relation to context, clinical implications and recommendations for further research.

### **Method**

The literature search used the primary terms: Learning Disability, offenders and treatment. The following search string was developed with related terms and

used to conduct an electronic search in EBSCOHost: ((Learning Disability OR Intellectual Disability OR Intellectual Limitations) AND (Offenders OR Sex Offenders OR Offending OR Offending Behaviour OR Deviant Behaviour OR Criminals) AND (Treatment OR Intervention OR Support)). Appendix D details a replicable strategy, which includes search terms; search term combinations; search limits; databases searched and detailed inclusion/exclusion criteria. The search was limited to English language peer reviewed articles from 2010 onwards (to February 2013). This omitted some reviews of earlier research in this area (Lindsay et al., 2010; Taylor & Lindsay, 2010). Removing duplicates and excluding research with children and adolescents reduced the initial search results from 90 to 56 papers. A subsequent review of abstracts included only literature concerning adults, which was community-based and situated in the UK, this left seven papers. An additional hand search of issues from the *Journal of Intellectual Disabilities and Offending Behaviour* previously known as the *Journal of Learning Disabilities and Offending Behaviour* (between 2010 and February 2013) identified two additional pieces of literature. These journal issues were searched because the journal directly relates to the subject matter. The search identified nine papers for review. Another hand search of the reference sections in these articles found no other papers. A flow chart of the search is located in Appendix E and Table 1 (Appendix F) provides a summary of the identified papers.

First papers were individually critically appraised using the Critical Appraisal Skills Programme frameworks (CASP; Public Health Resource Unit, 2006) and guidelines outlined by Aveyard (2010), and subsequently, findings were analysed thematically. Critical appraisal broadly considers what the literature proposes, whether this is reliable, valid and applicable. For qualitative papers, attention is paid to the rigour of the methods and whether the results are credible.

As a qualitative method, thematic analysis is rooted in epistemology and this should underpin any decisions about methodology (Braun & Clarke, 2006). Regarding epistemology, the author of this paper assumes a Social Constructionist position. Social Constructionism suggests what exists is what we perceive to exist; knowledge is sustained by social processes (e.g. human interaction) and is influenced by history, society, and culture; knowledge is known as a construction and is linked to social action (Gergen, 1985). Consistent with this, a theoretical thematic analysis was utilised. For this, analysis is driven by a specific question, which was 'what treatment of offenders with a LD takes place in

the community?’ with attention to proposed treatment efficacy. The thematic analysis involved familiarisation with the results/discussion sections in the papers; information related to the review question and the proposed efficacy of treatment was coded; codes were clustered by similar meanings and incorporated into themes; the themes were reviewed after a one-week interval to ensure suitability. The analysis pursued semantic themes related to the historical, societal and cultural background of the literature review question outlined in the introduction. A flow chart of the thematic analysis process is located in Appendix G.

The results section presents an overview of the literature and themes. A critical appraisal follows, which is organised by themes.

## **Results**

### **Overview of Literature and Themes**

The systematic search identified nine pieces of literature for this review. All of the literature concerned treatment that had taken place prior to 2010. All of the papers unless stated otherwise included people with a LD and people with Borderline ability. All studies accounted for dropouts and described replicable treatments/interventions; none are tested in RCT’s. Five studies presented CBT-based treatment group programmes for sex offenders with a LD (Craig et al., 2012; Lindsay, Michie, Steptoe, Moore & Haut, 2011; Murphy et al., 2010; Newton, Bishop, Ettey & McBrien, 2011; Rose, Rose, Hawkins & Anderson, 2012). Two studies developed and evaluated CBT-based groups that enhanced problem-solving skills (Goodman et al., 2011; Lindsay et al., 2011). One study evaluated the introduction of a module that aimed to enhance empathy in LD sex offenders (Michie & Lindsay, 2012). One of the papers presented a focussed social approach to the treatment of offenders with a LD (Olsen & Heaton, 2011).

The thematic analysis highlighted Long-term CBT, Community Integration and Innovative Treatment Components (enhancing problem solving skills and empathy) as effective community based treatments. A small-sample size was highlighted as a limitation in some of the studies because it hindered establishing treatment effectiveness.

## Themes and Critical Appraisal

**Long-term CBT.** Four papers endorsed long-term treatments for male sex offenders with a LD (Craig et al. 2012; Lindsay, Michie et al., 2011; Murphy et al., 2010; Rose et al. 2012). The first study described by Craig et al. (2012) aimed to evaluate a long-term CBT-based treatment group for sex offenders, which lasted 14 months. The procedure, including measures, intervention, and analysis is thoroughly described. Most of the screening/assessment measures are validated for use with people with a LD (e.g. Victim Empathy Scale – adapted; Beckett & Fisher, 1994), apart from the Sexual Attitudes and Knowledge Assessment (SAK; Heighway & Webster, 2007). Participant information was limited to sample size (n=14 men), living arrangements (e.g. independently, probation hostel), offence history, average age and IQ. There was no information about community engagement, except that this was unsupervised and three men had curfew times. With dropouts accounted for, t-test results are published for 12 men and outline some statistical significance. Tables of the results, including insignificant results, are provided with p values. At 12-month follow up none of the men had been reconvicted for a sexual offence, though it is conceded offences may not have been reported to the research team. The researchers reflected on possible confounding factors (e.g. implicit socialisation in group treatment), but do not consider community engagement. The results only show CBT-based treatment is effective, due to the small sample size. In light of this the researchers recommended further research. The impact of flaws (e.g. no control group, limited follow-up period etc.) and funding constraints were considered.

In their study, Lindsay, Michie et al. (2011) advocated long-term treatment of up to 3 years. The research was conducted in a forensic community service providing CBT-based treatment for sex offenders with a diagnosable LD. The data was routinely collected and was not subject to time-limited grants. The study compared treatment process/outcomes for male sex offenders against women (n=15) and male sex offenders against children (n=15). The groups were defined for research purposes; treatment groups were mixed. There was a follow-up period of at least 2 years. Validated measures (e.g. Questionnaire on Attitudes Consistent with Sex Offending; QACSO, Broxholme & Lindsay, 2003) and demographics (e.g. average age) are outlined. However, there is little detail provided about the community engagement for the individuals, except that this is open access. Whether this confounds the results is not considered. Analyses of

Variance and t-test results suggested that scores on the QACSO fell to levels consistent with non-offenders: between 18 and 36 months for offenders against women and at 24 months for offenders against children. The rate of reoffending at follow-up was 23% with no significant differences between groups. The results section is a strength of this paper with p values (set at  $<0.05$ ) and large effect sizes consistently stated. Research limitations are sensitively discussed (e.g. a sex offender control group is problematic) and findings that endorse long-term treatment are embedded into the wider evidence base.

Murphy et al.'s (2010) study is a controlled treatment trial across secure and community sites. The trial entailed a programme underpinned by a CBT approach. Helpfully the researchers provided information about the yearlong procedure and the professionals implementing it (e.g. led by a CP). The trial utilised validated measures at pre/post treatment and at 6 month follow up (e.g. QACSO). Outcomes and quantitative analyses (t-test) suggested treatment is effective across sites. The results also detailed characteristics of the men, including how some engaged with the community (e.g. college). With regard to reoffending, 3 of the 46 male participants committed a further non-contact sexual offence during treatment; none of the men committed a further offence at six-month follow up. A diagnosis of Autism was statistically linked with a likelihood of reoffending. However, Murphy et al. approached this with caution given the small numbers. The researchers acknowledged limitations of their study (e.g. no control group) and advocated further research. The authors also acknowledged problems with further research into long-term treatments, with follow-up period constrained by time limited research grants.

Rose et al. (2012) evaluated outcomes of a long-term CBT-based treatment group for sex offenders. The methods, measures and analysis of treatment process and outcome are thoroughly described. Participant information is provided including, offence history, average age and IQ ( $n=12$  men). The average IQ for this study fell in the extremely low LD range (IQ below 69); all men had a diagnosable LD. There is no information about how participants are engaged in the community, only where they live (e.g. with parents, residential care setting). Statistically significant outcomes from paired sample t-tests are provided in a table of results with P values. Whilst there are significant changes in the pre to post treatment measures (e.g. QACSO), the researchers used a Reliable Change Index (RCI) to combat the difficulties of using t-tests with small samples. For the QACSO 10 of 12

men recorded reliable change post treatment and 9 out of 12 at follow up; there were no statistically significant results at follow up. At 18 month follow up, one man committed a further sexual offence, but three moved to placements where they received less supervision. A critique of the methods and results was offered in the discussion. Therapeutic relationships and community-based treatment were emphasised; particularly the potentially lower cost and autonomy in community-based treatment. However, related flaws are not discussed, even though one man had reoffended.

**Community Integration.** The success of community-based interventions is indicated by two service development papers (Newton et al. 2011; Olsen & Heaton, 2011). The first paper that indicated the importance of community integration concerned The SHEALD Project (Newton et al., 2011). The paper described a CBT-based treatment service for sex offenders; all with a diagnosable LD. Reference is made to a linked paper that provides a helpful context and rationale for the service (McBrien et al., 2010). An assessment process is described that used standardised tests and referenced protocol to ensure people are able to engage with CBT (e.g. Dagnan & Chadwick, 1997). There is no critique of these measures, but analysis between a treatment suitable and unsuitable group found no significant differences. A summary of information about the participants was included (n= 7 men who consented to treatment). This provided details on previous treatment, diagnoses, significant relationships, living arrangements and some information on how individuals are engaged in the community (e.g. college or voluntary work). The treatment, process and outcome measures are outlined (e.g. QACSO). Quantitative analyses were conducted, but results were not statistically significant and not reported. The researchers suggested the small sample size hindered statistical analyses. However, at 12-month follow up none of the participants had reoffended. Other measures of change were summarised: decreased support and increased engagement with the community for some men; feedback from support staff and from those who provided treatments. However, the feedback process was not underpinned by a rigorous methodology. The researchers offered a balanced discussion that reviewed strengths and limitations. Further research was recommended to review increases in community engagement and reductions in support as measures of treatment efficacy.

In their 2011 paper, Olsen and Heaton described a housing-based support service. This focussed on the community integration of offenders with a LD and/or mental health diagnosis, through the development of positive and valued social roles. A thorough rationale and aims for the service were detailed, which were: to support an individual who engages voluntarily, to develop and maintain a tenancy and presence in the community. A case study with positive outcomes was included, which illustrated how the service works. It concerned a woman without a LD, but with diagnoses of Asperger's Syndrome, Depression, and Anxiety. The account followed no rigorous method and neither the authors' epistemological position nor biases are acknowledged. Consequently, the results are questionable and the study appeared biased toward a social intervention. There was minimal reflection on the flaws of the approach; only to a lack of funding that seemed straightforward to rectify. Olsen and Heaton recognised the case study was straightforward and that work with 'high-risk' offenders could present with problems (e.g. community rejection). They proposed how to address some complications, yet did not consider potential weaknesses. Offenders living with a LD were referred to briefly in this section, with regard to difficulties in finding paid employment. Again they proposed how to rectify these difficulties (e.g. social support), with no reference to weaknesses. At the end of the paper, the service is promoted as a success supported by the results from a 2010 service evaluation. Throughout 2 years, 83% of people avoided reoffending and 97% secured a tenancy. The case study and the authors' proposals grounded these results. Olsen and Heaton did not recommend sourcing further results.

**Innovative Treatment Components.** Three studies developed and evaluated innovative components to treatment programmes (Goodman et al., 2011; Lindsay et al., 2011; Michie & Lindsay, 2012). Goodman et al. (2011) described the development of an adapted thinking skills programme for offenders, delivered in the context of forensic community services (Dinani, Goodman, Swift & Treasure, 2010). Reference to an earlier paper outlining these services offered a helpful background. Underpinned by CBT, individuals are supported to develop skills to achieve their goals in a pro-social rather than an anti-social way (e.g. to problem solve). The intervention is outlined in a replicable way: using a module-by-module approach with author considerations to the evidence base and to the needs of people with a LD (e.g. a need for more support to identify/express basic emotions). The success of the intervention is highlighted by two prior unpublished

service evaluations cited by the authors (a focus group with service users; feedback from referrers) and a case study. Helpfully, the authors presented both the strengths and weaknesses indicated by the evaluations. However, the case study illustrated a positive intervention process for one man moving on from offending to community integration. The case study is a description, which is not underpinned by a clear method with author biases disclosed. Whilst the paper reviews why adaptations were made to the programme, it does not consider the possible flaws of these. Goodman et al. emphasised the importance of on-going evaluation and conceded the need for a formal evaluation of treatment effectiveness.

Lindsay et al. (2011) conducted a pilot evaluation on a Social Problem Solving and Offence Related Thinking Programme (SPORT). The programme is based on supporting offenders with a diagnosable LD, to develop skills to deal with risk and avoid reoffending. Measures are outlined and reference was made to a factor analysis of the Social Problem Solving Inventory – Revised measure (SPSI-R). Limited participant information was detailed (i.e.  $n = 10$ , average age/IQ and reason for referral for violent or sexual offences), with no reference to community engagement. A thorough analysis of the results was provided, using Analyses of Variance and t-test post hoc analyses; f-values, p values and effect sizes are stated. The results show that treatment encouraged an approach to problem solving that is more positive and less impulsive. It was duly noted that effect sizes are volatile due to the small number of participants; subsequently a need for further research with a larger sample was proposed. Additional flaws are recognised in a reflective discussion (e.g. assessor bias; short-term follow up).

Michie and Lindsay (2012) introduced a component to enhance empathy to a treatment programme for sex offenders. The introduction considered evidence that empathy is positively related to pro-social behaviour. Participant information detailed all men had a diagnosable LD, but there is no reference to community engagement. Treatment effects were compared between a treatment group ( $n=10$  males) and a control group ( $n=10$  males). The Interpersonal Reactivity Index (IRI; Davies, 1980) was used to measure empathy. An Alpha co-efficient for the measure was calculated (0.71), this was considered low yet appropriate for a small sample size. The researchers conceded there was no examination of the test-retest reliability or validity of the measure. Analyses of Variance and t-tests showed a significant increase in empathy scores between pre, post and 3-month

follow-up. Significant differences between control and treatment groups indicated the empathy component increased empathy. Flaws were acknowledged, with particular regard to reliability and validity.

## **Discussion**

### **Summary of Findings**

All of the literature outlined replicable ways of working with people with a LD who present with offending behaviour. In this regard, these interventions are applicable to other community services providing treatment to offenders with a LD. Treatment developments are adapted CBT-based programmes for groups of mainly male (sex) offenders, which include enhancing problem solving skills and empathy. Researchers endorse that these treatments are long-term (at least 12 months; e.g. Craig et al. 2012), but this can leave follow-up periods restricted by funding (e.g. Murphy et al., 2010). However, results from short-term treatments and short-term follow-ups are questionable (e.g. Lindsay et al. 2011). There are issues in the reliability of quantitative analyses of some of the treatment outcomes: a small sample size is likely to be a confounding factor. Due to small samples sizes and a lack of control non-treatment groups it is difficult to establish treatment efficacy. Nonetheless, reviewed studies report low reoffending rates; this is not comparable across studies due to variations in follow-up (3 to 24 months). Some authors suggest that community integration and reduced support (e.g. moving to less supported accommodation) are also indicators of positive outcome (e.g. Newton et al., 2011). However, community engagement is neither consistently described nor evaluated. Feedback from participants, support staff, and treatment providers is embedded in some of the papers, this provides a helpful illustration of positive outcomes, but is open to researcher bias.

### **Context**

Consideration of the review in relation to the wider context (e.g. including all offenders with a LD) should be approached with caution, because the papers reviewed largely refer to the treatment of male sex offenders with a LD. There are usually higher numbers of male offenders with a LD compared with female offenders with a LD in contact with CLDTs (approximately 20-40% are female, e.g. Wheeler et al., 2009), which is likely to influence the evidence. Women are also

less likely to receive community-based treatment, because offence profiles and subsequent treatment/support pathways can differ between males and females. For example, women may receive secure treatment due to an increased presence of factors like severe mental illness (Lindsay et al., 2004). That said, instances of women offending may be underreported in the community; Wheeler et al. (2009) make this suggestion in relation to an increase in rates of female offenders with a LD over recent years. Therefore, it may be relevant to pursue further research into community-based treatment, which includes women. However, including women in groups receiving treatment is problematic. One reason for this is that females are unlikely to be included in sex offender treatment groups where men may have offended against women, to minimise possible risks (e.g. access to potential victim) and to keep everyone safe. Again, this means females are likely to receive different treatment. Given there may be less numbers of females to form a treatment group due to less female offenders, this could limit the opportunities to review group treatment for female offenders.

Despite the review lacking evidence for the community-based treatment of female offenders, the results do reflect the current status-quo for CBT in society and in the treatment of offenders with a LD (McQueen, 2009; Lindsay et al., 2010). The developments confirm the importance of providing treatment adapted or designed for people with a LD. Moreover, long-term treatment appears to meet the needs of this population. Most of the researchers respond to social policy requirements, by providing rates of reoffending (Lindsay et al., 2010), and whilst these rates are low, few studies identify whether these outcomes are maintained long-term. Indeed, whether any reductions in reoffending relate to treatment is difficult to establish. With few exceptions in the reviewed studies (e.g. Lindsay, Michie et al., 2011), small-sample sizes and a lack of non-treatment controls undermine establishing treatment efficacy. Consequently, other measures of efficacy are utilised in some studies including feedback from offenders with a LD. This reflects the context of sourcing feedback from people who are receiving the treatment. However, this is not in line with rigorous qualitative methods as suggested by Macdonald et al. (2003).

According to the current developments, community integration and reduced support are indicators of positive outcomes. Despite the theories that underpin community-based treatment and the emphasis placed on these by Lindsay (2005), it is not clear how an individual or group is engaged with the community in most of

the reviewed papers. While it may not be within the scope of the papers to do so, the purpose is to describe/evaluate community-based treatments. Therefore, it is surprising that much of the literature does not record community engagement in more detail.

### **Clinical Implications**

Despite problems of achieving statistical significance, the treatment developments remain clinically relevant. The research informs clinicians, working with offenders with a LD, about treatment innovations and potentially useful adaptations. This provides a rationale for research to continue in clinical settings and emphasises the importance for clinicians to publish their work (including audit and service evaluations). Routinely recorded data for research in clinical settings, may address the issues with short-term follow up stressed in this review. However, there may be additional ethical implications (e.g. consent).

The current published developments endorse adapted CBT-based programmes in the treatment of offenders. As stated, a CP or forensic psychologist is likely to be involved directly or indirectly (e.g. via supervision or consultation) in CBT. Given the programmes require adaptations; this would entail training specific to LD and may necessitate multi-disciplinary input (e.g. Speech and Language Therapy). Long-term treatments are also likely to require support from other professions (i.e. support workers to support attendance), but these could present a cost implication to services. On the other hand, social models of support outlined do not demand psychology input. However, if support workers provide social interventions, supervision from qualified staff like psychologists is essential, because of the challenges that working with offenders with a LD might present (e.g. risk to themselves or others; community rejection).

### **Limitations of Literature Review**

The literature search identified a number of other reviews in this area (Taylor & Lindsay, 2010; Lindsay, 2011) which reviewed worldwide developments prior to 2010. Conversely, the remit of this review excluded developments in treatment outside of the UK, prior to 2010. It is possible that these exclusions consist of vital developments, which is a flaw of this paper. Another flaw is the author's reference to context and social constructionism. In the thematic analysis, the author identifies themes in the research in relation to the wider context. While

the author is transparent about epistemology and presents replicable methods, identifying themes relative to context that the author dictates is questionable.

### **Recommendations for Further Research**

Future research endeavours should operate long-term follow-up periods and address whether positive treatment outcomes are maintained. This review encourages clinicians to conduct research, audit and/or service evaluation in their clinical work with offenders with a LD. This should include detailing how individuals are engaged in a community before, after and possibly during treatment. While people are likely to engage in the community in different ways, recording how and evaluating this may indicate what aspects of community engagement, if any, are relevant to the treatment of offenders with a LD. Given the potential for individual differences, it may be important to pursue the perspectives of offenders with a LD and to attempt to include other offenders, not just male sex offenders.

Research that employs methods less affected by sample size are due consideration. Qualitative methods compared with quantitative methods are less effected by sample size and often stipulate a small sample size (e.g. n=6), because it is more conducive to in-depth analysis (e.g. Interpretative Phenomenological Analysis; IPA, Smith, Flowers & Larkin, 2009; Narrative, Atkinson, 2010 etc.). Qualitative methods do not approach data in the same way as quantitative and are unlikely to satisfy the statistics required by social policy. However, the views of people who are in receipt of treatment are crucial to improving interventions and services. Qualitative research that accesses these views or experiences of people in relation to treatment outcomes is a recommendation for further research. As stated by Macdonald et al. (2003), this could complement the quantitative evidence base.

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**Paper 2: Research Project**

**Stories of Offenders with a Learning Disability: why we do/do not reoffend**

**Word Count: 8118**

## Abstract

Offenders with a Learning Disability (LD) may receive community-based treatment to address their offending behaviour. Little is known about the offender's perspective, their experience of treatment and what they consider helps them to avoid reoffending. Using a narrative approach, this paper explores why offenders with a LD do and do not reoffend. Six male offenders living in the community were interviewed. The narrative outcomes propose that offenders with a LD do not reoffend when they fear punishment or loss of something meaningful to them, particularly community engagement and relationships. However, offenders must be able, or have support to make decisions to avoid offending. The research has some issues with bias and is limited to the context/s considered in the analysis. The outcomes emphasise the relevance of community-based treatment, complement quantitative studies, and suggest that we can understand more about offenders with a LD by asking them to tell their stories.

*Keywords: Community, Learning Disability, Offenders, Qualitative.*

## **Key Practitioner Message**

- Offenders with a Learning Disability value meaningful community engagements and relationships.
- Offenders with a Learning Disability need to be able, or have support available to, make pro-social decisions to avoid offending behaviour.
- Long-term support including someone to talk to is vital to offender treatment.

## **Introduction**

Estimates indicate that between 2% and 10% of people who offend live with a Learning Disability (LD; Lindsay, 2011). Jones and Talbot (2010) highlight considerably higher prevalence rates of between 20% and 30% in some UK prisons. In the community, inconsistencies in recording or reporting offending behaviour as such hamper estimations (Wheeler et al. 2009). Difficulties in establishing numbers could mean services are less prepared to respond. However, clinicians and researchers continue to develop an evidence base to understand more about offenders with a LD. This concerns characteristics, assessment, risk and evaluating treatment/support (Lindsay, Hastings, Griffiths & Hayes, 2007; Taylor & Lindsay, 2010). Given much of this research employs quantitative methodology, this paper pursues a need for qualitative research to complement the current evidence base. Using a narrative approach the paper aims to understand more about why offenders with a LD, who live in the community, do or do not reoffend.

### **Learning Disability**

Many individuals included in the estimations of offenders with a LD do not meet the diagnostic criteria (i.e. they are of 'Borderline' ability, having an Intelligence Quotient (IQ) between 74 and 81; Lindsay, Michie & Lambrick, 2010). To meet the criteria for a LD in the UK an individual should have: an IQ score below 70 (below 74 incorporates the appropriate standard deviation); concurrent impairments in social and adaptive abilities; these difficulties have been present since childhood (British Psychological Society; BPS, 2001). Some offenders who live with Borderline ability share similar difficulties to those with a LD (e.g. problems with processing speed; Zetlin & Murtaugh, 1990) and for this reason, they are included in some research and treatment. However, it remains important to make the diagnostic distinction as many specialist LD services exclude people without a LD.

### **Offending Behaviour**

Offending behaviour is conduct that is in contravention of law. For offenders with a LD this behaviour could bring them into contact with the Criminal Justice System (CJS), but it is likely they will receive treatment orders that divert them

away from custodial sentences; this is sometimes due to a lack of appropriate adapted treatment in UK prison services (Wheeler et al. 2009). Therefore, treatment for offending behaviour often takes place in secure or community settings. Community services are either specialist forensic (who meet the needs of offenders with a LD) or generic (e.g. Community Learning Disability Teams; CDLT). The latter meet the needs of most people with a LD who live in the local community.

### **Limitations of the Current Evidence Base**

Social policy and service developments are often contingent on the evidence for effective treatments, which reduce the risk of offending behaviour or the harm resultant from the behaviour. A problem with the research in this area is a lack of Randomised Controlled Trials (RCTs), considered 'gold standard', in tests of treatment (Lindsay, 2011). In addition to the lack of non-treatment control groups, small sample sizes hinder establishing treatment effectiveness (e.g. Craig, Stringer & Sanders, 2012; Murphy et al., 2010). In response to this, some researchers provide descriptions of positive change, which include reductions in support and engagement in the community (e.g. unsupported time to access leisure activities, Newton, Bishop, Ettey & McBrien, 2011). However, what is described is inconsistent across community-based treatment research, is not determined by an explicit method, and may be open to researcher bias. Therefore, it may be questionable to conclude that community engagement, highlighted in this way, is a dependable measure of change. Because of this, descriptions of positive change are unlikely to inform social policy and/or service development despite their possible relevance. Moreover, whether community integration (e.g. attending college) is considered a positive change might be dependent on the individual's rather than the researcher's perspective: the individual's perspective may determine whether community integration and/or treatment helps them to avoid offending behaviour. To understand why people with a LD do or do not reoffend, while mindful of small sample sizes and the lack of non-treatment controls, it may be helpful to implement qualitative methods. As Macdonald, Sinason and Hollins (2003) suggest, analysis of the experiences and views of people who receive treatment may complement quantitative analysis of outcomes.

### **Qualitative Research involving people with a Learning Disability**

In recent years, there has been an increase in qualitative research with people with a LD (Atkinson et al., 2000; Munford, Sanders, Mirfin-Veitch & Conder, 2008; Tuffrey-Wijne, Bernal, & Hollins, 2008). Yet, the views of people with a LD remain underrepresented in research and society (Atkinson, 2010). Atkinson outlines the importance of the life stories of people with a LD, which reflects aspects of reintegrating these individuals in society (e.g. Normalisation; Wolfensberger, 1972). A person with a LD is an 'expert witness' of their life, rather than just an individual who should be cared for. Furthermore, an individual's perspective on culture and the effects of practice and policy on their lives should redress the balance of research into pathology, deficits and so on. Society accepts people living with a LD are a 'vulnerable' population and are more likely to experience social disadvantages, physical disability, mental illness, and loneliness (Collishaw, Maughan & Pickles, 2004; Disability Rights Commission, 2006; Dosen & Day, 2001). In terms of research ethics, these may present as complex issues that require careful attention; e.g. the issue of loneliness in engaging in a research partnership to tell a personal story; the issue of trauma/mental illness in the telling of a story of abuse. However, as Atkinson suggests, not creating an opportunity for an individual with a LD to tell their story, albeit with appropriate safeguards, may greatly limit our understanding.

### **Qualitative Research involving Offenders with a Learning Disability**

Talbot (2009) echoes Atkinson by suggesting the views of offenders with a LD in prison settings are underrepresented. The Prison Reform Trust is aiming to address this through listening to the views of prisoners in the project 'No One Knows' (Jones & Talbot, 2010; Talbot & Riley, 2007). Despite this initiative, there is currently little research regarding the views and experiences of offenders with a LD in and outside of prison. Recent papers include: Macdonald et al. (2003), who conducted an Interpretive Phenomenological Analysis (IPA) on the experience of people with a LD attending two different psychotherapy community treatment groups (one for women, one for male sex offenders) and Isherwood, Burns, Naylor and Read (2007), who conducted an IPA of the accounts of six detained men with a LD, about the onset of offending. The outcomes of the Isherwood et al. paper highlighted predominately social factors in the onset of offending, which include victimisation, vulnerability in relation to peer-influenced offending, and isolation

that led to wanting to fit in. Lastly, Breckon, Smith and Daiches (2013) used Grounded Theory in a secure hospital setting, to develop a model that indicates the perceived readiness of an offender with a LD to engage in psychological therapy. Aspects of the model include stability/predictability and development of relationships with staff.

### **Criticisms of the Qualitative Research**

Given the individual nature of views and experience, qualitative outcomes are difficult to generalise. In the research summarised here, it is possible the outcomes represent a shared experience or view. Therefore, individuals who receive the same psychotherapy treatment, described by Macdonald et al. (2003), may share commonalities in their experiences. However, it is likely group dynamics may create difference (Holmes, 2010). Notably, O'Brien et al. (2010) suggests caution in generalising outcomes, in that where the research takes place can hamper this (e.g. secure units, community). For example, the characteristics of offenders with a LD who live in the community may not match the standard profile of people living with a LD who offend and access services (e.g. young male, substance abusing). Wheeler et al. (2009) found that of 237 referrals to community services, there was near to an equal number of men and women referred. Because of this, and individual/group differences there is a need to conduct further research in different settings.

There is the potential to repeat IPA studies like Isherwood et al. (2007) in the community. This may begin to address some of the difficulties in generalising findings. However, despite the recent popularity of IPA and its strengths (e.g. in depth analysis for small sample sizes, Smith, Flowers & Larkin, 2009), there are limitations. In the main, IPA is less concerned with context than it is with the individual's perspective, which it suggests exists permanently in an individual. Conversely, other approaches suggest a perspective (or narrative) is co-constructed between an interviewer and interviewee (i.e. the perspective or narrative exists when it is constructed, e.g. Narrative method; Squire, 2008). In Narrative method, the analysis considers the interviewer and interviewee's contexts, which influence the co-constructed narrative. Analysis also considers wider influences of historical, social and cultural contexts. Attention to context in this way is not an aspect of IPA, but could be vital in research with offenders with a

LD, because context is likely to have an effect on many aspects of their lives (e.g. diagnoses, treatment pathway and treatment availability).

### **Rationale for the Current Research**

Conducting qualitative research with offenders with a LD, living in the community, will complement the current evidence base. The research should ask offenders with a LD about why they do and do not reoffend. Since no existing publication addresses this, outcomes could inform the development of support services and social policy. Qualitative methodology should be sufficiently robust and consider the influence of context (e.g. research, historical, social and cultural). The method should also consider the role of the researcher in co-construction of a perspective or narrative. Outcomes of this research may be of interest to those with current investment personally, clinically, socially and politically in offenders living with a LD.

### **Research Question**

The research question is:

- What factors influence whether or not offenders with a LD living in the community go on to re-offend?

### **Research Aims**

This research aims to:

- 1 Explore the reasons why offenders with a LD living in the community do or do not reoffend.
- 2 Establish what themes relative to context/s (outlined in Table 1, see page 47) are common across the offenders' stories/narratives.
- 3 Develop psychological theories about why offenders with a LD do or do not reoffend.

## **Method**

### **Narrative Method**

**An Overview.** Narrative method is concerned with the stories people tell about events or experience. The underpinning theory suggests that human lives

are lived through the making and exchanging of stories (Murray, 1999). Narrative researchers seek to listen to these stories in single case, small and large cohort studies. There is no recommended sample size for research endeavours, but the analysis should reflect the overall number of participants (e.g. a single case study requires a more in depth analysis; Squire, 2008). Narrative researchers also seek to understand the narratives of stories in a number of ways, including in relation to content and/or structure. Researchers suggest the method should stem from the researcher's accepted definition of what a narrative is and the assumptions linked with this. This process serves to outline a replicable method, but relative and interacting factors mean methodological details are unique to the research conducted. The factors include the research context, the researcher's epistemological position and the researcher-participant relationship. The researcher should present these factors justly, openly and in a reflexive manner to enable the reader to judge the research on its value to them and then the wider evidence base.

**Pursuit of a Narrative Method.** The current research is interested in why offenders with a LD living in the community do or do not reoffend. The interest is in the experience of the offender (e.g. why they avoid reoffending), rather than in a specific event (e.g. an offence). Therefore, the following definition and linked assumptions proposed by Squire (2008) fit with the research question and aims.

**Accepted definition and linked assumptions.** Squire (2008) defines narratives as stories of experiences, which are often general (e.g. the experience of breaking the law), with less focus on an event in time (e.g. what happened when you were arrested for arson). The assumptions linked with this definition suggest narratives are meaningful and sequential (linked by theme rather than structure: beginning/middle/end or clauses); unique to humans in the way they make sense of an experience; re-represent and reconstruct experience, in that the story is not told in the same way twice; and signify personal changes through transformation, which is the audience's interest in a good or better story. Using an illustrative example 'the experience of breaking the law', full descriptions of the linked assumptions are located in Appendix H.

**Understanding in Context.** Related to the definition and assumptions, Squire suggests that understanding experience-centred narratives takes place within a social and cultural framework. For the 'experience of breaking the law', consideration would be given to research evidence regarding breaking the law,

laws and policy. This is not an exhaustive list of considerations in relation to the example and those considered in research are dependent on the researcher and research context.

### **The Current Research**

**The Researcher.** The researcher is a Clinical Psychologist in training, who has worked in many community settings in clinical and research roles with people with a LD. This has involved work with offenders with a LD and those with a LD at risk of offending. In the current research, the researcher may benefit from knowledge and experience of work with people with a LD. However, it is crucial the researcher remains aware of biases that knowledge and experience may create.

**Social Constructionism.** The researcher holds a social constructionist position. Social constructionism suggests that knowledge is what we perceive to exist; is known as a construction; is influenced by history, society and culture; is sustained by social processes (e.g. human interaction) and is linked to social action (Gergen, 1985). For the current research, this position assumes the social process of storytelling in an interview constructs narratives. These narratives are dependent on the contexts of the interviewee and the interviewer (researcher), history, society and culture of offenders with and without a LD. Table 1 (see page 47) outlines this contextual information: these are contexts decided by the researcher in relation to the wider evidence base. To limit the contextual considerations in this time-limited study, selection of participants is restricted to one local service.

Table 1

*Contexts considered in the Narrative Analysis*

Context	Example
Learning Disability (LD):	
Cultural	Diagnosis
Historical	Deinstitutionalisation; Normalisation
Social	Policy
Needs	People with a LD are more likely to suffer with mental illness
Offenders with/out LD:	
Theories	Cohen (1955); Hirschi's Control Theory (1969)
Characteristics	Gender; Criminogenic needs e.g. anger; drug addiction
Management	Prison; Inpatient; Community supervision
Treatment	Pathway; Availability; Cognitive Behavioural Therapy (CBT, e.g. Stop and Think); Length; Community Integration; Psychology; Psychiatry
Offender Support networks	Family; Friends; Social provision
Current Research:	
Researcher	Clinical Psychologist Training; Social Constructionism
Service Context	Community Learning Disability Team; Specialist Professionals

**Ethical Considerations.** The research project was peer reviewed and sponsored by Keele University (Appendices I & J). NHS Ethical approval was granted by the National Research Ethics Service (NRES) Committee West Midlands – Coventry and Warwickshire (Appendix K). Permission to conduct the research was provided by a West Midlands based NHS Research and Development department. For the protection of participant identity this permission is anonymised (Appendix L).

**Service Context.** A CLDT based in the West Midlands provided access to potential participants. At the time of the research (2013), the CLDT consisted of Psychiatrists, Associate Specialists, Clinical Psychologists, Counsellors, Nurses, Occupational Therapists, Speech and Language Therapists, Physiotherapists, Assistant Psychologists/Practitioners and Health Care Support Workers. The team worked in collaboration with other agencies including Social Services (Community Nurses and Social Workers). Prior to this research, specialist teams were in place across the CLDT and Social Services to meet the needs of people with a LD who offend or are at risk of offending. Due to funding reductions, many of these teams were disbanded. However, professionals in the CLDT and Social Services continued to work in collaboration.

**Recruitment.** Opportunistic sampling was used to recruit participants, in adherence with the inclusion and exclusion criteria.

***Inclusion Criteria.***

- Individuals who meet the criteria of a LD diagnosis (i.e. BPS, 2001).
- Individuals who accessed LD services to reduce their risk of offending.
- Individuals aged 18 to 65 years.
- Individuals presumed to have capacity to consent.

***Exclusion Criteria.***

- Individuals aged 18 and over in full-time school education, because these individuals do not receive a service from the CLDT.
- Individuals in current contact with the CJS for an offence (e.g. on bail).
- Individuals who presented a risk to themselves or others.
- Concerns about an individual's capacity to consent (e.g. an individual struggles to retain information), which were highlighted in a review of

their capacity to consent conducted by a Clinical Psychologist (Gate Keeper to the research).

A Clinical Psychologist in the CLDT (Gate Keeper) sent invitation letters to a consent meeting with the researcher (Appendix M), to potential participants. The invitation letter welcomed participants to attend the meeting with support from a professional, family member, friend or advocate, if they so wished. Enclosed with the invitation letters were slips to opt in to the consent meeting (Appendix N). Individuals who opted in were sent a letter proposing a date for the consent meeting (Appendix O). At the consent meeting, potential participants were provided with a standard and accessible information sheet (Appendices P & Q). The researcher provided support to read the information sheets if needed. Potential participants were asked to initial a consent form to confirm whether they would like to take part in the research (Appendix R); the researcher used a list of consent form prompts to inform this process (Appendix S). Consent was also sought for the Clinical Psychologist to supply some demographic/offence related details about the participant (Appendix T); this process ensured the accuracy and consistency of the information. The details were required to establish any possible risks to the researcher and the relevance of the research in relation to the current literature. An interview date was agreed with those who consented to participate and an interview letter was sent to confirm this (Appendix U). At this point participants were given a number to protect their identities (e.g. Participant 1). The staged consent process described here enhanced the participants' capacity to consent with due consideration to issues of: improving understanding, retention, and ability to communicate a decision (Arscott, Dagnan & Stenfert Kroese, 1998; Cook & Inglis, 2008; Inglis & Cook, 2011).

**Participants.** Of 21 invitation letters, five individuals declined the invitation, seven did not respond and nine agreed to meet with the researcher. Of the nine, eight men attended the initial meeting and consented to take part in the research interview, two of these later declined. Six men were interviewed. Five of these men consented to the Clinical Psychologist sharing demographic information; four men consented to the sharing of offence related information. In relation to possible risks to the researcher, the two men that declined to share offence related information chose to have support/supervision from a Support Worker/Counsellor during their interviews. For the other four men, two were interviewed alone and two chose to have support from a Support Worker/parent. Participants who had support present,

chose to have what their support person said included in the interview recordings/transcript.

**Demographics.** All of the six men interviewed lived in the community, five had unsupervised community access and one man disclosed at interview that he had supervised community access. For the five men that consented to the disclosure of demographic details the age range was between 19 and 46 years with an average age of 34 years. The index offences of the five men included fire setting, theft, violent and sexual offences. All of these offences necessitated police involvement and two of the five men received treatment in a secure unit. For some men there were more recent, less serious, offences (e.g. criminal damage). The period since the last offence ranged between 1 and 10 years, with an average period of 4.5 years. All of the six men had received support from CLDT psychologists/counsellors to try to reduce their risk of offending (one man disclosed this at interview); four men received support from CLDT psychiatrists. Other support included generic drug and alcohol counselling and community based support from the Local Authority.

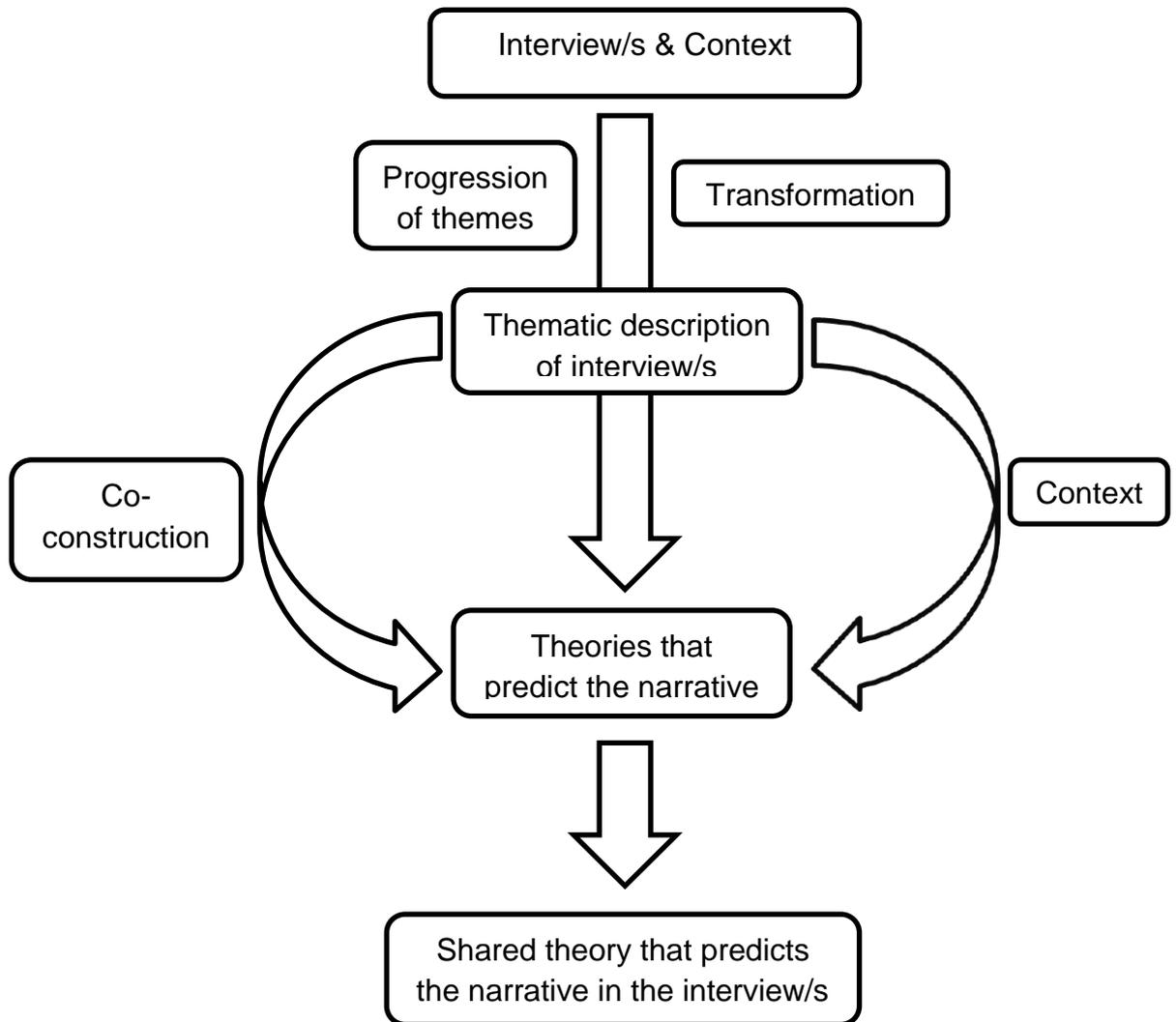
**Procedure.** The researcher collated and summarised demographic and offence related information. On the interview dates, the researcher confirmed consent with each participant (Appendix R). Then participants were interviewed using a list of prompts consistent with the method proposed by Squire (2008; Appendix V). The list is sensitive to difficulties in understanding, with suggestions of alternative prompts with the same or similar meaning. The researcher was an active participant in the interviews (Holstein & Gubrium, 1995); using the prompts to encourage participants to expand on narratives in their stories (e.g. 'tell me more about that'). The researcher also summarised and confirmed detail provided by the participants. Each interview was audio-recorded and subsequently transcribed; any input from the support worker or family member was also recorded. Interviews lasted between 9 and 36 minutes with an average length of 22 minutes. At the end of the interviews, participant numbers were confirmed. For the analysis, these numbers were transformed to pseudonyms.

**Narrative Analysis.** Interviews were analysed using a narrative approach defined by Squire (2008). Firstly, interview transcripts were described thematically individually and collectively; Appendix W provides an example of this. The themes related to the context/s outlined in Table 1 (see page 47). Throughout this process, attention was paid to the progression of themes in the interviews (i.e. how

narratives developed), and aspects of transformation (i.e. the researcher seeks a positive/life changing story). An independent peer crosschecked highlighted themes and thematic descriptions for validity. Then thematic descriptions were analysed and theories were developed that provided a predictive explanation/s to the interviews. A hermeneutic circle (Figure 1, see page 52), as per Squire (2008), was used to move back and forth between the interviews and context/s to find more evidence for these emerging explanations. Again, the context/s outlined in Table 1 (see page 47) were considered. The hermeneutic process aimed to provide a fuller understanding of the narrative by embedding it into context and by paying specific attention to the progression and co-construction of the narrative and elements of transformation. The analysis lasted one month and was completed when a theory was developed that explained the narratives across the interviews.

Figure 1

*Narrative Analysis: Hermeneutic Circle*



## Results

### Individual Stories

Individual stories are told using verbatim quotes from the interviewee, which are italicised. Pseudonyms or initials represent the interviewees (e.g. Fred: F; Jamie: J, etc.). Interjections by the Researcher (R) are noted when transformation occurs i.e. the Researcher seeks a positive/life changing story. Brackets and ellipses highlight additional information or omissions respectively (e.g. Researcher prompts). Themes that emerged from the analysis are highlighted in square brackets, as they appeared in the interview. These relate to the contexts listed in Table 1 (see page 47). The stories of Fred and Jamie are detailed and the stories of Rueben, Herbie, Patrick and Bob are in Appendix X. Fred's story shares many aspects of the stories in the Appendix; Jamie's story has some differences.

**Fred's Story.** Fred does not reoffend because: *F: I've changed me life umm I don't go out drinking no more, only if I go to weddings like with me family [...] Uhh I don't mix around with the other people uh the wrong people no more Um I'm a different person [...] Umm I did a lot of work on the treatment programmelum not to reoffend again if I did the court said they chuck the the uh they chuck the key away and I'll be in for life next time if it happens again/so it did sh\_/it did scare me a little bit when he said that/and now I changed I'm a different person I've moved on from that um and that's it [Stop and Think/Fear of Consequences]/F: I've got a girlfriend now see and that's made my life a bit better [Relationships]/F: yeah [laughs] yeah I'm a busy bee me now/yeah it keeps me mind occupied saves me being bored as well/yeah I was bored in the past, I didn't have nothing to do I didn't have no job to go to and all that/and now I've got college and work experience and gardening what I'm doing at the moment that's made me feel quite chuffed with meself/R: you feel quite chuffed with yourself?/F: yeah I'm proud of me self/R: and what are they like to feel? Chuffed and proud?/F: happy I can get a job in the near future/R: yeah/F: um just keep on thinking forward instead of backward that's what I'm thinking [Community Integration].*

**Jamie's Story.** Jamie tells a story supported by his Mum (M), he does not reoffend because: *J: cannabis has actually helped my life more than anything [...] /M: it does calm him down [Maladaptive Coping]. J: I'd rather go raving than I would clubbing/cause alcohol turns people into assholes/OK/M: You've met a lot of people going to raves and they've never took the mickey out of you or nothing*

*have they?/J: no/M: they've always been you know and you keep in touch with them don't you?/J: yeah you meet people from all over I went to (rave)[...]/everyone's on the same level that's why/M: they don't know him do they either they don't know what's in the past is the past they don't know 'cause it's past[...]/they take you for who you are don't they Jamie?/J: I prefer to mix with people that are on the same level as me don't I? [...] I can count my mates on me hand though can't I?/M: you can now yeah [Relationships/Community Integration]. M: I mean you've got to admit since you've seen (Clinical Psychologist) and (Psychiatrist) and you've understood what was wrong for all these years and you've accepted it a lot better and you understand it more now don't you because it does help talking to (Clinical Psychologist) doesn't it?/J: yeah it does help talking to (Clinical Psychologist) [Someone to Talk to]. J: don't get me wrong like yeah I've done some things that are illegal [...] to make a bit of money I did start selling cannabis for a while/yeah it did yeah believe me I did make a fair bit of money didn't I?/I was happy I was happy doing it got to do it to me mates like know what I mean and therefore I'm not hurting no one and then I got jumped like by 15 (people) with me mum like which is when I stopped doing it/R: mm OK and you don't do that anymore?/J: no but I would go back to doing it any day of the week 'cause the money is brilliant/R: so what stops you from doing that?/J: putting my Mum and Dad in danger/R: so you don't want to put Mum and Dad in danger anymore?/J: no/R: that sounds like a really good idea actually/ [Fear of Consequences/Relationships]. R: yeah so what you've said to me here, I'll just go through the things to check that I've got it right things that keep you out of trouble is taking cannabis, going to raves, having good mates that you can count all on one hand/J: yeah/R: um it helps talking to (Clinical Psychologist)/J: mm [...] M: if it hadn't of been for (Clinical Psychologist) and (Psychiatrist)/J: I wouldn't be here/M: and our GP I do not know/J: I wouldn't be here plain and simple/M: I don't know what'J[...] have happened/J: I'd have topped meself a long time ago and I've tried it a few times and the hard and the hard the one thing I go through a lot [Someone to Talk to/Long-Term Support].*

### **Collective Story**

Male offenders with a LD living in the community do not reoffend because they fear the consequences. These consequences may be direct like punishment or indirect like effects on family members or victims. To avoid reoffending, men

keep busy by engaging in enjoyable activities in the community, they also have someone to talk to (e.g. Psychologist/Counsellor or carer). This helps the men to manage feelings like anger, to think about the effects of offending, and/or to problem solve. Problem solving using treatment protocols like 'Stop and Think' mean the men can, independently or with support, make decisions to avoid reoffending. On-going and long-term support from services is a valuable resource, but there is a need to balance this with increased independence. The men also value and strive for improved relationships with family members and/or new relationships with friends and partners. Some men continue to avoid reoffending by using maladaptive coping strategies like smoking cannabis.

### **Emerging Explanations for Narrative**

Offenders with a LD who live in the community do not reoffend because they:

- fear the consequences of their offending behaviour e.g. effects on victim/family; punishment; personal losses of relationships and community integration.
- are integrated into the community through activities they enjoy. These activities have elements of autonomy and keep them busy.
- have someone to talk to help them to avoid reoffending (e.g. carer/Psychologist/Counsellor); they are able to stop and think before they act with/without support.
- are able to manage difficult feelings with/without support.
- have long-term treatment/support available.
- have improved relationships with family and they are able to make new friends.
- are aware of the risks of maladaptive coping strategies e.g. drug taking.

### **Predictive Explanation for Narrative**

In this instance, offenders with a LD who live in the community, share a narrative that they do not reoffend when they fear punishment or loss of something meaningful to them. Therefore, if an offender is engaged in meaningful community integration, relationships and support, in that they would not risk losing it, then this

could mean they are less likely to reoffend. However, the offender must be able, or have support to make decisions, which helps them to avoid offending behaviour.

## **Discussion**

### **Summary of Findings**

Analysis of the interviews indicates community integration, improved and new relationships, long-term support (including someone to talk to), insight and ability to manage risks/feelings are themes in a narrative for six male offenders with a LD, which could mean they are less likely to reoffend. Interestingly, fear of consequences is an overarching theme to the narrative: indirect consequences to the victim or victim's family and more prominently direct consequences to the individual (i.e. of punishment or personal loss). This could mean the six men avoid reoffending because if they offend, they perceive loss of something with a personal meaning. While there are individual differences in this, collectively personal meaning for the six men exists in community integration (e.g. activities with friends or college) and improved or new relationships (e.g. family or friends). Therefore, offenders with a LD are less likely to reoffend when they are integrated into the community and have meaningful relationships. Consideration is due to the wider relevance of these outcomes, despite the small sample size, particularly given the attention paid to context throughout the analysis.

### **Context and Theories**

The collective narrative reflects the current trends for community based treatment and support of offenders with a LD (e.g. Newton et al. 2011; Craig et al. 2012 etc.). Due to the varied offence profiles, this is not limited to sex offender treatment, which is common in other research papers. The community element of this treatment/support is a prominent aspect of the narrative. For five of the six men, they look forward to engagement in the community in pro-social ways (i.e. ways that benefit others and society): attending college, activities with friends, dog walking etc. The men keep busy by doing things they enjoy. Some of the men interviewed have trouble with aspects of community engagement (e.g. being kicked out of college), and emphasise a need for support to manage these problems. Bob said, "well (Counsellor) like helps me to try and calm me down things like help me with my behaviour [...] like I don't wanna get in more trouble

with like college and get kicked out and that” (Bob’s story, Appendix X). This echoes possible problems of integration for high-risk offenders and offenders with a LD described in Olsen and Heaton’s (2011) paper (e.g. community rejection, finding paid employment etc.). Although collectively the men value support, they also value and strive for autonomy. Balancing support and autonomy is due consideration in relation to risk, which also balances the rights of the offender with the rights of society (Beail, 2010).

Community engagement in the stories is largely pro social. However, Jamie’s story shows he engages in drug taking and raving/clubbing, which society might suggest is anti-social. Jamie appears to balance the risks of this with the consideration he manages his mood (i.e. chills out) and has new, positive relationships (i.e. with people who do not judge him and do not know his past), which help him to avoid reoffending. Improved and new relationships are another prominent aspect of the narrative. This is a thought-provoking finding, because evidence points to accessing, initiating and maintaining relationships presents with difficulties for some people with a LD (McConkey, 2010). Notwithstanding, it is not surprising that the men, in avoiding offending behaviour, had or sought better relationships, given anti-social relationships and isolation are linked with offending behaviour (Isherwood et al., 2007). Fred said “I’ve got a girlfriend now see and that’s made my life a bit better” (Fred’s story). Yet, it is the potential loss of these better relationships and afore-mentioned community integration that deters these men from reoffending.

Loss and punishment is something that requires more attention. Since deinstitutionalisation, society has improved community access and opportunities for people with a LD, including those who offend (Olsen & Heaton, 2011). As stated, community integration is something valued by the men who avoid reoffending. The stories suggest that the current level of community engagement and improved/new relationships was not present for the men before and during their offences. Fred said “I’ve changed me life” (Fred’s story) and Herbie reflected, “I did have a few friends but they weren’t like proper friends” (Herbie’s story, Appendix X). This indicates the men offended because they were not involved in the community through activities they enjoyed and had poorer relationships. This coheres with early theories proposed by Cohen (1955) and Hirschi (Control Theory; CT; 1969), which theorise the development of offending behaviour. In summary, they propose that if pro-social behaviours are modelled and reinforced,

there is positive engagement with the community, and people have self-control, then there is less offending behaviour. For Cohen, increased pro-social opportunities are paramount to this. For Hirschi, four factors enable this: *attachment* to societal values; *involvement* in communities; *belief* in societal laws; and *commitment* to society and understanding of the personal losses likely due to arrest or imprisonment.

The research outcomes also cohere with Social Learning Theory (SLT). This theory suggests that an individual learns within a social context through the observation of others' behaviour and the rewards and punishment they may receive (known as vicarious reinforcement; Bandura, 1977). Whether an individual models the behaviours they observe, is dependent on the interaction between the context (e.g. access to the community; ability to influence their own environment), the individual's skills or self-efficacy, and personal factors like attitude, knowledge and motivation. For example, the men in the current research might observe pro-social behaviours like others succeeding and receiving praise on college courses; have access to college and the ability to engage in courses, and have a positive attitude towards attending college. Therefore, the men learn and model pro-social behaviours (e.g. attending college) meaning community engagement helps them to avoid reoffending. To illustrate access and attitude, Fred said "now I've got college and work experience and gardening what I'm doing at the moment that's made me feel quite chuffed with meself" (Fred's Story). SLT could also explain the fear of consequences or loss that might result from offending, highlighted in the narrative. If behaviours change through the interaction of the factors discussed, then negative reinforcement, like punishment, is unlikely to result in a direct change in behaviour. Therefore, if the men interviewed have the knowledge that they will experience loss through offending and the skills to behave in a pro-social way, then according to SLT, they could avoid reoffending.

The stories suggest the men understand consequences of offending behaviour through contemplating personal consequences and/or the effect for others (e.g. the victim). Some men displayed empathy, which is linked to pro-social behaviours (Michie & Lindsay, 2012) and others used treatment protocols like 'stop and think'. The latter enables the men to consider the conceivable consequences to their actions (e.g. go back to the secure unit; lose friends etc.) and then to make a pro-social decision and avoid offending (e.g. do not set a fire). Rueben said "I've learnt all my risks and everything what what I might come up

against or so if anything happens or anything how can I control that/and how to control the situation that I'm in" (Rueben's story, Appendix X). Predictably, ability to problem solve in a pro-social way is linked to reductions in reoffending (Lindsay et al., 2011). While some of the men recall this skill from previous treatment, all of the men describe talking through this process with a LD trained worker (e.g. Support Worker, Psychologist/Counsellor). The men also describe having someone, again a LD trained worker, to talk to about difficult feelings (e.g. anger). Where anger is present and relates to anti-social behaviour, they refer to support from a Clinical Psychologist/Counsellor. Patrick said "coming to the appointments (Clinical Psychologist) [...] stops me from being angry" (Patrick's story, Appendix X). Someone to talk to that is trained, 'stop and think' and make different decisions, and manage difficult feelings are elements of some treatment programmes underpinned by CBT (e.g. Murphy et al., 2010; Lindsay et al., 2011). This aspect of the narrative reflects the status quo for CBT in the treatment of offenders and in society. Relative to having someone to talk to, the men valued long-term support, which is something that helps them to avoid reoffending. Given at least four of the men continue to work individually with a Psychologist/Counsellor at least one year after their last offence, this emphasises the need for long-term specialist support/treatment. In line with current programmes, CBT adapted or designed for offenders with a LD could inform this support/treatment. It is important to consider the likely clinical and cost implications of this, in order to develop services to provide this long-term, adapted support/treatment.

### **Clinical Implications**

As discussed, the research reflects and provides evidence for some community-based treatment developments. It also adds weight to the use of holistic programmes, which address multiple factors that support offenders with a LD to avoid reoffending (e.g. Lindsay 2009; Murphy et al., 2010.). Nevertheless, it may be helpful to review these in light of this research. The predominant therapeutic approach in models is CBT; this requires trained professionals and adaptations for people with a LD, which necessitates further training or collaboration with other professionals (e.g. communication aids from Speech and Language Therapy). Trained support workers, nurses, psychiatrists and psychologists may provide CBT, but due to the challenging nature of work with offenders with a LD, workers should have available supervision and consultation

from qualified professionals (e.g. clinical psychologists; Whitton, Collinson & Adams, 2013). Supervision and consultation are likely to keep down costs for the long-term support/treatment advocated. However, there is a need for direct, long-term or at least available psychological support, emphasised in the stories. Psychologists/counsellors are usually better equipped to meet the complex needs of offenders with a LD, including clinical needs related to difficult feelings and illicit substance use, again emphasised in the stories. Possible links between these factors and mental health issues (Frisher, Crome, Macleod, Millson & Croft, 2005), and the increased likelihood of someone with a LD experiencing such issues is a clinical concern (Dosen & Day, 2001).

Contrary to mental health, community engagement is often outside of the clinical remit. This is because clinicians have little influence over opportunities available to offenders with a LD. Yet, it is clinically relevant since a lack of meaningful engagement could compromise treatment outcomes: whether an offender avoids reoffending. Ultimately, an offender with a LD will determine what community engagement is meaningful to them. However, clinicians could educate offenders on how pro-social choices can benefit themselves and others. Consequently, this might improve relationships with others. Treatment programmes that integrate the Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) assist this. The GLM supports offenders to make 'good life goals' that contribute to society in pro-social ways. Through re-evaluation of their lives, setting good life goals, offenders reintegrate into the community. In addition to the GLM, clinicians could liaise with social services to increase community opportunities and then to enhance the offender's ability to access and manage these. Here a clinician could use CBT and strategies like 'stop and think' that stress the consequences of offending behaviour. Consequences should mirror losses perceived by the offender, relative to their experience (e.g. loss of friendships, favoured activities etc.) as per the research outcomes, not just imposed consequences from the CJS.

Despite treatment and support, offenders with a LD can experience problems with community engagement (e.g. difficult relationships and community rejection like being 'kicked out of college') as highlighted in this study. This could mean an offender is less likely to avoid reoffending, because they have nothing meaningful to lose. CBT and the GLM are predominantly individual or group based therapies that are unlikely to tackle these wider issues. Therefore, other

approaches are due clinical consideration. Community Psychology approaches involving therapeutic work supporting communities to manage and/or accept ex-offenders and Systemic approaches involving family work to address difficult relationships might be beneficial. Without this, clinical interventions and offenders with a LD alike may be set up to fail. Clinicians should also consider the increased risks associated with community integration for some offenders with a LD. The men interviewed had not reoffended for at least one year, but for some men they had committed other offences since their index offence. Whether these took place in the community is unknown, yet it highlights the need for risk assessment to minimise chances of reoffending. Overall, risk assessments should assess community engagement, autonomy and appropriate support for the offender balanced with the rights and safety of society. To establish whether these elements are assessed it is important to review the risk assessments used with offenders with a LD living in the community.

### **Methodological Strengths and Limitations**

Foremost, the short length of the interviews limits the narrative outcomes. It is possible to describe the stories in this paper as narratives of experience, but they represent merely a snapshot of experience. It is usual for interviews that inform narratives to be longer or revisited, to allow a narrative to develop (Squire, 2008). Despite this, the current time-limited study provides a good grounding in narrative style research with offenders with a LD, which could be revisited in further research with the same participants. As stated in the linked assumptions section (Appendix H), narratives re-represent experience and are not told in the same way twice, which undermines the reliability of the research. Moreover, the interviewer and potential audience have an effect on the narratives. Given the researcher is a Trainee Clinical Psychologist working in the CLDT, even with no conflict of interest as a participant's therapist, this could mean the interviews were more or less positive depending on what the men wanted the CLDT to hear, or indeed the wider readers of this paper. Gilbert (2004) terms the former as 'professional surveillance'. It is challenging to remove dynamics, but the researcher could have conducted research in another CLDT. In addition, the men were accustomed to talking therapies and were not obliged to tell the truth, which could skew the narrative because the men may have presented themselves as individuals who behave pro-socially, when they actually behave anti-socially.

Relative strengths to a CLDT professional acting as a researcher include familiarity and sensitivity to the participants' context and needs (e.g. impaired understanding, communication etc.). For example, to enhance understanding, the researcher used a schedule of prompts that provided different ways to ask the same question (Rogers, 1999). This also enhanced rigour as the same schedule was used for each participant. The researcher followed recommendations to crosscheck meaning during the interviews with the men and with a carer/support worker if present (Atkinson, 1997). In further research, separate interviews with family/carers could enhance this process. Unfortunately, the men/carers did not crosscheck a full transcript, which is usual in other qualitative methods; an independent peer who also checked elements of the analysis for relevance checked these. Where this falls short of triangulation, it limits the influence other researchers, their context/s and biases may have on the research. Not allowing a participant to endorse transcripts and subsequent analyses, might mean there are mistakes in transcription and conflict in interpretation. The ethics of interpretation is a problematic issue, as the researcher cannot wholly appreciate what it is like to be an offender with a LD.

The researcher biases the interview process and subsequent narrative, particularly using transformation. While seeking a good story is a legitimate element to narrative research, it is questionable for whom this serves. As stated, some aspects of Jamie's story are potentially anti-social (i.e. going to raves and drug taking), yet new relationships and feeling chilled are pro-social aspects and help him to avoid reoffending. It is not the remit of this paper to establish whether Jamie's level of drug taking is classed as reoffending, indeed at some level it may be. Nevertheless, for Jamie drug taking that leads to him chilling out is linked to a reduction in his reoffending. It is possible Jamie's story has pro social elements (e.g. new relationships) because the researcher sought them. It is difficult to ascertain this without a more in-depth analysis of the co-construction and perhaps the language in the interview. However, co-constructing a story that is pro-social and more acceptable to society could benefit Jamie, but this is a dubious claim. The researcher also biases the context/s outlined in Table 1. Despite making explicit how these were determined, the list is not exhaustive and it is debatable whether offenders with a LD would recognise or have access to these contexts, which questions their relevance. In addition, the researcher's social constructionist

view that stories are society's constructs might mean true individual meaning is lost to a contextual understanding.

It is difficult to generalise the results from the research for a number of reasons. As O'Brien et al. (2010) caution generalising in relation to the research setting, there are also issues related to gender bias and the small sample size. The focus of this research is community-based and involves only six male offenders with a LD, so the results may only tell us more about these individuals. Nevertheless, the outcomes outline a collective story and a predictive explanation to the narrative, even though the men told different stories and differed in characteristics like age, index offence and treatment pathway. Therefore, the outcomes could resonate with other offenders with a LD and in other settings; validity is contingent on this, regardless of directly asking offenders with a LD about why they do and do not reoffend. The analytic process embedded the narrative/s into context strengthens this suggestion, but due to there being more men than women with a LD who offend, this is gender biased. Given the study did not include women; the outcomes may only resonate with other men or services working with men. Including women in research akin to this would be a vital development.

## **Conclusion**

Embedded into context, the narrative and predictive explanation adds further weight to the proposition: pro-social opportunities and integration in the community could be as important as the treatment provided for offenders with a LD (Lindsay, 2005). The outcomes complement quantitative studies regarding community-based treatment, but perhaps tell us why the community element is important. Although there are limitations, this is an innovative piece of research that suggests we can understand more about offenders with a LD by asking them to tell their story.

## **Recommendations for Further Research**

In addition to the further research recommendations stated, it might be helpful to understand what community engagement opportunities are available to offenders with a LD. This research should involve consideration to opportunities to improve or encourage new relationships. It may be helpful to routinely record

information for research purposes, particularly given the small number of offenders with a LD and the long-term support they need.

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**Paper 3: Reflective Review**

**Overcoming the Barriers to Completing a Thesis: It is worth it!**

**Word Count: 2505**

## **Summary**

This paper offers a reflective commentary on the process and completion of a research thesis. Overcoming the barriers to completion is the focus of the commentary. Wider, professional and personal considerations add to the discussion.

## **Introduction**

Conducting a thesis is one element of a doctorate in Clinical Psychology. While some trainees seem well equipped to complete a thesis (i.e. academically), no amount of preparation will fully equip them for the barriers they might struggle to overcome. This commentary offers personal reflections on the conduct of this thesis: 'I've changed my life': Understanding what helps Offenders with a Learning Disability to Avoid Reoffending. The paper is written largely in the first person and is focussed on how I overcame the barriers to project conception, completion of the literature review and subsequent research. Attention is paid to the literature search, review methodology and outcomes, approval processes, recruitment, methodological limitations: analysis and interpretation, and ethical issues. To add to the discussion, there is due consideration to wider, professional and personal contexts.

## **Project Conception**

Project conception usually starts in discussions with colleagues and supervisors. The discussions focus on ideas for research from experience or literature. I initially found inspiration from my experience working as an Assistant Psychologist in a Community Learning Disability Team (CLDT). In the CLDT, I was struck by the number of referrals for eligibility assessments that the psychology team received. Eligibility to CLDT services is dependent on whether an individual has a Learning Disability (LD), and a psychologist usually assesses this. The British Psychological Society (BPS, 2001) state that a LD consists of: an Intelligence Quotient (IQ) below 70; coexisting deficits in social and adaptive abilities; difficulties present since childhood. In particular, I wanted to find out more about eligibility and the relevance of psychometric tests used in this context. The project I designed required a large number of participants, which was achievable in relation to my doctorate deadlines and the number of referrals the psychology service received. However, whilst preparing my literature review and forms for peer and ethical approval, the number of referrals declined, which meant that the project was no longer viable. This was the first barrier I met in the conduct of a thesis. Given the time and effort I had put into this project it was incredibly disappointing. Fortunately, the benefits of good support systems (i.e. supervision)

and the motivation to conduct research helped me to overcome this barrier, although now time was of the essence to find new inspiration for a different project.

My final yearlong training placement in a CLDT provided inspiration for the second project: the thesis. Given I had previous CLDT experience as an assistant, in this final year I sought to advance my skills and work with people with a LD who had offended, or were at risk of offending. Discussions with colleagues and an initial scan of the current evidence base sparked my interest in what treatment and support of offenders with a LD takes place in the community. This became my literature review question. I was also interested in the role for Clinical Psychology in this treatment and support.

## **Literature Review**

### **Literature Search**

Research into the treatment and support of offenders with a LD in the community is relatively small compared with the research in secure settings (Taylor & Lindsay, 2010). However, this, what might seem narrow area, is efficiently researched and regularly reviewed by experienced researchers (e.g. W. R. Lindsay; J. Rose etc.). This meant that the literature search I conducted in February 2013 was succeeded by research papers and a thorough chapter published soon after (Lindsay, 2013). At this point, I considered whether my efforts to write a literature review would be worthwhile. I felt daunted by the prospect of writing a review that could be overshadowed by other publications. Discussions with peers helped me to recognise these feelings as another barrier to completing a thesis, which I needed to overcome. I regained focus and completed a search, adhering to my strategy and date limits, a final nine papers were identified.

### **Review Methodology and Outcomes**

To review the literature, I followed the process of critical appraisal and thematic analysis suggested by Aveyard (2010). On reflection, I am unsure whether the suggestion to combine these methods was helpful. While I have used critical appraisal before, this was the first time I had used thematic analysis in this context. The thematic analysis identified themes across the results and discussion sections of the papers, which helped to organise the appraisal in the review.

However, I consider that the themes merely stated the obvious about the literature: predominantly current treatment developments are adapted Cognitive Behavioural Therapy (CBT) programmes for groups of (sex) offenders with a LD, which include innovative treatment components to enhance empathy and problem solving skills, and involve community integration. The thematic analysis was not a barrier as such, but it was time consuming and, in my opinion, added little to the review. That said, the review only included nine papers, which is a small number; perhaps a thematic analysis used with a larger number of papers would provide a more interesting outcome. Despite personal frustrations with this aspect of the methodology, the review outlined a gap in the current evidence base and encouraged qualitative research to explore: what factors influence whether or not offenders with a LD living in the community go on to re-offend?

## **Research Project**

### **Peer and Ethical Approval: Involving People with a Learning Disability in Research**

To achieve peer and ethical approval for research with people with a LD, careful consideration is due to the capacity to consent. However, researchers in the LD field stress that capacity should be presumed and research materials (e.g. information sheets and consent forms) should be accessible to enhance understanding, which in turn promotes capacity (Cook & Inglis, 2008; Inglis & Cook, 2011). Preparing accessible materials was a laborious element of my research. I made efforts to adhere to guidance (e.g. 'Write it how you say it', DoH, 2010) and consult with the CLDT. Despite this, at various stages throughout the approval processes, I was surprised by the lack of understanding some reviewers had in relation to accessible information (e.g. information should not be written in short form/how you say it), particularly given the role for this in other contexts (e.g. research with children). Fortunately, these reviewers were in the minority, yet it still impacted on my research, given I had to address all of the reviewers' comments. While I was motivated to address this issue and what I perceived was indifference towards the needs of people with a LD, this challenge would take time and the time I had to complete my thesis before the deadline was already compromised. In addition to the time pressures, I felt undermined by the lack of understanding in light of the efforts I made to get the accessible information right. Support systems

(i.e. supervisors, family and friends) encouraged me to persist and gain approval. On reflection, finally gaining approval took a great deal of persistence. This echoes Gilbert (2004) in his paper about involving people with a LD in research: “researchers will need flexibility and patience, as well as imagination, ingenuity and reflexivity. A good measure of persistence would not go amiss either” (p.307). With Gilbert in mind, I wonder how many people are discouraged by the need for persistence in research with people with a LD. In my clinical training cohort, I was certainly within a minority of trainees that conducted research in this area. However, when I chose to do this research, I could not predict the tenacity and support I was going to need.

### **Recruitment**

Gilbert (2004) also refers to patience in research with people with a LD, which reflects the recruitment stage in my research. To meet the needs of people with a LD and promote their capacity to consent, my research design included a staged consent process (i.e. two or more meetings to discuss what the research entails and confirm consent). Prior to this, there was an invitation letter to a research information meeting, which required potential participants to opt in. The staged process allows people time to develop an understanding of the research, speak with others about it, and make an informed decision about participation. It also allows the researcher to check out whether a potential participant retains information from one meeting to the next. In addition, staged consent provides people with more opportunities to withdraw. As people opted in and then withdrew from my research, I wondered if the staged consent process was hampering engagement. At first and second meetings, people seemed positive and agreed to participate, but they missed subsequent interview meetings. It is unclear whether this was a definite opt out, or if the effort to attend research meetings at their cost and time was not a priority for people, or if they needed more support. Overall, the staged consent process meant recruitment was fraught with uncertainties and took a lot longer than anticipated.

At the same time as recruitment, I was grappling with the likelihood that I was going to miss the thesis hand in deadline. This was possibly the most difficult time in the conduct of a thesis; admittedly not everyone experiences this barrier. During this phase, I questioned my project choice; it is a sensitive and challenging topic, with a vulnerable client group. After discussions in supervision, I applied for

extenuating circumstances in relation to the barriers I had faced. The application was upheld and I felt some relief, but this alone did not give me the determination to continue with the project. This happened when I conducted my first interview with Fred (to protect anonymity this is a pseudonym). Fred told me a story where he reflected a real sense of achievement in how he avoids reoffending and what his life is like now. I felt privileged to listen to Fred and after the interview, Fred told me he was pleased and that no one had asked him to tell his story before (Fred agreed to the inclusion of this comment in my reflections). There was no obligation for the participants to share their experiences about participation with the researcher, but Fred's comment confirmed the research was providing some offenders with a LD a new opportunity. I previously read that people with a LD had limited opportunities to share their stories (Atkinson, 2010); my experience with Fred personified this and motivated me to continue with the research, for him and for other people with a LD.

### **Methodological Limitations: Analysis & Interpretation**

The research project employed narrative methodology outlined by Squire (2008). As recommended by Squire, analysis and interpretation is a sole endeavour, unless this involves the participant. This process limits the effect of researcher bias on individual stories, so that other researchers do not 'muddy the waters'. While my six interviews were relatively short compared with those in Squire's research (approximately five hours vs. several meetings lasting many hours), I was surprised to find how arduous the analysis was, particularly doing it alone. However, I did concede to checking the first stage of my analysis with a peer to confirm the relevance of my interpretation in relation to the interviews. This was largely because I felt a lack of confidence in myself using the method for the first time. Nonetheless, the overall interpretation and outcomes support and add to the current evidence base. Despite incorporating all six of the interviews, I was pleased that the outcome did not completely lose sight of the individual stories. The research proposed that offenders with a LD do not reoffend when they are engaged in and fear losing, meaningful community based activities or relationships. The research also proposed that offenders must be able, or have available (long-term) support, to make decisions to avoid offending.

## **Ethical Issues**

In qualitative research, identifiable information is often changed or omitted to protect the anonymity of the participants. This was true of my thesis, but it meant prominent aspects of individual stories were altered. This was a difficult part of the process because I felt the stories lost important elements that reflected personal meaning (e.g. about race and culture). In supervision, I discussed alterations in depth and decisions were reached about what changes should be made. Ultimately, I had a commitment to participants to protect their anonymity. However, it was a challenging position between ethics and people who might be better placed to make these choices. On reflection, future narrative research would benefit from a collaborative process with participants to reach these decisions. However, issues of protection would remain the responsibility of the researcher; perhaps wider discussions about anonymity in research with people with a LD would be useful. As Swain, Heyman and Gillman (1998) suggest, people with a LD might be proud of their contribution and wish to share it publically.

## **Other Considerations**

### **Wider Considerations**

Interestingly, not all of the research conducted with people with a LD is available in an accessible format. Providing this is often at the discretion of researchers, but is sometimes a condition of approvals. At the beginning of this thesis, I decided that an accessible version is essential, particularly given the personal nature of the narrative method. However, Gilbert (2004) considers that two versions might maintain the societal division between people with and without LD. That said, an accessible thesis is unlikely to meet academic requirements, but in future research as a Clinical Psychologist, providing one accessible write up is a worthwhile consideration.

### **Professional Considerations**

**Clinical Psychology.** At the beginning of this thesis I was interested in the role for Clinical Psychologists in community-based work with offenders with a LD. At completion, I have a better understanding of the role in relation to addressing criminogenic needs (e.g. needs related to offending that require clinical interventions: managing difficult feelings and substance misuse, Lindsay et al.,

2013) and maintaining treatment outcomes. From my research, I also have an understanding that this clinical work is long-term and could necessitate a similar amount of commitment and perseverance to overcome potential barriers, but that the results for people like Fred and for clinicians alike make it worthwhile.

### **Personal Considerations**

The conduct of a thesis has been a challenging personal endeavour. I have learnt to persist and maintain focus on an end goal, and when this wanes to draw on support systems. I have also learnt that I am passionate about working with people with a LD. In addition, I would not have done this research without my motivation to understand more about why offenders with a LD do and do not reoffend.

### **Conclusion**

This commentary describes the barriers I experienced in the conduct of a thesis, and how I overcame these. Even though these barriers might be different for every trainee, I hope this commentary offers some inspiration for those moments when time is compromised or when motivation is lacking; it is worth it. While I, like Gilbert, would recommend persistence, I would also recommend seeking support from supervisors, peers, family and friends. Given there may be barriers in any area of research, not just LD, I would strongly advise choosing a project with a clinical population that motivates you and who you are committed to working with.

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Squire, C. (2008). Experience-centred and culturally oriented approaches to narrative. In M. Andrews, C. Squire & M. Tamboukou (Eds.), *Doing narrative research* (pp. 41-62). London: Sage Publications.

Swain, J., Heyman, B. & Gillman, M. (1998). Public research, private concerns: ethical issues in the use of open-ended interviews with people who have learning difficulties. *Disability & Society*, 13, 21-36.

Taylor, J. L. & Lindsay, W. R. (2010). Understanding and treating offenders with learning disabilities: a review of recent developments. *Journal of Learning Disabilities and Offending Behaviour*, 1(1), 5-16.

**Appendix A**  
**Journal of Forensic Practice: Style Guidance**

Editors: Neil Gredecki and Carol A. Ireland

Online ISSN: 2050-8794

**Manuscript requirements**

In addition to the manuscript requirements detailed below each paper should also include a bulleted list of the specific implications for practice of the paper/research. This should be placed at the end of the paper and before the references.

Please prepare your manuscript before submission, using the following guidelines:

Format	All files should be submitted as a Word document
Article Length	Articles should be between 5000 and 7500 words in length. This includes all text including references and appendices. Please allow 350 words for each figure or table.
Article Title	A title of not more than eight words should be provided.
Article Title Page	An Article Title Page should be submitted alongside each individual article using the template provided. This should include: Article Title; Author Details (see below); Acknowledgements; Author Biographies; Structured Abstract (see below); Keywords (see below); Article Classification (see below).
Author Details	Details should be supplied on the Article Title Page including: Full name of each author; Affiliation of each author, at time research was completed; Where more than one author has contributed to the article, details of who should be contacted for correspondence; E-mail address of the corresponding author; Brief professional biography of each author.
Structured Abstract	Authors must supply a structured abstract on the Article Title Page, set out under 4-7 sub-headings (see our "How to... write an abstract" guide for practical help and guidance): Purpose (mandatory); Design/methodology/approach (mandatory); Findings (mandatory); Research

limitations/implications (if applicable); Practical implications (if applicable); Social implications (if applicable); Originality/value (mandatory); Maximum is 250 words in total (including keywords and article classification, see below).

- Keywords** Please provide up to 10 keywords on the Article Title Page, which encapsulate the principal topics of the paper (see our "How to... ensure your article is highly downloaded" guide for practical help and guidance on choosing search-engine friendly keywords). Whilst we will endeavour to use submitted keywords in the published version, all keywords are subject to approval by Emerald's in house editorial team and may be replaced by a matching term to ensure consistency.
- Article Classification** Categorize your paper on the Article Title Page, under one of these classifications: Research paper; Viewpoint; Technical paper; Conceptual paper; Case study; Literature review; General review.
- Headings** Headings must be concise, with a clear indication of the distinction between the hierarchy of headings. The preferred format is for first level headings to be presented in bold format and subsequent sub-headings to be presented in medium italics.
- Notes/Endnotes** Notes or Endnotes should be used only if absolutely necessary and must be identified in the text by consecutive numbers, enclosed in square brackets and listed at the end of the article.
- Research Funding** Authors must declare all sources of external research funding in their article and a statement to this effect should appear in the Acknowledgements section. Authors should describe the role of the funder or financial sponsor in the entire research process, from study design to submission.
- Figures** All Figures (charts, diagrams, line drawings, web pages/screenshots, and photographic images) should be submitted in electronic form.

All Figures should be of high quality, legible and numbered consecutively with arabic numerals. Graphics may be supplied in colour to facilitate their appearance on the online database. Figures created in MS Word, MS PowerPoint, MS Excel, Illustrator should be supplied in their native formats. Electronic figures created in other applications should be copied from the origination software and pasted into a blank MS Word document or saved and imported into an MS Word document or alternatively create a .pdf file from the origination software. Figures which cannot be supplied in as the above are acceptable in the standard image formats which are: .pdf, .ai, and .eps. If you are unable to supply graphics in these formats then please ensure they are .tif, .jpeg, or .bmp at a resolution of at least 300dpi and at least 10cm wide.

To prepare web pages/screenshots simultaneously press the "Alt" and "Print screen" keys on the keyboard, open a blank Microsoft Word document and simultaneously press "Ctrl" and "V" to paste the image. (Capture all the contents/windows on the computer screen to paste into MS Word, by simultaneously pressing "Ctrl" and "Print screen".)

Photographic images should be submitted electronically and of high quality. They should be saved as .tif or .jpeg files at a resolution of at least 300dpi and at least 10cm wide. Digital camera settings should be set at the highest resolution/quality possible.

#### Tables

Tables should be typed and included in a separate file to the main body of the article. The position of each table should be clearly labelled in the body text of article with corresponding labels being clearly shown in the separate file. Ensure that any superscripts or asterisks are shown next to the relevant items and have corresponding explanations displayed as footnotes to the table, figure or plate.

#### References

References to other publications must be in Harvard style and carefully checked for completeness, accuracy and consistency. This is very important in an electronic



communication technologies in tourism 2007 proceedings of the international conference in Ljubljana, Slovenia, 2007, Springer-Verlag, Vienna, pp. 12-32.

For unpublished

conference proceedings      Surname, Initials (year), "Title of paper", paper presented at Name of Conference, date of conference, place of conference, available at: URL if freely available on the internet (accessed date).

e.g. Aumueller, D. (2005), "Semantic authoring and retrieval within a wiki", paper presented at the European Semantic Web Conference (ESWC), 29 May-1 June, Heraklion, Crete, available at: <http://dbs.uni-leipzig.de/file/aumueller05wiksar.pdf> (accessed 20 February 2007).

For working papers              Surname, Initials (year), "Title of article", working paper [number if available], Institution or organization, Place of organization, date.

e.g. Moizer, P. (2003), "How published academic research can inform policy decisions: the case of mandatory rotation of audit appointments", working paper, Leeds University Business School, University of Leeds, Leeds, 28 March.

For encyclopedia entries

(with no author or editor)      Title of Encyclopedia (year) "Title of entry", volume, edition, Title of Encyclopedia, Publisher, Place of publication, pages.

e.g. Encyclopaedia Britannica (1926) "Psychology of culture contact", Vol. 1, 13th ed., Encyclopaedia Britannica, London and New York, NY, pp. 765-71.

(For authored entries please refer to book chapter guidelines above)

For newspaper

articles (authored)              Surname, Initials (year), "Article title", Newspaper, date, pages.

e.g. Smith, A. (2008), "Money for old rope", Daily News, 21 January, pp. 1, 3-4.

For newspaper

articles (non-authored) Newspaper (year), "Article title", date, pages.

e.g. Daily News (2008), "Small change", 2 February, p. 7.

For electronic sources If available online, the full URL should be supplied at the end of the reference, as well as a date that the resource was accessed.

e.g. Castle, B. (2005), "Introduction to web services for remote portlets", available at: <http://www-128.ibm.com/developerworks/library/ws-wsrp/> (accessed 12 November 2007).

Standalone URLs, i.e. without an author or date, should be included either within parentheses within the main text, or preferably set as a note (roman numeral within square brackets within text followed by the full URL address at the end of the paper).

## **Appendix B**

### **Journal of Intellectual Disabilities: Style Guidance**

Editor: Ruth Northway

Online ISSN: 1744-6295

#### **Manuscript requirements**

The aim of the journal is to publish original research or original contributions to the existing literature on intellectual disabilities.

Your manuscript should ideally be between 6000 and 8000 words long, and double spaced. Please also supply an abstract of 100-150 words, and up to five keywords, arranged in alphabetical order.

**Declaration of conflicting interests.** Within your Journal Contributor's Publishing Agreement you will be required to make a certification with respect to a declaration of conflicting interests. Journal of Intellectual Disabilities does not require a declaration of conflicting interests but recommends you review the good practice guidelines on the SAGE Journal Author Gateway.

**Other conventions.** 'Intellectual disability' and 'intellectual disabilities' should be written out in full in all instances and never abbreviated to 'ID'. Please provide a list, in alphabetical order, of abbreviations used, and spell them out (with the abbreviations in brackets) the first time they are mentioned in the text. As far as possible, please avoid the use of initials, except for terms in common use.

**Acknowledgements.** Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

All contributors who do not meet the criteria for authorship should be listed in an 'Acknowledgements' section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

**Funding Acknowledgement.** To comply with the guidance for Research Funders, Authors and Publishers issued by the Research Information Network (RIN), Journal of Intellectual Disabilities additionally requires all Authors to acknowledge their funding in a consistent fashion under a separate heading.

Please visit Funding Acknowledgement on the SAGE Journal Author Gateway for funding acknowledgement guidelines.

**Permissions.**

Authors are responsible for obtaining permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please visit our Frequently Asked Questions on the SAGE Journal Author Gateway.

**Manuscript style.**

**File types.** Only electronic files conforming to the journal's guidelines will be accepted. Preferred formats for the text and tables of your manuscript are Word DOC, RTF, XLS. LaTeX files are also accepted. Please also refer to additional guideline on submitting artwork [and supplemental files] below.

**Journal Style.** Journal of Intellectual Disabilities conforms to the SAGE house style. Click here to review guidelines on SAGE UK House Style

**Reference Style.** Journal of Intellectual Disabilities adheres to the SAGE Harvard reference style. Click here to review the guidelines on SAGE Harvard to ensure your manuscript conforms to this reference style. If you use EndNote to manage references, download the SAGE Harvard output style by following this link and save to the appropriate folder (normally for Windows C:\Program Files\EndNote\Styles and for Mac OS X Harddrive:Applications:EndNote:Styles). Once you've done this, open EndNote and choose "Select Another Style..." from the dropdown menu in the menu bar; locate and choose this new style from the following screen.

**Manuscript Preparation.** The text should be double-spaced throughout and with a minimum of 3cm for left and right hand margins and 5cm at head and foot. Text should be standard 10 or 12 point.

**Your Title, Keywords and Abstracts:** Helping readers find your article online. The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google. Please refer to the information and guidance on how best to title your article, write your abstract and select your keywords by visiting SAGE's Journal Author Gateway Guidelines on How to Help Readers Find Your Article Online.

**Corresponding Author Contact details.** Provide full contact details for the corresponding author including email, mailing address and telephone numbers.

Academic affiliations are required for all co-authors. These details should be presented separately to the main text of the article to facilitate anonymous peer review.

**Guidelines for submitting artwork, figures and other graphics.** For guidance on the preparation of illustrations, pictures and graphs in electronic format, please visit SAGE's Manuscript Submission Guidelines. Figures supplied in colour will appear in colour online regardless of whether or not these illustrations are reproduced in colour in the printed version. For specifically requested colour reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

**Guidelines for submitting supplemental files.** Journal of Intellectual Disabilities does not currently accept supplemental files.

**English Language Editing services.** Non-English speaking authors who would like to refine their use of language in their manuscripts might consider using a professional editing service. Visit <http://www.uk.sagepub.com/journalgateway/msg.htm> for further information.

## **Appendix C**

### **Clinical Psychology Forum: Guidelines for Contributor**

Editor: Graham Turpin

Online ISSN: 0269-0144

#### **Guidelines**

Clinical Psychology Forum (CPF) welcomes contributions which are original, innovative, authoritative and of interest to the membership of the Division. We aim to publish a variety of contributions ranging from personal reflections on clinical practice to critiques of current health policy, innovations in service development, and audit and research studies.

From time to time we commission reviews and Special Issues. We also act as a major communication channel between the DCP and its subsystems, and its membership by publishing a monthly DCP Chair's Column, DCP Update and various regular columns and features.

We also publish correspondence either regarding articles published within CPF or around issues of general interest to the membership.

Articles submitted to CPF will be sent to members of the editorial collective for refereeing. Reviewers will assess each contribution in relation to the manuscript's clarity and economy of expression; its critical and analytic stance; whether its original or innovative; and, where appropriate, that methods and results are well described, methodological sound and any conclusions drawn are valid. Overall, articles must be relevant and of interest to the profession (see Advice from the Editorial Collective below, originally published in CPF 227, November 2011, p.9). The reviewer shall then communicate directly with the authors.

Articles of 1000-2500 words including references are welcomed. If you feel an article longer than 2500 words is justified please state the reasons in an accompanying letter and these will be considered by the reviewer.

Contributors are asked to use language which is respectful and psychologically descriptive rather than medical, and to avoid using devaluing terminology (i.e. avoid clustering terminology like 'the elderly' or medical jargon like 'patients'). In addition, language should conform to the Society's guidelines on non-sexist or discriminatory terminology. We acknowledge that language is

context specific and that occasionally authors may wish to justify the use of particular terms commonly adopted within specific contexts. Please include any such qualifications within an accompanying footnote.

Please email one electronic copy and post one hard copy of your contribution to the CPF administrator, Sue Maskrey (details below). Please ensure that your contact details (email and current postal address), current employer and job role are included in case the editors need to contact you. Please do not submit articles directly to the Editor.

### **Other points to consider.**

- All contributors should read the FAQs about publishing in Clinical Psychology Forum before submitting a manuscript.
- When sending copy, make sure it is double-spaced, in a reasonable sized font (no less than 11 point) and that all pages are numbered.
- Include a 40-word summary (maximum) at the beginning of the paper.
- Include the first names of all authors, give their job titles and affiliations, and remember to give an email address and full postal address for correspondence.
- Please include a word count at the end (including references).
- Spell out all acronyms the first time they appear.
- Give references in the format set out in the Society's Editorial Style Guide (Modified American Psychological Association Style, see guide). If a reference is cited in the text, please make sure it is in the list at the end.
- Do not include tables and figures unless they are essential and save space or add to the article. All figures should be in black and white and easily reproducible.
- Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.
- We reserve the right to shorten, amend and hold back copy if needed.

## **Appendix D**

### **Search Strategy**

#### **Search Terms**

**Primary Terms.** Learning Disability; offenders; treatment.

**Related Terms.** Intellectual Disability/Intellectual limitations; offending/deviant behaviour; criminals; intervention/support

#### **Search Term Combinations**

((Learning Disability OR Intellectual Disability OR Intellectual Limitations)  
AND (Offenders OR Sex Offenders OR Offending OR Offending Behaviour  
OR Deviant Behaviour OR Criminals) AND (Treatment OR Intervention OR  
Support))

#### **Search Limits**

- English Language Only
- Peer Reviewed
- Date of Publication/s: January 2010 to February 2013.
- Articles concerning adults only.

#### **Databases Searched**

- EBSCOHost  
(MEDLINE;CINHALPluswithFullText;PsychINFO;PsycARTICLES;  
PsycBOOKS;ebookCollection)

#### **Exclusion Criteria**

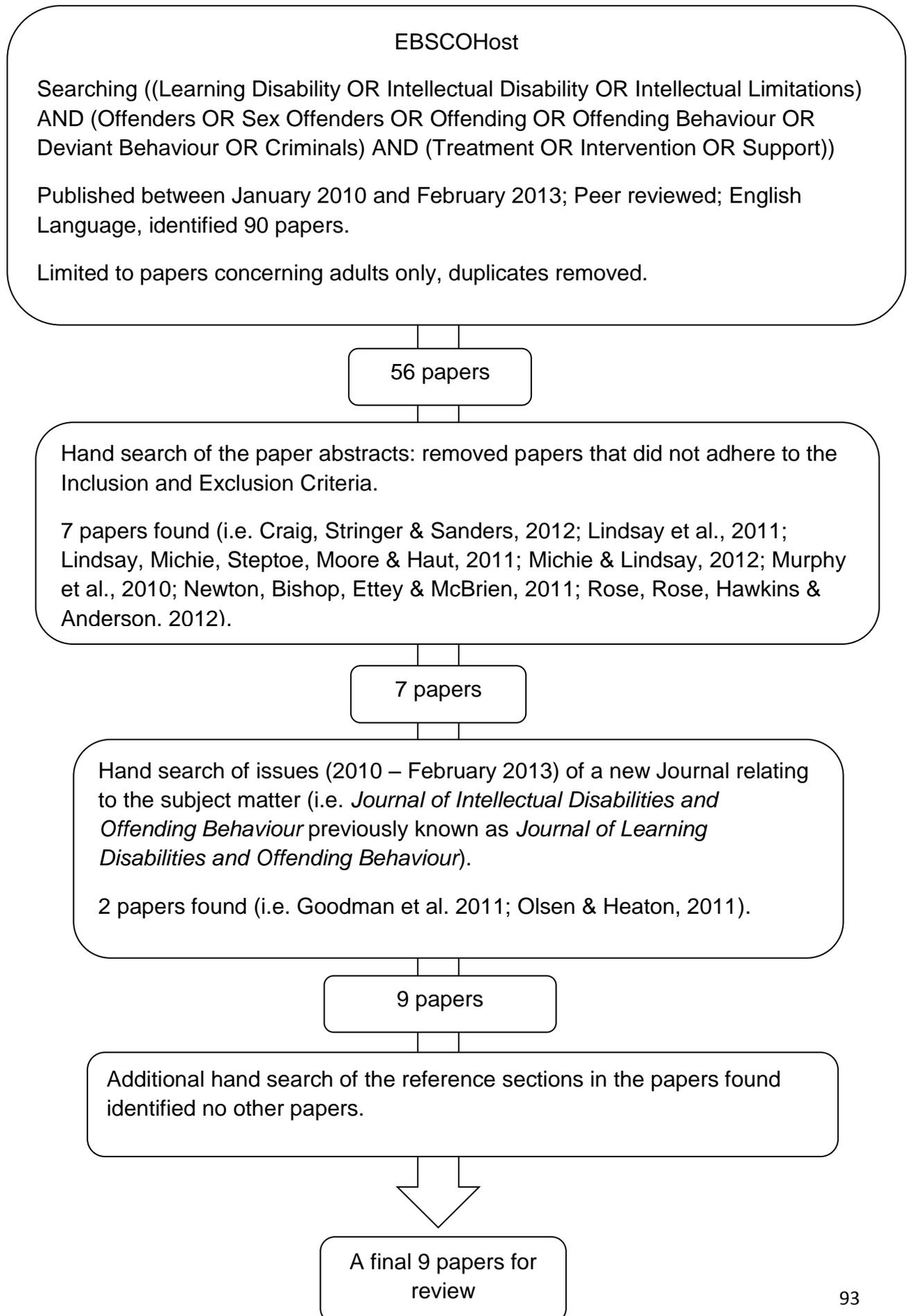
- Research with children/adolescents
- Secure-based treatment
- Outside of the UK

#### **Inclusion Criteria**

- Literature concerning adults (+18 years)
- Community-based treatment
- Situated in the UK

## Appendix E

### Literature Search Flow Chart



**Appendix F**  
**Literature Review Summary Table**

Table 1

*Summary of the papers identified in the Literature Review*

Reference	Summary
Craig, Stringer & Sanders (2012)	Quantitative study: Evaluates a long-term (14 months) CBT-based programme for sex offenders. Results for 12 men: at 12-month follow up no reconvictions for a sex offence. CBT effective, but analysis confounded by small sample size.
Goodman et al. (2011)	Descriptive study of a CBT-based thinking skills programme for offenders. Outcomes of a service evaluation, a case study and feedback from a focus group suggest the programme is effective.
Lindsay et al. (2011)	Quantitative study: Evaluates a pilot of a CBT-based problem-solving programme. Results for n=10 indicate that treatment encourages a positive problem solving approach. Problems in the statistical analysis related to small-sample size are discussed.
Lindsay, Michie, Steptoe, Moore & Haut (2011) (up	Quantitative study: Compares long-term to 3 years) CBT-based treatment for sex offenders against women (n=15) and sex offenders against children (n=15). Statistical analysis indicates treatment efficacy. Reoffending rate at 2 year follow-up 23%.
Michie & Lindsay (2012)	Quantitative study: Evaluates a CBT based treatment component to enhance empathy. Compares n=10 male sex offenders against a treatment control group n=10. Statistical analysis suggests the empathy component increased empathy from pre to post treatment and at follow up.

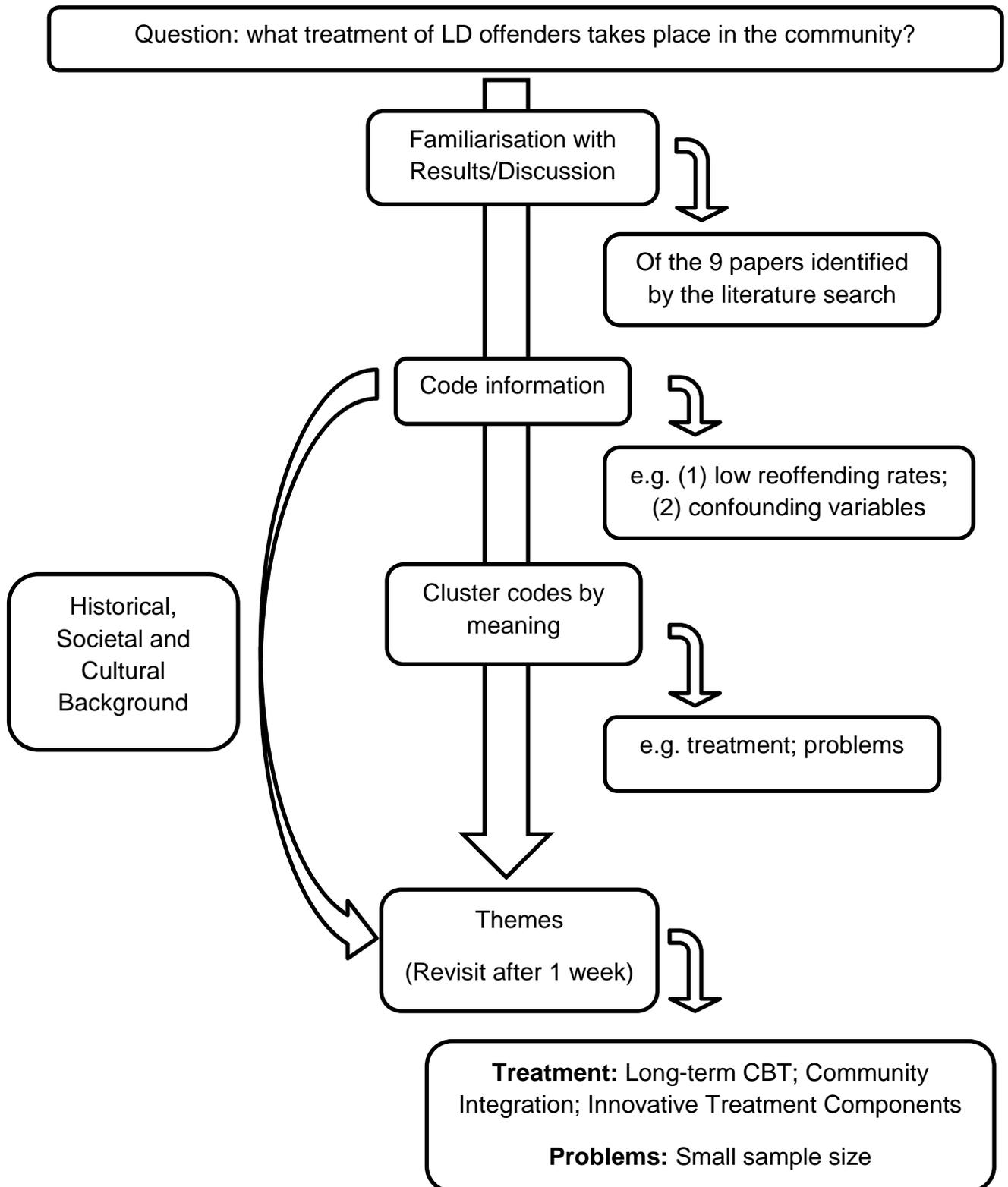
Table 1 - continued

*Summary of the papers identified in the Literature Review*

Reference	Summary
Murphy et al. (2010) trial	Quantitative study: Controlled treatment in secure and community settings of a CBT based treatment programme for sex offenders. Statistical analysis indicates treatment is effective across sites. During treatment 3 of 46 participants reoffended. At 6 month follow up none of the men reoffended.
Newton, Bishop, Ettey & McBrien (2011)	Quantitative study: Evaluates a long-term CBT based treatment programme for sex offenders. At 12 month follow up none of the participants (n=7 men) reoffended. No statistics are specified due to problems with a small sample size in the analysis.
Olsen & Heaton (2011)	Service development study: Describes a housing-based support service for offenders with a mental illness and/or a Learning Disability. The authors reference a service evaluation to indicate success of the service. After 2 years, 83% of people did not reoffend and 97% secured a tenancy.
Rose, Rose, Hawkins & Anderson (2012)	Quantitative study: Evaluates long-term CBT based treatment for sex offenders (n=12 men). Statistically significant changes on treatment measures at pre and post treatment are explored using the Reliable Change Index. One man reoffended at 18 month follow up.

## Appendix G Thematic Analysis Flow Chart

This chart depicts the process of the thematic analysis of the results and discussions sections of the papers identified in the literature search.



## **Appendix H**

### **Narrative Method: Linked assumptions**

Squire (2008) defines a narrative as a story of experiences. Using the example 'experience of breaking the law' the linked assumptions to this definition are outlined here:

- Meaningful and sequential; a 'personal narrative' includes stories linked by theme and stories in the past, present, future and imaginative tenses. A person's 'experience of breaking the law' could include a number of instances of deviant, not necessarily illegal, behaviour linked through themes of 'disappointment' or 'rebellion'. The instances could be both past and present, and not in a chronological order, but an order that is sequential and meaningful to the person.
- Unique; the sequential and temporal ordering of narratives is exclusive to humans. A narrative is a person's way of making sense of an experience. In regard to this, a person's 'experience of breaking the law' may include stories of their deviant behaviour at school, illegal behaviour later in life, interspersed with news stories of high profile offenders from before they were born. The latter stories highlight uniqueness, in that narratives are fundamental to the social world through the telling and recounting of stories.
- Re-present, reconstruct and express experience; people do not and cannot recount narratives and stories in the same way twice. To this end, recounts of narratives at varying times are often with different words that may have different meanings (e.g. 'I wasn't arrested for arson' vs. 'I didn't get nicked for that fire'). Additionally, the way in which someone tells a story of experience is dependent on the audience and contexts. With regard to the 'experience of breaking the law' a person may tell a police officer and a solicitor linked, but very different stories. Therefore, while a narrative is an expression of the individual's experience, it is essentially co-constructed with the audience and the wider contexts. The person may tell a researcher interested in writing a book on the 'experience of breaking the law' a different story again.

- Transformation and change; narratives signify personal changes for the person. This relates to the audience's interest in 'good' stories. Looking for improvement in a person's story is common in interaction. Therefore, co-construction could create a 'better' narrative for the individual. With regard to the 'experience of breaking the law', a social worker may recap aspects of the person's story that regards avoiding breaking the law.

# Appendix I

## Peer Review Approval Letter



RESEARCH AND ENTERPRISE SERVICES

14 January 2013

Clare Passey  
Staffordshire and Keele Doctorate in Clinical Psychology,  
Staffordshire University,  
Faculty of Sciences,  
Leek Road, Stoke-on-Trent, ST4 2DF

Dear Clare

**Using a narrative approach to tell the stories of offenders with learning disabilities: why we do/don't reoffend**

As you know the above project was initially awarded a grade 2 but following assessment of your response to the issues raised the project now has received final approval from the Independent Peer Review Committee and can be submitted for ethical approval.

I am attaching a letter addressed to the Chair of the NHS REC along with the original peer review comments which you can enclose with your NHS REC application.

**Management approval**

You should arrange for all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

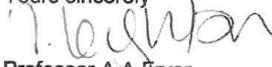
All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant care organisation before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Clinical trial of a medicinal product**

Please remember that, if your project is a clinical trial of a medicinal product, MHRA approval is required. You must submit a request for a clinical trial authorisation under the Medicines for Human Use (Clinical Trials) Regulations 2004. Further details can be found at <http://www.mhra.gov.uk/home/groups/lunit1/documents/websiteresources/con2022633.pdf>

If you have any queries, please do not hesitate to contact Nicola Leighton on 01782 733306.

Yours sincerely

  
PP Professor A A Fryer

Chair – Independent Peer Review Committee

Enc

CC R&D Office, f

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## Appendix J

### Sponsorship Letter



26th July 2012

#### VERIFICATION OF INSURANCE

#### TO WHOM IT MAY CONCERN

We act as insurance brokers to the above client and in this capacity can provide brief details of their current Professional Indemnity policy

Insured	Keele University, Keele University Science Park Ltd and Keele University Science and Business Park Ltd.
Insurer	RSA Group
Period of Insurance	1 <sup>st</sup> August 2012 to 31 <sup>st</sup> July 2013
Policy Number	SA13328793
Limit of Indemnity	£5,000,000 for each claim and in the aggregate in respect of all claims first made in any one period of insurance with one automatic reinstatement of the limit to provide an additional £5,000,000 of cover in the aggregate if the first £5,000,000 is exhausted.  In respect of claims made against the Insured in the USA or Canada the Limit of Indemnity is restricted to £1,000,000 in the aggregate in any one period of insurance, with no automatic reinstatement.
Excess	£25,000 each and every claim

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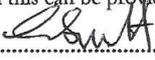


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This letter shall be governed by and shall be construed in accordance with English law and the courts of England and Wales shall have exclusive jurisdiction.

We trust that this information is sufficient for your purposes however, should you require additional detail this can be provided upon agreement from our client.

SIGNED.....  ..... DATED: 26<sup>th</sup> July 2012

**PRINT NAME: George Smith**

**For and on behalf of Lockton Companies LLP**

# Appendix K

## National Research Ethics Service Approval Letter



### NRES Committee West Midlands - Coventry & Warwickshire

The Old Chapel  
Royal Standard Place  
Nottingham  
NG1 6FS

Telephone: 0115 8839311  
Facsimile: 0115 8839294

07 March 2013

Miss Clare L Passey  
Trainee Clinical Psychologist

Dear Miss Passey

<b>Study title:</b>	Using a narrative approach to tell the stories of offenders with learning disabilities: why we do/don't reoffend.
<b>REC reference:</b>	13/WM/0078
<b>IRAS project ID:</b>	120691

The Research Ethics Committee reviewed the above application at the meeting held on 27 February 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Andrea Graham, [nrescommittee.westmidlands-coventryandwarwick@nhs.net](mailto:nrescommittee.westmidlands-coventryandwarwick@nhs.net)

#### Ethical opinion

- The Chair introduced herself to you and asked you to introduce yourself to the Committee.
- The Committee thanked you for your study and advised it was interesting and worthwhile
- The Committee advised your narrative approach is interesting
- The Committee asked you about the vulnerability of the group and whether or not they have capacity to consent. You explained the assumption is they have capacity to consent for this study. You explained you have experience of working with adults with learning difficulties and are currently on a specialist placement in a forensic setting.
- You explained you are aware of the complexity around working with this group and you will make sure the information is accessible and Participants know what is expected of them.
- You explained to the Committee you use a document called 'consent and people with

intellectual disabilities' to determine capacity and your procedures are in accordance with the protocol.

- You explained the learning disabilities team have been consulted in developing the study.
- The Committee asked you whether Participants would understand the term "offending". You confirmed they would be familiar with the term as they are involved in community services for their offending behaviour.
- You were asked about the sentence "worked with Learning Disability Services" in the 'What is this Research about?' section of the Participant Information Sheet. You explained it is service user language and means recipient.
- The Committee asked you what you would do if the Participant discloses any criminal activity. You explained you would work in line with guidance as there are policies in place surrounding risk/disclosure. You reassured the Committee any concerns would be raised through the appropriate channels.
- The Committee asked you whether it would be made clear to the Participant you may need to report any information they disclose if it relates to criminal activity. You confirmed it would be.
- The Committee asked you whether you had considered informing Participants GP of their involvement in the study. The Committee explained it was usual in this type of study to inform a Participants GP in the event the Participant becomes distressed, worried or stressed as a result of the interview. You conceded the point and will discuss it with Participants.
- You were asked about the comments made in your peer reviews as some comments are negative. You explained alongside this process you have raised concerns about the nature and manner of the feedback given. You advised the Chair of the Peer Review Committee has apologised and would make sure the policies were changed to make sure it did not happen again. The Committee thanked you for your explanation and for being open with the Committee.
- The Committee asked you what procedures are in place to protect her own safety whilst interviewing Participants. You explained you are well supported, offices are alarmed and the interviews are recorded in case there is an issue.
- You were asked about the interview length as 2 hours is a long time. You explained 2 hours will be the upper limit. You explained you wanted to give Participants plenty of opportunity to tell their story however you are mindful of giving Participants breaks. You explained it could be split over 2 meetings if necessary.
- You were asked why you would be storing information at your home. You explained it would only be stored at home if you had conducted an interview at the end of the day. The data would then be transported back to the office the following day.
- The Committee explained your Consent Form should contain initial boxes and not tick boxes. You explained you were concerned some Participants may not have the dexterity to initial the boxes. The Committee explained anyone could tick a box so they should at least attempt to initial the boxes.
- The Committee explained to you the Consent Form should contain a box to agree to the interview being audio recorded,

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Ethical review of research sites**

## NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### Additional Conditions

- The Consent Form should be amended as follows;
  - 1) Boxes should be initialled rather than ticked.
  - 2) There should be an additional paragraph added to the Consent Form to agree to the interviews being recorded
  - 3) You should seek consent to inform the Participants GP they are involved in the study.

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

### Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity		26 July 2012
Interview Schedules/Topic Guides	1	30 January 2013
Investigator CV		29 January 2013
Other: CV - Academic Supervisor		30 January 2013
Other: Appendix A - Invitation to Initial Meeting Letter	1	30 January 2013
Other: Appendix B - Reply slip	1	30 January 2013
Other: Appendix C - Invitation to Individual Meeting Letter	1	30 January 2013
Other: Appendix G - Invitation Letter to Interview	1	30 January 2013
Other: Appendix F - Demographic Checklist	1	30 January 2013
Participant Consent Form: Appendix E1 - Consent Form Prompts	1	30 January 2013
Participant Consent Form: Appendix E2 - Consent Form	1	30 January 2013
Participant Information Sheet: Appendix D1 - Information Sheet	1	30 January 2013
Participant Information Sheet: Appendix D" - Information Sheet (accessible version)	1	30 January 2013
Protocol	1	01 February 2013
REC application		30 January 2013
Referees or other scientific critique report		14 January 2013
Summary/Synopsis	1	30 January 2013
Summary/Synopsis	1	30 January 2013

#### **Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### **After ethical review**

##### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

**13/WM/0078** **Please quote this number on all correspondence**

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely

A. 

**Dr Helen Brittain**  
**Chair**

Email: [nrescommittee.westmidlands-coventryandwarwick@nhs.net](mailto:nrescommittee.westmidlands-coventryandwarwick@nhs.net)

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*  
*"After ethical review – guidance for researchers"*

Copy to: *Nicola Leighton, Keele University*  
*Ms Audrey Bright, £*

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**NRES Committee West Midlands - Coventry & Warwickshire**

**Attendance at Committee meeting on 27 February 2013**

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Jane Appleton	Nurse	Yes	
Mr Roger Balcombe	Retired Chartered Engineer	Yes	
Dr Geraldine Brady	Senior Research Fellow	No	
Dr Helen Brittain	Clinical Psychologist Retired	Yes	Chair
Mrs Barbara Canning	Senior University Lecturer	Yes	
Mr Roger Cross	Senior Clinical Pharmacist	Yes	
Dr Matthew Dunn	Consultant Accident and Emergency	Yes	
Dr John S Fenlon	Statistical Consultant	Yes	
Mrs Louise Harmer	Clinical Skills Tutor	Yes	
Mrs Moya Horton	Retired University Lecturer (Physiotherapy)	Yes	
Mrs Evette Hunkins-Hutchinson	Lecturer Health Care Management	No	
Dr Adrian Neal	Principle Clinical Psychologist	No	
Dr Ashok Roy	Consultant Psychiatrist/Children and Adults lacking Mental Capacity	No	
Dr Gurnam Singh	Principal Lecturer in Social Work	Yes	

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>
Ms Andrea Graham	Committee Coordinator

**Appendix L**  
**Research and Development Department Approval Letter**



NHS Foundation Trust

Research and Development  
Block 7

Our Ref: AB/R241

21 March 2013

Email: [\[redacted\]](#)

Ms Clare Passey  
Trainee Clinical Psychologist

Trust HQ

Dear Clare

**Study title: Stories of offenders with learning disabilities**

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust the Lead Officer for Research Governance (Eleanor Bradley), and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated 18 March 2013 which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

 (Head of R&D)

Mrs Kim Thompson  
R&D Manager

**Appendix M**  
**Invitation Letter to Consent Meeting**

**Confidential**

Dear **NAME OF PARTICIPANT**

My name is Clare Passey, I am training to be a Clinical Psychologist and I am carrying out some research. I would like to find out more about people who have worked with Learning Disability services. And people who have offended. I would like to interview you, because what you say could help make these services better.

I would like to invite you to meet with me on

**DATE & TIME**

**at Address**

At this meeting, I would like to talk about the research and the interview. You can ask me any questions about the research and the interview. The meeting should take no longer than 1 hour. If you would like to bring someone with you for support this is OK. If you do not want to attend the meeting, this is OK.

Please fill out the Reply slip to let me know if you can attend the meeting or not. Please post the Reply Slip back to me in the envelope.

If you would like to change the date or time of the meeting you can ring (Number)

I look forward to meeting you.

Yours sincerely

Clare Passey

Trainee Clinical Psychologist

**Appendix N**  
**Reply Slip: Opt in**

**NAME OF PARTICIPANT / ADDRESS**



Please tick the box you agree with

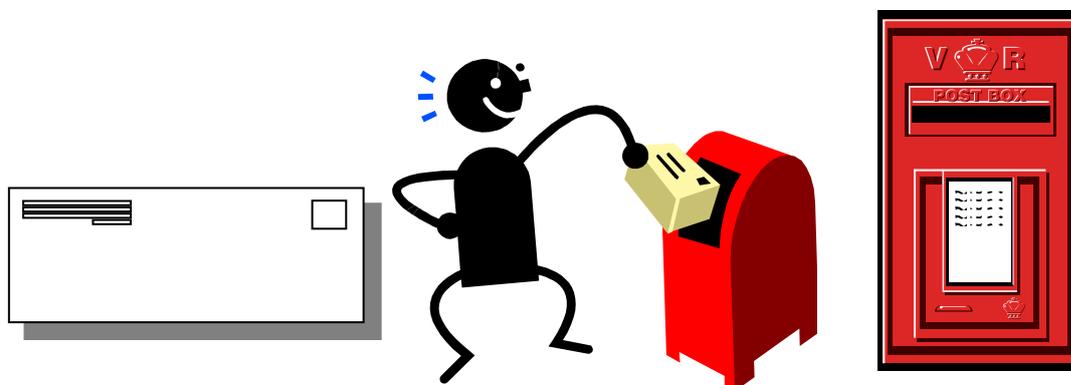
1. I can attend the meeting on **DATE/TIME**
  
2. I am interested in the research. But I would like to change the date and time of the meeting
  
3. I am not interested in the research, I cannot attend the meeting

Please sign and date

\_\_\_\_\_

Signature                      Date

**Please put the Reply Slip in the envelope and post it. Thank you.**



**Appendix O**  
**Invitation Letter to Consent Meeting**

**Confidential**

Dear **NAME OF PARTICIPANT**

Thank you for letting me know you **can/cannot** attend the meeting about the research.

I would like to **confirm/change** this meeting, **on/to**

**DATE & TIME**

**at Address**

If you would like to change the time or date of the meeting please ring (number).

I look forward to meeting you.

Yours sincerely

Clare Passey

Trainee Clinical Psychologist

## **Appendix P**

### **Standard Information Sheet**

#### **'Stories of offenders with learning disabilities: why we do/don't reoffend'**

Before you decide whether you would like to take part in this research, I would like you to understand why it is being done and what it will involve for you. We can use this information sheet or the information sheet with pictures to talk about the research together. You can choose which one we use and you can have copies to take away with you. You can read it with someone else or listen to what it says on a CD. If you would like a copy of the CD, please let me know. If you have any questions about the research, please ask me.

#### **What is this research about?**

I am interested in finding out more about people who have offended. I am also interested in people who have worked with Learning Disability services. Because of this, I would like to interview you. I will say things like 'Tell me about why you do/not offend'; 'Tell me about what helps you to avoid offending'. What you say could help to improve the way services work with people who have offended.

#### **Why have I been asked to take part?**

You have been asked to take part because **PROFESSIONALS NAME** said that you might be interested in the research. You have also worked with Learning Disability services.

#### **Do I have to take part?**

You do not have to take part in this research, this is OK.

I will ask if you would like to take part in the research and if you are happy to spend an extra 1 – 2 hours being interviewed. If you say **YES** I will ask you to sign a consent form to say you have agreed to take part in the research. Then we will agree when we will meet for an interview. Even at the interview, you can stop at any time.

If you say **NO** this is OK. You will no longer be involved in the research.

#### **What does taking part involve?**

Taking part involves a meeting where I interview you. The meeting will last 1 – 2 hours. You can come to this meeting on your own or bring someone with you for support.

Taking part also involves **PROFESSIONALS NAME** filling out a checklist about you. It asks basic information about you (e.g. if you are male or female), your offending history and the services you have used. Please ask if you want to see a copy of the checklist.

#### **What information will be included in the research?**

What you say will be included in the write up of the research, but no one will know it is you. Once you agree to take part I will give you what is called a Participant I.D only you and the research team will know what this is. Your Participant I.D. means your name and other personal details will be kept confidential.

#### **Will my personal details be kept confidential?**

Yes. All information about you will be kept confidential. But if I felt there was a risk to you or others I would have to pass this information on to other professionals, your GP or the police to keep you and everyone else safe.

All information about you will be securely locked away. The Participant I.D. information will be separately locked away.

**What happens if I decide to withdraw?**

You do not have to take part in this research, this is OK. And if you agree to take part, you can still change your mind without giving a reason. I will delete or destroy any information you have given to me. Please let me know if you want to withdraw from the research. You can withdraw at any time even after you have done the interview.

**What if there is a problem?**

If you take part in the research, it is unlikely to cause you any problems. But if are worried about it or you want to speak with someone about taking part, you can talk to me when we meet or phone (number) or you can phone Dr on (number).

If you are unhappy about the research, please let me know when we meet or phone (number) or you can phone Dr Helena Priest on (number).

If you are still unhappy and want to complain, you can contact (Patient Advice Liaison Service Details)

**What will happen to the results of the research?**

What you say will be written up with what other people have said and sent to a journal for publication. I cannot guarantee whether the research will be published in a journal. But I am happy to send you a short write up. Please let me know if you would like a copy.

**Who has reviewed the study?**

This research has been reviewed and given favourable opinion by Coventry & Warwickshire Research Ethics and Keele University Independent Peer Review Committees.

**Where can I get further information?**

You can ask for more information when we meet or you can phone (number)

These are my details:

Name: Clare Passey Job Title: Trainee Clinical Psychologist

Address: Staffordshire and Shropshire Professional Doctorate, Staffordshire University, Faculty of Health Sciences, Staffordshire University  
Leek Road, Stoke-on-Trent, ST4 2DF

Email: [c.l.passey@keele.ac.uk](mailto:c.l.passey@keele.ac.uk); [clare.passey@nhs.net](mailto:clare.passey@nhs.net)

Telephone: (number)

**Appendix Q**  
**Accessible Information Sheet**

Finding out about why people do and do not reoffend



What the research is about

Clare Passey Tel (number)

Hello,

I am interested in people who have offended.



I am also interested in people who have worked with Learning Disability Services.

I also want to improve the way Learning Disability Services work with people like you.



I want to talk with you to find out why you do or do not reoffend.

What you say could help improve services.

You can decide if you want to take part. It is OK to talk to someone else about your decision.

If you say no I will not contact you again.



If you say yes we will agree a date for me to interview you.



At the interview when you talk, I will write down what you say. I will also make a tape of your words.

You do not have to talk to me.

You can withdraw at any time.



I would also like to ask PROFESSIONAL's NAME for some information about you and your history.

All information about you will be kept private. But if I feel there is a risk to you or others I will need to tell someone to keep you safe.



All of your information will be locked away.



What you say will be written as a story and published in a journal for other people to read. But no one will know it is you.

Taking part in the research is unlikely to cause you problems. But if you are worried you can talk to me or someone else.

## Appendix R Consent Form

Project Title: 'Stories of offenders with learning disabilities: why we do/don't reoffend'

Name of researcher: Clare Passey

**Please initial the box if you agree**

I agree to take part in the research



I agree for Clare Passey to write down what I say



I agree to be tape-recorded



I agree for **PROFESSIONALS**  
**NAME** to share some information  
about me

I can withdraw at any time

I agree for Clare Passey to inform  
my GP I am taking part in the  
research

**Please Sign:**

\_\_\_\_\_  
Name of participant/ID                      Date                      Signature

\_\_\_\_\_  
Name of researcher                      Date                      Signature

**Appendix S**  
**Consent Form Prompts**

Project Title: 'Stories of offenders with learning disabilities: why we do/don't reoffend'

Name of researcher: Clare Passey

1. Check that the Participant has *read/listened* to the *information sheet/CD*
  
2. Does the participant have any questions? Do the answers I have given make sense?
  
3. The participant can stop the interview and withdraw at any time without giving a reason
  
4. Does the participant understand that after the interview, what he/she says will be written up as a story and published in a journal for other people to read. But nobody will know it is them
  
5. If the participant agrees for me to inform their GP of their participation in the research, request GP details
  
6. Sign consent form: one copy for researcher, one for participant
  
7. Remind participant at interview

## Appendix T Demographic Checklist

Dear **PROFESSIONALS NAME**

**PARTICIPANT NAME** has given consent for you to complete the following checklist about them. It would be helpful if you could do so and return in the stamped addressed envelope as soon as possible. If you cannot give exact details, please estimate where possible and make clear that this is the case.

Thank you in advance for your time

Yours Sincerely

Clare Passey

Trainee Clinical Psychologist

### CHECKLIST

○ **Sex**

Male  Female

○ **Age**

18 – 24  25 – 30  31 – 35  36 – 40  41 – 45

46 – 50  51 – 55  56 – 60  61 – 65  65+

○ Type of Offence/Reason for access to services (e.g. sexual offence; fire setting etc.)

○ Type/Level of input from services (e.g. Section; Community treatment order; Psychology Input etc.)

○ Period since last offence

**Appendix U**  
**Invitation to Interview Letter**

**Confidential**

Dear **NAME OF PARTICIPANT**

Thank you for agreeing to take part in an interview.

As we agreed, I would like to meet with you on

**DATE & TIME**

**at Address**

If you have any questions or you would like to change the time or date of the meeting please ring (number)

I look forward to seeing you on DATE.

Yours sincerely

Clare Passey

Trainee Clinical Psychologist

## **Appendix V**

### **Interview Prompts**

INTRODUCTION: I am interested in people who have offended. I am also interested in people who have worked with Learning Disability services. Today I would like to listen to you. What you say could help to make services better.

#### ***CONFIRM CONSENT/SIGN CONSENT FORM***

#### **PROMPTS:**

- Tell me your story
- Start at the beginning
- How did you meet [\*Professional's name]?
- How did you get involved with LD services?
- Tell me about why you do not offend/break the law/get into trouble with the police
- Tell me about what helps you to avoid/stop offending/breaking the law/getting into trouble with the police
- Tell me more about [that]
- Take your time
- Would you like to take a break?

## **Appendix W**

### **Thematic Descriptions**

#### **Individual Thematic Descriptions**

**Fred: Thematic Description.** Fred does not reoffend because he has changed his life. He has better relationships with his family and now has a girlfriend [Relationships]. He is worried that if he reoffends then he will go to prison [Fear of Consequences]. Fred stops and thinks about the consequences and keeps busy, doing activities so that he avoids reoffending [Stop and Think/Community Integration:].

**Jamie: Thematic Description.** Jamie does not reoffend because he smokes cannabis [Maladaptive Coping]. He has made friends with people who do not judge him; he goes to raves and enjoys music with these friends [Relationships/Community Integration]. In the past, Jamie sold cannabis, but he no longer does this because he does not want to put his family in danger [Fear of Consequences/Relationships]. Jamie has problems in the community, he was asked to leave college. Jamie and his family feel let down by many services; they would like more long-term, support. Jamie values the support he has received from a Psychologist, Psychiatrist and a GP that has helped him to avoid offending behaviour [Someone to Talk to/Long-Term Support].

**Rueben: Thematic Description.** Rueben does not reoffend because he will get caught and there are serious consequences to offending behaviour. Rueben also suggests there are consequences for his victims and their families [Fear of Consequences]. Rueben met with a psychologist, but said that it took time to talk about his offending [Someone to Talk to/Long-Term Support]. Rueben has reflected on his past behaviour and now makes decisions to avoid offending [Stop and Think]. He is writing a novel about his life, which helps him to see the risks. Rueben does activities in the day independently that keep him busy [Community Integration], but he would like to make new friends. He has better relationships with his family [Relationships].

**Herbie: Thematic Description.** Herbie does not reoffend because he has 'grown out of it' and believes he will lose everything [Fear of Consequences]. Herbie says that he now has things to look forward to; he keeps himself occupied so that he is not bored [Community Integration]. If Herbie worries that he will make

the wrong decision and offend, he speaks to someone like his carer [Someone to Talk to/Long-Term Support].

**Patrick: Thematic Description.** Patrick does not reoffend because he should not have offended in the first place. Patrick also says that meeting with a Psychologist helps him to stop feeling angry and to avoid offending behaviour [Someone to Talk to/Stop and Think]. Patrick keeps busy by attending college and doing things like dog walking; he is supported in the community, which helps to keep him out of trouble [Community Integration]. However, Patrick would like to have more independence.

**Bob: Thematic Description.** Bob does not reoffend because he will get kicked out of college [Fear of Consequences]. He meets with a counsellor to talk about managing angry feelings; when he feels angry he tries to do something different like walking away from a situation [Someone to Talk to/Stop and Think] Bob tries to keep himself busy with college and other activities to avoid offending behaviour [Community Integration]. Bob has made new friends and would like a girlfriend [Relationships].

### **Collective Thematic Description**

**Fear of Consequences.** Most of the men interviewed fear the consequences of reoffending; this includes direct (e.g. punishment) and indirect consequences (e.g. for the family of the victim).

**Community Integration.** All of the men engage in activities in the community. Some try to keep busy so they avoid offending.

**Stop and Think.** All of the men said that they make different decisions to avoid offending, for example by keeping busy or by using treatment protocols like 'Stop and Think'.

**Someone to Talk to.** All of the men said that they valued having someone to talk to (e.g. Psychologist/Counsellor or carer) to help them to avoid reoffending. Some men said meetings helped them to manage their feelings.

**Relationships.** Some of the men spoke of improved relationships with their family since offending. Some of the men have made new friends and have intimate partners; the other men would like this in the future.

**Long-Term Support.** Most of the men talked about ongoing or long-term support from services. Where services were not available long-term, one of the men felt let down.

## Appendix X

### Individual Stories

Following are the four individual stories for Rueben, Herbie, Patrick and Bob.

#### Rueben's Story

Rueben does not reoffend because: *R: these days I can't or anyone like me can't get away with it [...] because um back in the day in the 90's and also the 2000's umm back then they had the police [...] and um somehow I was getting away with it/at one point several points actually/but I know these days I can't get away with it 'cause I know they got the police then you got the other persons/family (of the victim) that I had to think of they might want to kill me or something [...] serious consequences/because I know the rules and everything all change for offenders/today but back then it was like a hush hush about it [...] yeah it's also it's also in media today [Fear of Consequences]. They (Service/Psychologist) helped to see that it's wrong but it's also learning about your victims [...] and help you to talk about your offence/I had so many tears come into my face because I was there for that particular reason [...] I just learned that I can't talk anything in general/because they're only there for one thing and that's that/R: yeah, so did you learn to talk about it then?/RU: no not really no/it took me a good while [Someone to Talk to/Long-Term Support]. R: at the moment I'm writing um a novel/so that's also taking the risks out of the situation I've learnt all my risks and everything what what I might come up against or so if anything happens or anything how can I control that/and how to control the situation that I'm in [Stop and Think]. R: I I think trying to have a normal life uh [...] well the normal way of life is that you don't do none of this (offending) stuff [...] it's like normal you like you just like the sun you like to play football you've got a couple of tattoo by now [...] I want new friends [Community Integration/Relationships]. R: um it (the novel) might be published [...] so it's my birthday treat for my Mum to have I'm hoping to publish that [Relationships].*

#### Herbie's Story

Herbie does not reoffend because: *H: well I don't offend because I've grown out of it certain stuff [...] and also because I've got things to look forward to [...] well if I reoffend I'll lose everything/R: so tell me more about the things that you've got to look forward to/H: well I've got my bike obviously which is part of my*

life I've got a home I've got friends and also I've got my mum I've contacted which I've got a good relationship going/R: so is that different to when you offended, did you have friends and things then or have things changed?/H: I did have a few friends but they weren't like proper friends [Fear of Consequences/Community Integration/Relationships]. H: I try and do things to keep myself a bit busy so I'm not bored and I'm not going to reoffend [...]/H: well it's good because it's like I said before instead of bottling it up inside me and letting it build up over time I just talk about it now and again just to get rid of the problem because if kept it there/and then another problem arises then I keep that in there then all the problems in there will start building up so to say certain things/to try and get it all out so there is nothing there [Someone to talk to/Long-Term Support].

### **Patrick's Story**

Patrick does not reoffend because: *it's not big now [...] I shouldn't have done what I did in the first place [...] coming to the appointments (Clinical Psychologist)[...] stops me from being angry [Someone to Talk to/Stop and Think]. P: I go to college [...] dog walking [...] I do I like going there I'm going there to (at the weekend) [...] R: and does (support worker) and other people help you to do that? P: yeah [...] so I progress and come back to independence hopefully [Long-Term Support/Community Integration].*

### **Bob's Story**

Bob does not reoffend because: *B: well (Counsellor) like helps me my to try and calm me down things like help me with my behaviour and all that how to calm yourself down and that so yeah/I usually turn around and just walk away (from a difficult situation) 'cause there's a lake at college I just head down there and just on me own walk around [...] sometimes I have a mate with me [...] they usually try to calm me down, but it usually doesn't work I just completely ignore what they say and just go and lash out [...] but sometimes it does work [Someone to Talk to/Stop and Think]. B: like I don't wanna get in more trouble with like college and get kicked out and that [Fear of Consequences]. B: I'm just thinking about the future now 'cause there is stuff happening with the future and all that [...] yeah I uh socialise with clubs and that college clubs and that yeah so [...] umm all kinds of stuff trips, computers, XBOX, pool, music and all that/R: and do you get into trouble when you're doing all of that?/B: no/R: no so keeping yourself busy/B:*

*yeah/R: doing things that you enjoy/B: mm yeah/R: you don't get wound up, that sounds really good/B: mm [Community Integration]. R: and what would you like to do? B: more things with other people like me mates that I might get at this new college [Relationships].*