Healthy Sex Programme UK

Prison

Individual Work

Group Work

Type of intervention

Target group, levels of prevention and sub-groups:

Tertiary prevention

(Potential) Offenders

Adults (21 Years +) | Male | Interventions for those with Disabilities/Learning Difficulties, Prison, Individual Work, Group Work | English

Target population

The Healthy Sex Programme (HSP) aims to meet the needs of adult male sexual offenders with outstanding treatment needs in relation to sexual interests, in both custody and the community. It is also designed to be flexible and responsive enough to meet the needs of intellectually disabled sex offenders (IDSOs) who require this specialist intervention. The HSP is a revised version of the accredited Healthy Sexual Functioning Programme (HSFP) which was accredited for delivery in custody in 2004. HSP was piloted with a view to submitting it for full accreditation in Autumn 2013.

Delivery organisation

National Offender Management Service (England and Wales)

Mode and context of delivery

The treatment method is broadly cognitive-behavioural. That is, methods aim to intervene in the pathway to offending by restructuring attitudes that support or permit sexual offending and changing previous dysfunctional behaviours by building new skills and resources.

HSP is being developed for accreditation. As such, all providers of the programme are subject to audit procedures. The purpose of audit is to ensure that the programmes are being delivered as intended, both operationally and clinically. Operationally, audit ensures that programmes receive appropriate management support and attention, that delivery is not compromised by insufficient resources, that staff are supported and that assessments and other paperwork are completed in an appropriate and timely way. The clinical assurance process ensures that the quality of treatment

delivery is in line with expectations. Each programme is rated against two criteria; the quality of delivery of the programme and the quality of treatment management. The QA process involves examination of treatment documents such as "products" (work completed by participants) and logs and reports by programme staff; viewing at least three recordings of sessions and examining the supervisor's records (such as observational notes and supervision records).

Level/Nature of staff expertise required

The HSP is designed to be delivered by a Forensic Psychologist in Training, a Registered Psychologist or a fully qualified Probation Officer. HSP therapists must be experienced facilitators of sex offender treatment programmes. All staff working on sex offender programmes in custody undergo a nationally-prescribed comprehensive selection process followed by residential training during which their understanding, competencies and abilities will be assessed. Staff must first be assessed as suitable to become a facilitator. This will involve completion of various psychometric assessments and interviews with local managers. They then have to pass an assessment. Those who are successful will attend training in the fundamental skills associated with working with sexual offenders and then the core programme specific training. Only experienced facilitators who have a proven track record in successful delivery of primary treatment programmes are eligible to apply to become an HSP therapist. If successful in a therapist assessment centre they will attend further training specific to the HSP. Those staff who pass the training will provide treatment under the supervision of a Treatment Manager or designated supervisor.

Intensity/extent of engagement with target group(s)

Each session on the HSP can last between 30 minutes and 1.5 hours. Delivery is at the rate of one or two sessions per week. Providing the session length remains within these limits and providing the total does not exceed 30 hours, the programme can be delivered in any number of sessions. For example, a higher number of sessions lasting 30 minutes can be delivered, if it is felt this would be more helpful and responsive to the participant's learning style.

The HSP is designed to be most beneficial if completed following primary treatment. Therefore, in most cases it will be recommended for offenders after they have completed Core (TOPO 1a) (and Extended, TOPO 1b, if necessary) or the Becoming New Me SOTP (TOPO 3a). When it rolls out in the community, it will, in most cases, be recommended for offenders after they have completed a community sex offender treatment programme. However, it is also now possible to recommend the HSP for an offender prior to, or alongside his completion of primary treatment. This may be in instances where the offender does not have time to complete primary treatment and the HSP is considered essential to his risk management (i.e. he will be released from prison or his license will expire), or where the offender is unable to engage effectively in primary treatment due to the strength of his needs in relation to his sexual interests i.e. he is experiencing highly intrusive sexual thoughts and urges. In the latter cases, the completion of the HSP may enable the offender to gain some control over his sexual thoughts and urges so that he is more able to engage in a group based programme and to benefit from this.

Description of intervention

The HSP is a 1:1 programme although there may be opportunities for small group work within the delivery format. The number of sessions spent on each block will vary according to the needs of each participant.

Programme Aims

- To help participants understand healthy sex and healthy sexual thoughts
- To help participants explore their own sexual interest/s, sexual thoughts and sexual arousal patterns
- To help participants work out what triggers their offence-related sexual arousal or healthy sexual arousal
- To help participants increase their healthy sexual thoughts and arousal
- To teach participants ways to manage and feel in control of their sexual thoughts and urges
- To give participants better skills to have healthy and satisfying sexual relationships with adults
- To update relapse prevention plans in relation to managing offence related sexual thoughts and arousal

Outline of blocks:

Pre Programme: The aim of these sessions is to allow the therapist and participant to introduce themselves to each other, explore how the participant feels about starting the programme, to establish the participant's level of motivation, to complete the risk and success factors analysis interview, to explore the participant's individual needs and to decide if a referral for medication is necessary.

Module 1: Engagement: This module is about introducing the participant to the programme, reviewing what he has done in previous treatment, discussing what might get in the way when talking about sexual interests, discussing what support he will need throughout the course and deciding how the participant and the therapist can work together in treatment

Module 2: Understanding my sexual interests: This module is about having a clear idea of the sexual interests the programme will focus on, how the participant experiences these interests for example, what kinds of sexual thoughts and feelings he has currently, where he thinks his sexual interest/s came from and the life experiences he has had that have been significant in this. The module ends with the therapist and participant deciding together what will be the focus of the rest of the programme (treatment planning).

Module 3: New Me and sex: This is the main module in the programme. It contains a variety of exercises which aim to help the participant to live with and manage his inappropriate sexual interest without acting on it and committing a further sexual offence. It draws on techniques such as behaviour modification, urge surfing, trigger management and mindfulness. Exercises are chosen to be tailored to the needs of the participant. Some participants might focus more on exercises that help them to accept their sexual interest and live with it whilst also achieving other goals that help to take them away from offending. Others might complete exercises that help their sexual interest to feel less arousing or to make healthy sexual thoughts more arousing.

Module 4: Sex and a better life: This module includes a variety of optional exercises that can be chosen to complement the work completed in module 3. They can be done at any time throughout the programme and include things such as understanding what healthy sex is, dealing with worries about sex, improving relationships, sex education, talking about sexual beliefs and pornography.

Module 5: Bringing it all together: This is a very short module and involves talking about what the participant has learned on the programme and how he is going to take this forward. It also reviews his goals and talks about how he feels about the programme coming to an end.

Evaluation

Large-scale research indicates that sex offenders who receive treatment, in both prison and community settings, have a lower sexual reconviction rate than those who do not receive treatment. Cognitive-behavioural treatment is the most effective, especially if paired with pharmacological treatment (for examplehormonal drugs that reduce sexual drive). Other approaches (psychotherapy, counselling and non-behavioural treatment) generally do not reduce reconviction.

Hanson, Bourgon, Helmus, & Hodgson (2009) examined 22 studies that met minimum standards for methodological quality and found an eight percentage point difference (10.9% and 19.2%, respectively, or a relative 43% reduction) between treated offenders and untreated controls. Sex offender programmes which follow the risk, need and responsivity principles lead to the largest reductions in reconviction. Medium and high risk sexual offenders benefit most from treatment.

Schmucker & Losel (2009) combined 26 high-quality research studies of sex offender treatment. The sexual offending reconviction rate for treated offenders was on average 3.4 percentage points lower than that for untreated offenders (this can also be phrased as a 27% reduction in sexual offending). The general reoffending rate was also reduced by treatment. Mandatory treatment had as much impact as voluntary treatment. The treatment effect was better for juveniles and for high risk offenders and was better in well-documented programmes and programmes that were delivered through individual sessions as well as group work.

The impact of cognitive behavioural interventions with sexual offenders is as good as, and in some cases better than, the impact of many well accepted medical and psychological treatments (Marshall & McGuire, 2003).

There is an empirical literature into risk factors for sexual recidivism (for example Hanson & Morton-Bourgon, 2004), which provides useful guidance on the essential targets for treating those with sexual deviance (Mann, Hanson, & Thornton, 2010). The established risk factors are often viewed as clustering into four domains (Craissati & Beech, 2003; Hanson, 2000): sexual arousal factors; attitudes tolerant of sexual deviance; interpersonal deficits; and selfregulation deficits. Mann, Hanson and Thornton (2010) summarised this literature and found that having an offence related sexual interest (including a sexual preference for pubescent or prepubescent children, sexualised violence and the presence of multiple paraphilia) is one of the strongest known risk factors for sexual reoffending. The HSP has been developed for those with problems in this area.

This programme has been piloted in custody. HSP applied for accreditation in the autumn 2013. A programme of evaluation will be in place to support delivery of this programme.

References

Craissati, J. & Beech, A. (2003). A review of dynamic variables and their relationship to risk prediction in sex offenders. *Journal of Sexual Aggression, 9,* 41–55.

Hanson, R. K. (2000). Treatment outcome and evaluation problems (and solutions). In Laws, D. R., Hudson, S. M., & Ward, T. (Eds.), *Remaking relapse prevention with sexual offenders* (pp. 485–499). Thousand Oaks, CA: Sage

Hanson, R. K. & Morton-Bourgon, K. (2004). *Predictorsof sexual recidivism: An updated meta-analysis*. Research report 2002–02, Public Safety and Emergency Preparedness Canada.

Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A Meta-analysis. *Criminal Justice and Behavior*, 36, 865-891.

Mann, Hanson, & Thornton, 2008). The established risk factors are often viewed as clustering into four domains

Mann, R.E., Hanson, R.K. & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22*, 172-190.

Marshall, W. L. & McGuire, J. (2003). Effect sizes in the treatment of sex offenders. Int. J. of Offender Therapy and Comparative Criminology, 47, 653-663

Schmucker, M & Losel, F. (2009). A systematic review of high quality evaluations of sex offender treatment. Paper presented at the Annual Conference of the European Society of Criminology, Ljubljana, Slovenia.

Contact details

Her Majesty's Prison and Probation Service
102 Petty France,
London,
SW1H 9AJ
United Kingdom

Email public.enquiries@noms.gsi.gov.uk Main
switchboard 01633 630941
https://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service