Effectiveness of group CBT for people with learning disabilities/autism and sexually harmful behaviour: the SOTSEC-ID model

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Plan

- What is known about sex offenders with learning disabilities & treatment for them?
- Evidence from research literature and the SOTSEC-ID model
- People with autism vs those with LD
- Training events: SOTSEC-ID & ySOTSEC-ID
- Conclusions
Sexual offending by non-disabled men

- Grossly under-reported to police (fewer than 50% of people ever tell anyone; around 20% are notified to police; few lead to conviction)
- Victim surveys (Britain and Ireland):
  - about 50% women have been victims of exhibitionism
  - around 20% of women (fewer men) victims of contact abuse
  - around 5-10% of women (fewer men) victims of rape
- 90-95% of sex offenders are men
- Most perpetrators are known in some way to victim
- Offenders often engage in grooming & stalking of victims; may do complex planning of offending
- Used to be thought sex offenders had one paraphilia (deviant sexual interest), targeted one age group, either inside or outside family. This no longer considered correct.
Treatment for non-disabled sex offenders:
recent years

- 1960s & 1970s: Sexual abuse seen as result of deviant sexual interests & arousal (also some occasional recognition of role of poor social skills)
- Led to behavioural techniques eg aversion therapy, orgasmic reconditioning & covert sensitisation
- Belief in medical model & anti-androgens
- Little evidence of effectiveness; under-provision of treatment
- Move to CBT approach – partly due to recognition of importance of cognitive distortions in the 1980s (e.g. work of Wolf, Abel, Finklehor & Marshall)
Does CBT work for non-disabled men?

- Hanson et al, 2002: Meta-analysis of 43 CBT studies of sex offender treatment (over 9,000 participants overall) - sexual offence recidivism rate: 12% for treated men vs 17% for untreated men

- Aos, Miller & Drake 2006: reviewed controlled CBT studies. CBT produced reduction in recidivism (31% reduction in community & 15% in prison sample)

- Kenworthy et al, 2006: Cochrane review of 9 RCTs (over 500 offenders), mostly paedophiles; variety of treatment methods:
  - one large CBT trial showed a definite reduction in recidivism
  - one large group psychotherapy trial showed treatment increased risk.

- More recent Cochrane review 2012
Men with learning disabilities/autism and sexual harmful behaviour: numbers

- Issues such as: convicted vs unconvicted men; contact vs non-contact offences
- Methodological difficulties: different samples (prison, hospital, community); ignoring filters & diversion in CJS; suggestibility & evasion issues
- Early studies: ? high prevalence of offending but very poor methodology (e.g., Walker & McCabe, 1973) study
- 50% of perpetrators of sexual abuse in LD services themselves have LD (Brown et al, 1995)
- Susan Hayes (1991): Prison survey found that:
  - 4% of offenders with LD convicted of a sex offence
  - 4% of non-LD likewise
Men with learning disabilities/autism & sexually harmful behaviour: characteristics

- Characteristics: often from violent, chaotic, neglectful families; frequently have other CB &/or convictions; often have mental health problems (Gilby et al, 1989; Day, 1994; Lindsay et al, 2002)
- Show cognitive distortions (Lindsay et al, 1998a,b,c)
- Recidivism: recidivism rate was 31% in convicted men with LD (Austr.) - about 2-3 X as high as that of non-disabled men - Klimecki et al (1994)
- History of abuse: Lindsay et al (2001) found 38% of sex offenders with LD had been abused c.f. 13% non-sex offenders with LD
- Not less knowledgeable about sex than other pwld (Langdon study & Lindsay study, both 2007)
Men with learning disabilities/ autism and sexually harmful behaviour: characteristics

- Victims: mainly other people with LD/autism, some children (less often non-disabled adults); usually victims known to the perpetrator – Gilby et al 1989
- Offences more opportunistic & less planned (less grooming & stalking)
- Often long history of sexual problems & multiple placements
- Often ‘offences’ not reported to police & even when reported, men mostly not prosecuted nor treated (eg Thompson, 1997)
CBT for men with & without LD/autism in UK in about 2000

- For men without LD/autism, group CBT recognised as the leading method of treatment (eg Hanson et al meta-analysis)

- Beckett, Beech et al. had evaluated: CBT for convicted sex offenders in prison sentenced to 4yrs+ (SOTP) & community-based programmes, run by probation, clinical psych & SW

- **Men with LD mostly excluded from these**: group CBT in few places only - some prisons (ASOTP), Janet Shaw clinic in Solihull (ASOTP), Northgate hosp programme near Newcastle, Bill Lindsay’s programme in Scotland
Does group CBT work for men with LD?

- Lindsay et al (1998a, b) showed some improvements in 6 men with LD & paedophilic offences & 4 men with LD & exhibitionism, after CBT
- Lindsay & Smith (1998): 2 years CBT was more effective than 1 yr CBT for men with LD, on probation
- Several very small studies showing non significant effects (Rose et al 2002; Craig et al 2006)
- Lindsay et al 2006: 70% harm reduction in 29 repeat sexual offenders with ID, after CBT
- Williams et al, 2007: significant improvements in scores from pre-group to post-group in 150 men following CBT in ASOTP programmes in prisons (not all ID)
Research in this field: problems

- Small numbers of potential participants
- Geographically dispersed
- Difficulty of establishing a control group
- Difficulty in obtaining ethical approval for research on vulnerable participants
- NHS ethical and operational approval procedures
SOTSEC-ID

- Sex Offender Treatment Services Collaborative - Intellectual Disability
- About 30 sets of therapists providing sex offender treatment for men with intellectual disabilities in England (& WL controls)
- Run training events & meet every few months (over 500 people trained)
- Set up sex offender treatment groups, shared treatment manual to guide therapy (ttmt lasts 1 yr; 2hr sessions, once per week, closed groups)
- Sharing core assessments measures
- Research funded by DoH, Care Principles, Bailey Thomas fund
Core assessments

- Once only: measures of IQ, adaptive behaviour, language, & autism
- Pre & Post group treatment:
  - Sexual Knowledge & Attitude Scale (SAKS)
  - Victim Empathy scale, adapted (Beckett & Fisher)
  - Sex Offender Self-Appraisal Scale (Bray & Foreshaw’s SOSAS)
  - Questionnaire on Attitudes Consistent with Sex Offending (Bill Lindsay et al.’s QACSO)
- Recidivism – further sexually abusive behaviour
Treatment content

- Group purpose, rule setting
- Human relations & sex education
- The cognitive model (thoughts, feelings, action)
- General empathy & victim empathy
- Sexual offending model (based on Finklehor model)
- Relapse prevention

Compared to non-LD programmes: Far more slow offence disclosure; more on sex education; far more pictorial material & less sophisticated on cognitive side
Now 109 men through treatment

- 18 sites; 27 groups
- Mean age 35 yrs (sd 11.7); 60% legally req to come
- Mean full scale IQ 66 (sd 6.4); mean BPVS 9yrs 7mths
- 96% of men, who agreed to join research, completed ttmt

Process measures:
- all p<0.001 for changes pre-group to post-group
- all p<0.01 for changes pre-group to 6 mth follow-up
- 10% showed further sexually abusive behaviour (6mths)
- Further SAB not related to age, IQ, personality disorders, pre-group & post-group scores on any process measure.
- Again: those with ASD more likely to re-offend (p<0.05)
Process measures (n=109)
Men with autism vs men with LD

- Significantly more likely to engage in non-contact offending than those with ID only
- Process measures: No significant differences on baseline measures (IQ etc), nor on any pre-group measures between ASD and non–ASD
- Process measures: No significant differences on any post-group measures between ASD and non–ASD, except QACSO (poorer for ASD)
- Interviews with those with ASD: suggested empathy a problem (Clare Melvin)
Follow-up data
(Heaton & Murphy 2013)

- 34 men (n.s. different in characteristics from 46 men in 2010 paper)
- Mean length of follow up 3yrs 8mths
- Significant improvements in SAKS, VE and QACSO during treatment (pre to post) were all maintained at follow-up – testing post-grp to f-u (SOSAS different)
- 8 out of 34 (24%) men showed further sexually abusive behaviour – but much less severe than pre-treatment; 2 of 34 (6%) re-convicted
- ‘Dodgy’ or ‘chain’ behaviours: 17 of 34 men
- Only late chain behaviours and ASD diagnosis related to further sexually abusive behaviour
Service user views from first group

- Good understanding of basic facts (duration, venue, facilitators, & rules, e.g. confidentiality rule)
- Good understanding why referred: ‘Because of my probation because of my sex offence to see if it would do me any good’
  ‘To help my sex urges and keep them under control; to be a better person when meeting women in the community’
  ‘To help us stop getting into trouble with the police; because I go out to masturbate’
Most could list some of what they did in group (not very coherently)

What they learnt:

‘Stopped me touching girls’
‘How people feel about us masturbating’ (in public)
‘Learnt not to go after women’
‘Learnt .. to put a condom on’
‘Learnt to help other people in the group’
‘What the police do when they arrest you’

Lots but not all could name the four stages of sexual offending (not OK sexy thoughts, making excuses, planning it, doing it)
Service user views (cont’d)

Best things
- ‘Having support every week’
- ‘We … talked about feelings about things, sorting the problems out’
- ‘Working together, helping each other’
- ‘We helped each other discuss … work on ways of preventing problems in the future’

Worst things
- ‘Telling people very private stuff, keeping people on trust’
- ‘Some didn’t talk’
Strengths & weaknesses

- Multi-site study with sufficient N
- Early results look promising for changes in sexual knowledge, cognitive distortions and empathy
- Establishment of a long-term data base to track recidivism and other relevant data on this group
- SOTSEC-ID established: supporting clinical research in an under-serviced and under-researched area
- Problem with obtaining sufficient controls
- Non-randomised assignment to treatment/control grp
- Problem of getting clinicians to collect data when they are very busy
- This treatment is only suitable for men with good verbal skills (i.e. mild learning disabilities)
What’s next?

- **SOTSEC-ID**
  - New treatment manual; next training July

- Training in risk assessments:
  - ARMIDILIO & START

- Young people: *Keep Safe* treatment model developed by Rowena Rossiter & colleagues
  - first draft of manual ready; 2 trial sites ran it
  - trained 35 people Bristol in February 2017
  - more training autumn 2017

- **SAFER-IDD**
Key references