Doctoral Thesis

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The paradox of forensic care: Supporting sexual offenders

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	Main text (incl. abstract)	Appendices (incl. title page, references)	Total
Thesis abstract	299	---	299
Literature review	7993	9069	17062
Research paper	7999	5599	13598
Critical appraisal	3889	2022	5911
Ethics section	---	6414	6414
Total	20180	23104	43284

Thesis Abstract

Perceptions of sex offenders are often negative due to the nature of their crimes, leading them to be viewed as a homogenous group. Previous research, has, however, suggested that for sex offender treatment to be effective, it needs to address the individual's specific criminogenic needs within a compassionate and on-judgemental setting. Given the significant impact of sexual abuse, understanding what factors promote treatment effectiveness and influence compassionate care is needed. This researched explored specific sex offender populations, child sex offenders and sex offenders with learning disabilities (SOwLD). The paradoxical nature of forensic services is considered, given the emphasis placed on compassionate care needed in the treatment of sex offenders, and the requirement for security to manage risk. The challenge in providing patient-centred care was acknowledged when treatment was mandated or delivered in secure environments, a common occurrence in forensic services.

In Chapter 1, qualitative research that explored the therapy experiences of child sexual offenders was synthesised. The themes reported within the eight identified studies were compared, resulting in the emergence of five superordinate themes. Results indicated the importance of non-judgemental, empathic, and compassionate support in improving meaningful engagement.

In Chapter 2, a qualitative research study was conducted which explored nursing professionals' experiences of working with SOwLD. This study identified the challenges and benefits of working with this population. Interpretative Phenomenological Analysis was used to develop themes from the narratives of eight nursing professionals. Two superordinate themes emerged: Becoming Janus and The pervasive influence. A lack of support or progress

could increase job-demands, in turn risking compassion-fatigue. Consideration is given to how staff wellbeing can be improved when working with this population

In Chapter 3, a critical appraisal was conducted to explore the use of labelling language within research and healthcare services, including how this could be changed.

Declaration

This thesis records research activity undertaken between July 2019 and June 2020 for the Doctorate in Clinical Psychology at Lancaster University. The work presented in this thesis is my own except where reference to other authors is made. This work has not been submitted for any other academic award.

Name: Claire Downs

Date: June 1st 2020

Signature:

Acknowledgements

I would like to thank those that offered their time to share their thoughts, feelings, and experiences with me. You all provided valuable insight into the reality of working in forensic services. I continue to admire your dedication to your patients and drive to maintain the compassionate care you deliver, despite challenges faced. I would also like to thank the research team; Dr Ian Fletcher and Dr Kelly Rayner-Smith for helping me navigate this thesis project.

I am grateful for the support from my family, my Mam, Dad, and sister Fiona, for their consistent motivation and help, especially when plans changed! I am forever proud to be part of “Team Downs”! Finally, I would also like to thank my partner Joe. Thank you for always helping me to look for the positives, as well as for the endless cups of tea!

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Chapter 1: Literature Review

Experience of sexual offending treatment programmes (SOTPs) from the perspective of those who have committed child sexual offences: A meta-synthesis

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Abstract

Background: The effectiveness of SOTPs remains inconsistent in the literature. Previous research has explored recidivism rates, rather than exploring factors needed to promote meaningful engagement as required for positive outcomes to be achieved. **Objectives:** To explore child sex offenders' experiences of engaging in sexual offence treatment programmes (SOTPs) to understand what may have influenced their meaningful engagement in therapy. **Method:** Four electronic databases were searched to identify relevant literature. Eight qualitative studies were included in this qualitative meta-synthesis. **Results:** Five Superordinate themes were identified: 1) Learning about oneself and others; 2) Motivation and engagement in therapy; 3) Shared experiences; 4) The therapist's role; and 5) Moving forwards. Participants described needing to understand what led them to offend, including an exploration of their own life experiences prior to offending. This helped provide insight into effective relapse prevention strategies. Participants valued peer support as this increased feelings of safety, promoting honesty. Therapists sustained motivation if perceived as caring and non-judgemental. Engagement in SOTPs enabled participants to have hope for the future. Negative experiences were expressed if individuality of participants was not acknowledged **Conclusions:** Group therapy can promote meaningful engagement in SOTPs. Ongoing assessment of participants' needs is needed to prevent disengagement. Strategies to maintain therapist wellbeing are needed to prevent this impacting negatively on the therapeutic relationship.

Key words: Sexual offence treatment programmes, offender experiences, child sexual offences

Introduction

Sexual abuse in childhood can have a significant impact on an individual's life (Merrick, Ports, Ford, Afifi, Gerhoff & Gorgan-Kaylor, 2017; Sumner et al., 2016), including increased risk of depression, suicide and substance misuse in adulthood (Craig, Zettler, Wolff & Baglivio, 2019; Merrick et al., 2017; O'Leary, Coohey & Easton, 2010). The true prevalence of child sexual abuse is difficult to determine, due to some abuse being unreported. A recent meta-analytic study has, however, suggested 13% of girls and 6% of boys have experienced sexual abuse (Barth, Bermetz, Heim, Trelle & Tonia, 2013), with similar estimated rates being reported in other reviews (Gorey & Leslie, 1997; Pereda, Guilera, Forns & Gómez -Benito, 2009; Stoltenborgh, Van Ijzendoorn, Eyser & Bakermans-Kranenburg, 2011). Given the prevalence of child sexual abuse, and the long-term adverse effects this can have, greater investment in identifying effective strategies to reduce sexual offending against children is needed (Långström, Enebrink, Laurén, Lindblom, Werkö & Hanson, 2013).

The psychological treatment of sexual offenders is an essential component in reducing reoffending (Jahnke, Philipp & Hoyer, 2015). How effective sexual offence treatment programmes (SOTP) are in reducing risk remains unclear, with contradictory findings being reported (Rice, 2010; Schmucker & Lösel, 2015). This lack of clarity indicates a need to better understand what factors influences how efficacious SOTPs are to ascertain "what works" in the treatment of sexual offenders. This has important implications in helping break the cycle of violence commonly associated with the sexual abuse of children (Fulu, Jewkes, Roselli & Garcia-Moreno, 2013). Having a better understanding of the therapeutic interventions offered to sexual offenders and individuals with a sexual interest in children is, therefore, needed.

Treatment of sexual offenders

Regardless of whether sexual offenders are seen to need treatment or punishment, the overall goal for SOTPs remains to reduce reoffending rates (Hudson, 2005). Whilst research has suggested SOTPs show promise in reducing reoffending, particularly when cognitive-behavioural therapy (CBT) techniques are incorporated (Hanson, Bourgon, Helmus & Hodgson, 2009; Schmucker & Lösel, 2008), the current evidence base for SOTPs has been criticised for being inconsistent (Day, Ross, Casey, Vess, Johns & Hobbs, 2019). Existing evaluation data appears to be weak, attributed to the lack of randomised controlled trials (RCT) exploring the efficacy of such programmes (Day et al., 2019), despite this being recognised as being the "gold standard" of evaluation research (Duwe, 2018). Whilst the use of RCTs in forensic environments sometimes raises ethical concerns, such as withholding treatment to have a control group, related studies have addressed this by comparing those in active treatment with those awaiting therapy as services do not typically have enough resources to offer therapy to all relevant individuals simultaneously (Duwe, 2018).

Individuals who engage in SOTPs are less likely to reoffend, yet recidivism rates are not significantly lower compared to those who received no treatment (Friendship, Mann & Beech, 2003; Hanson, 2010; Seager, Jellicoe & Dhaliwal, 2004). Many of these studies have focused upon risk and reoffending rates, yet few have considered the factors needed to facilitate this process of change (Walji, Simpson & Weatherhead, 2013). Previous research has consistently highlighted the importance of meaningful engagement to increase the likelihood of therapeutic outcomes being achieved (Holdsworth, Bowen, Brown & Howat, 2014; Horvath, Del Re, Fluckiger & Symonds, 2011; Orlinsky, Grawe & Parks, 1994; Thompson, Bender, Lantry & Flynn, 2007;), particularly important given that treatment "drop-out" is associated with high rates of recidivism in sexual offending populations (Sowden & Olver, 2017). Treatment engagement has received increasing attention within the forensic rehabilitation literature, with meaningful engagement being associated with increased likelihood of treatment completion and reduced offending (O’Brien & Daffern, 2017; Tetley, Jinks, Huband & Howells, 2011).

Given that the psychotherapeutic underpinnings of many SOTPs require participants to be actively engaged to learn new skills and knowledge integral to prevent offending (Brown, 2010), understanding what factors promote motivation and meaningful engagement is important. The Multifactor Offender Readiness Model (MORM; Ward, Day, Howells & Birgden, 2004) has highlighted the importance of motivation to change, treatment readiness and the therapeutic relationship in promoting treatment engagement; integral to reducing reoffending. A lack of meaningful engagement can impede the likelihood of therapeutic outcomes being achieved, regardless of therapeutic modality used (Ospal et al., 2016). This may account for why the efficacy of SOTPs remains unclear, particularly if individuals are motivated to complete therapy to purely secure release from prison rather than change offending behaviours. A better understanding of the experiences of participants is needed to gauge what factors increase the likelihood of meaningful engagement, particularly as this aids the process of therapeutic change (Howells & Day, 2003).

Previous research has demonstrated a strong relationship between meaningful engagement and treatment progress (Levenson & McGowan, 2004).This is particularly relevant for those with criminogenic needs, such as sexual offenders, as the likelihood of reduced recidivism is dependent upon the individual’s engagement rather than type or setting of the programme offered (Drieschner & Verschuur, 2010). Despite the importance of meaningful engagement in promoting therapeutic change being noted, theoretical investigation into treatment engagement is limited within offending populations (Gannaway, 2018). This indicated a need to better understand factors that promote the meaningful engagement of sexual offenders in their SOTPs.

The offenders' perspectives

Greater focus on qualitative methodologies can increase insight into what factors offenders believe are beneficial for promoting their engagement in SOTPs (Walji et al., 2013), which ultimately reduces their risk of reoffending. Previous quantitative and meta-analytic studies do exist (e.g. Alexander, 1999; Hanson, Bourgon, Helmus & Hodgson, 2009; Lösel & Schmucker, 2005; Melvin, Langdon & Murphy, 2017; Rice, 2010), but they often focus solely on reoffending rates (Walji et al., 2013). Such studies are valuable in evaluating whether SOTPs are effective in reducing reoffending but are unable to comment on what specific factors may contribute to this reduced risk. To date, there has been only one qualitative systematic review that explores the therapy experiences of sexual offenders (i.e. Walji et al., 2013). This review highlighted the importance of therapeutic relationships in increasing the likelihood of positive therapeutic outcomes being achieved. Participants in this review described needing to address their own abuse histories to better understand their offence cycles, which was considered important for reducing the desire to reoffend. One limitation of this study was that it involved a heterogeneous sample of different sexual offender groups (e.g. child sexual offenders, offenders against women, offenders against men). It is therefore difficult to determine what aspects of SOTPs are beneficial in reducing reoffending in child sexual offenders specifically, particularly as this population are deemed to have different criminogenic needs compared to other sexual offenders (Walton & Chou, 2015).

There has been a call for further research to explore what contributes to the effectiveness of SOTPs for specific subgroups of sexual offenders, including child sexual offenders (Grønnerød, Grønnerød & Grøndahl, 2015; Reid, Wilson & Boer, 2010). Existing research on child sexual offenders has focused upon the therapeutic techniques within SOTPs, rather than the lived experiences of offenders receiving intervention (Friedrich &

Leiper, 2006; Sandhu & Rose, 2012). Exploring how child sexual offenders experience SOTPs can help identify what factors are deemed valuable in promoting meaningful engagement, and therefore what contributes to reduced risk of offending. This is particularly so as child sexual offenders are considered to have higher rates of reoffending compared to other sex offender groups (Matravers & Hughes, 2003)

To address this gap in the research, this review aims to explore how child sexual offenders make sense of their experiences of therapy for sexual offences and what factors they perceive as integral to reducing their risk of reoffending.

Method

A meta-synthesis was used for the purpose of this review as it can integrate findings from different, but related, qualitative studies and allows for the understanding of complex experiences (Walsh & Downe, 2005). The processes in this review adhere to the principles recommended by “Enhancing transparency in reporting the synthesis of qualitative research” (ENTREQ; Tong, Flemming, McInnes, Oliver & Craig, 2012). Data were extracted from the themes reported by the authors of the included studies. This was to ensure that the qualitative information provided by each study was not taken out of context, increasing the likelihood of the findings of this synthesis being valid and reliable.

Search strategy

Four databases were explored on 17th October 2019: Medline, PsychINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Academic Search Ultimate (ASU). The search strategy was developed using the Sample, Phenomenon of Interests, Design, Evaluation, and Research Type tool (SPIDER; Tool 1). The SPIDER tool is an effective method for searching qualitative research (Cooke, Smith & Booth, 2012); the greater level of specificity was advantageous for searching the literature (Methley, Campbell, Chew-Graham, McNally, & Cheraghi-Sohi, 2014) due to the niche population being examined (i.e. child sex offenders’ experiences of therapy). Support from the Academic Liaison Team was sought to ensure that the search strategy developed was appropriate and that all relevant databases were explored, reducing the likelihood of relevant papers being missed.

All databases were searched individually for terms and keywords associated with sexual offending, experiences, and treatment programmes (Table 2). A decision was made to explore the databases in relation to all sexual offender typologies, as an initial scoping search demonstrated not all relevant papers included keywords or terms specific to child sexual offending.

Table 1. SPIDER terms

SPIDER terms	**Search concepts**
Sample	Individuals who have experience of engaging in therapy as an offender
Phenomena of Interest	Experiences of therapy from the perspective of sexual offenders
Design	Qualitative studies
Evaluation	Evaluating individuals’ experience of, reactions to, or perception of engaging in therapy for sexual abuse offences
Research Type	Qualitative research

Each database was searched separately using the systematic search strategy (Table 2). Only papers from peer reviewed journals were considered, to maximise the standards of quality of the research reviewed. An English language limiter was also applied. Once all databases were explored, duplications of identified studies were removed. Remaining studies were screened using the title and abstract search to ensure their relevance to the research question. Studies that met the inclusion criteria, as detailed below, were retained for further review. If unclear, papers were read in full to reduce the likelihood of relevant studies being missed. Eight studies were identified for this review (Figure 1).

Inclusion criteria

Studies were required to:

- Consider the direct experience of individuals who were engaging, or had engaged in, SOTPs regarding child sexual offences

- Use a qualitative methodology
- Reports clear themes in the results section
- Be published in a peer review journal
- Be published in the English Language

Exclusion criteria

Studies were excluded from the review if they met the following criteria:

- Utilised quantitative methodology or case studies
- Focussed upon the experiences of professionals delivering SOTPs
- Did not include therapy experiences related to child sexual offending

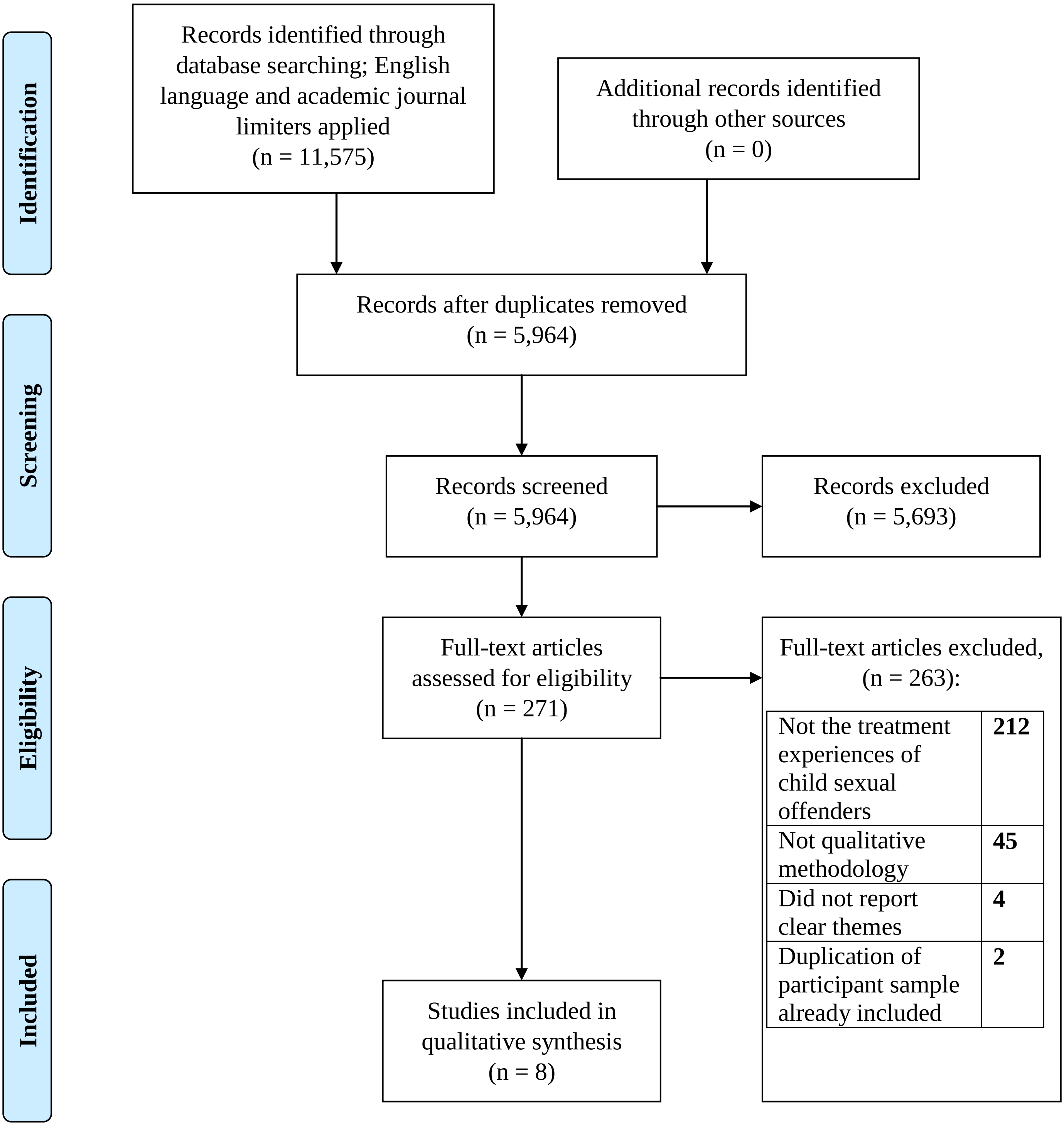
A cited article search was also conducted to identify studies not identified by the search strategy. This included reviewing the reference lists of included studies and exploring the “cited by” function on Google Scholar. Studies that appeared relevant for this review, due to the information presented in their title or abstract, were read in full to identify whether they met the inclusion criteria of this review. No additional studies were found.

Table 2. Search terms used in the systematic literature search

Database	Syntax	Publication date	Result
Medline	"sex* offend*" OR rapist* OR "sex* devian*" OR "sex* crimin*" OR pe?dophile* OR "sex* predator*" OR "sex* abus*" OR "sex* aggress*" OR "sex* offen?e*" OR "sex* inappropriat*" AND "perception*" OR "perceiv*" OR "feeling*" OR "belief*" OR "perspecti*" OR "experience*" OR "attitude*" OR "view*" OR "respons*" OR "impact*" AND "treatment*" OR "intervention*" OR "therapy" OR "correction*" OR "group therap*" OR "rehab*" OR "management*" OR "treatment* program*" OR "SOTP" OR "sex offen?e* treatment program*"	1913-2019	2930
PsycINFO	sex* offend*" OR rapist* OR "sex* devian*" OR "sex* crimin*" OR pe?dophile* OR "sex* predator*" OR "sex* abus*" OR "sex* aggress*" OR "sex* offen?e*" OR "sex* inappropriat*" AND "perception*" OR "perceiv*" OR "feeling*" OR "belief*" OR "perspecti*" OR "experience*" OR "attitude*" OR "view*" OR "respons*" OR "impact*" AND "treatment*" OR "intervention*" OR "therapy" OR "correction*" OR "group therap*" OR "rehab*" OR "management*" OR "treatment* program*" OR "SOTP" OR "sex offen?e* treatment program*"	1936-2018	7416
CINAHL	sex* offend*" OR rapist* OR "sex* devian*" OR "sex* crimin*" OR pe?dophile* OR "sex* predator*" OR "sex* abus*" OR "sex* aggress*" OR "sex* offen?e*" OR "sex* inappropriat*" AND "perception*" OR "perceiv*" OR "feeling*" OR "belief*" OR "perspecti*" OR "experience*" OR "attitude*" OR "view*" OR "respons*" OR "impact*" AND "treatment*" OR "intervention*" OR "therapy" OR "correction*" OR "group therap*" OR "rehab*" OR "management*" OR "treatment* program*" OR "SOTP" OR "sex offen?e* treatment program*"	1986-2019	1564

			1-12
Academic Search Ultimate (ASU)	sex* offend*" OR rapist* OR "sex* devian*" OR "sex* crimin*" OR pe?dophile* OR "sex* predator*" OR "sex* abus*" OR "sex* aggress*" OR "sex* offen?e*" OR "sex* inappropriat*" AND "perception*" OR "perceiv*" OR "feeling*" OR "belief*" OR "perspecti*" OR "experience*" OR "attitude*" OR "view*" OR "respons*" OR "impact*" AND "treatment*" OR "intervention*" OR "therapy" OR "correction*" OR "group therap*" OR "rehab*" OR "management*" OR "treatment* program*" OR "SOTP" OR "sex offen?e* treatment program*"	1950-2019	3165

Figure 1. PRISMA (Moher, Liberati, Tetzlaff & Altman, 2010) flow diagram



Quality appraisal

Identified studies were appraised using the Critical Appraisal Skills Programme (CASP) checklist for qualitative studies (CASP, 2018). The focus upon rigour, credibility and relevance allows studies with a range of different methodologies to be appraised (Hunt, Wilson, Caputi, Woodward & Wilson, 2017). This was relevant for this review, where identified studies varied in their methodological approaches.

Each study was rated in accordance with CASP guidance, with potential scores ranging from 0 (i.e. no criteria was met) to 10 (i.e. all criteria had been met). The primary researcher and a colleague rated each study independently before comparing scores. There was a high consensus in the ratings and any differences were resolved through discussion. Six studies were of good quality, demonstrating clear evidence for at least eight of the ten items listed in CASP. The remaining two studies were of moderate quality, demonstrating evidence of between five and seven checklist items. No papers were excluded based upon the critical appraisal to prevent relevant findings being missed based upon minor errors (Sandelowski & Barroso, 2003), instead the critical appraisal was used to “quality-check” the synthesis. Final ratings are provided in Table 4. Appendix 1-B provides rationale for the scores reported.

Synthesis

A meta-synthesis approach, as described by Noblit and Hare (1988), was taken to synthesise common themes across the identified studies. The first step involved reading each study repeatedly to ensure familiarity with the themes reported. This made it easier to identify key themes that recurred across the different studies. One study included sub-themes (Drapeau et al., 2005), which were reviewed separately from the overarching theme reported. This was due to the sub-themes reported appearing more similar to themes identified in alternative studies, rather than the overarching title chosen by the author. Key themes were then examined alongside other themes reported by different studies to identify similarities of findings. This allowed studies to be translated into each other, aiding in the process of identifying overarching key themes.

Results

Study characteristics

The eight studies identified for this review are outlined in Table 3. Studies were conducted in the UK, Norway, Canada, Ireland and the USA. Two studies (Dervley, Perkins, Whitehead, Bailey, Gillespie & Squire, 2017; Willemsen, Seys, Gunst & Desmet, 2016) did not include the location of their studies. All studies were published between 2004 and 2017. Five studies were not included in the previous review by Walji et al (2013), with the three shared studies being published prior to 2013. There were 129 participants across the identified studies. One study did not state participant gender. When reported, there were 97 male responses and 1 female response included within this review. Two studies also included the experiences of professionals or family members (Dervley et al., 2017; O'Halloran et al., 2016). These third-party responses were not included.

Studies were based in prisons (N =2) and the community (N= 2). The context of four SOTPs were not clear, other than one was facilitated within a private clinic (Cooper & Holgersen, 2016) and another involved participants being transferred from prison (Willemsen, Seys, Gunst & Desmet, 2016). Two studies did not make clear reference to the location of the SOTPs.

Studies varied in the modality of the SOTP being reviewed, which included CBT approaches (N=2,) utilisation of the principles of the Good Lives Model (Ward & Brown, 2004; N =2) and relapse prevention (N=1). Other studies did not explicitly name the therapeutic modality used but reported aims of understanding and processing experiences of those having difficulty with sexuality (Cooper & Holgersen, 2016) and preparing group members for community living (Williams, 2004). Two studies were unclear regarding the therapeutic modality (Thomas, Phillips & Blaine, 2015; Willemsen et al., 2016).

Participants varied as to what point they were in their therapy journey. This included experiences of completed therapy (N=3) and ongoing therapy (N=5). Two studies included both past and current experiences of therapy (Colton et al., 2009; Thomas et al., 2015). One study did not state where participants were in their treatment. Data were collected by open-ended questionnaires (N=2), and through interviews (N=7). This included semi-structured interviews (N=4) and phenomenological interviews (N=1). The type of interviews used was not stated in two studies. One study collected data from both semi-structured interviews and questionnaires. Methods of data-analysis included thematic analysis (N=3), comparative analysis (N=1) and secondary analysis (N=1). Two studies did not explicitly state their method of analysis other than qualitative analysis was used. One study thematically coded data using Yalom’s principles of therapeutic factors for group therapy (Yalom, 1995).

All studies provided in-depth descriptions of the psychotherapeutic experiences of child sex offenders.

Table 3. Summary of study characteristics

Author(s), (Year)	Aim(s) of the study	Country	Sample Size	Age range (years)	Sex	Data collection method	Method of qualitative data analysis
Colton, Roberts & Vanstone (2009)	To explore the views of child sexual offenders undertaking the prison treatment program	United Kingdom	35	22-58 years	25 Male	Interviews	Qualitative analysis
Cooper & Holgersen (2016)	To explore what people who have committed sexual offences against children find useful in therapy	Oslo, Norway	4	Not explicitly stated	4 Male	Semi-structured interviews	Explorative, thematic analysis
Dervley, Perkins, Whitehead, Bailey, Gillespie & Squire (2017)	To explore child sexual offenders' experience of completing a treatment programme.	Not stated	13	Not stated Mean = 47.3 (SD; 10.6) years	13 Male	Interviews	Thematic analysis
Drapeau, Körner, Granger & Brunet (2005)	To examine what child sexual offenders think about treatment, as well as their daily experience of a treatment programme	Quebec, Canada	23	25-61	23 Male	Semi structured interviews	Comparative analysis
O'Halloran, O'Reilly, Travers, Quinn, Stack, Cartin, Finnegan &	To explore the therapeutic events for those engaging in a community based treatment programme	Republic of Ireland (ROI) & Northern Ireland	21 (14 ROI; 7 NI)	Not stated	Not stated	Semi-structured interviews & qualitative questionnaire	Thematic analysis

Ewart-Boyle (2016)	for sexually abusive behaviour	(NI)					
Thomas, Phillips & Blaine (2015)	To discover the meaning of therapy experience to 11 community-dwelling child sexual offenders	United States of America	11	35 - 56	10 male; 1 female	Phenomenological interviews	Secondary analysis
Williams (2004)	To examine the responses of child sexual offenders who have participated in multiple sex offender treatment programs, regarding their personal experiences	Utah, USA	9	24-69	9 Male	Open-ended Questionnaire	Qualitative analysis
Williemson, Seys, Gunst & Desmet, 2016)	To elicit feedback from child sexual offenders about helpful aspects of experiential group therapy	Belgium	13	Not reported	13 Male	Semi-structured interviews	Thematically coded according to Yalom’s therapeutic factors for group therapy

Table 4. CASP (2018) quality appraisal

		Quality criteria										Score	Rating
		1	2	3	4	5	6	7	8	9	10		
		Clear research aims	Method-logy	Research design	Recruit-ment strategy	Data collection	Considers relationship between participant and researcher	Considers ethics	Data analysis	Clear findings	Research was valuable		
Author(s) of study	Colton, Roberts & Vanstone (2009)	1[1]	1	0	1	1	0	0	0	1	1	6	Moderate
	Cooper & Holgersen (2016)	1	1	1	1	1	1	1	1	1	1	10	Good
	Dervley et al. (2017)	1	1	1	1	1	0	1	1	1	1	9	Good
	Drapeau et al. (2005)	1	1	1	1	1	1	0	1	1	1	9	Good
	O'Halloran et al. (2016)	1	1	1	1	1	0	1	1	1	1	9	Good
	Thomas, Phillips &	1	1	1	1	1	0	1	1	1	1	9	Good

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[1] Scores of 1 indicate evidence for the item. 0 indicates no clear evidence for the item

Blaine (2015)											
Williams (2004)	1	1	1	1	1	1	1	1	1	0	9	Good
Willemsen et al. (2016)	1	1	1	0	1	0	0	1	1	1	7	Mod-erate

Synthesis of findings

This meta-synthesis focused upon exploring the psychotherapy experiences of child sex offenders. Five super-ordinate themes were found: 1) Learning about oneself and others; 2) Motivation and engagement in therapy; 3) Shared experiences; 4) The therapist's role; and 5) Moving forwards. Table 5 provides examples of theme development.

Theme 1: Learning about oneself and others

Six studies identified themes related to this theme (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). Developing victim awareness and empathy was valued as it enabled participants to realise the true impact of their offending (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015, Williemson et al., 2016). Victim empathy reduced any denial participants had regarding their responsibility for their offences (O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016).

> "It opened up my eyes to what the victim was feeling … I was thinking that I wasn't hurting him, that he was the one coming to my house. But what I learnt was that I had actually conditioned him to do what I wanted." (Colton, Roberts & Vanstone, 2009, p.327).

Accepting responsibility for offences is an important component in relapse-prevention (Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). This was aided by "offence confrontation" (i.e. sharing details of their offences), encouraging recognition of precipitating and perpetuating factors to offending (Colton, Roberts & Vanstone, 2009; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015). This meant participants could receive support for their underlying difficulties that contributed to their offending (Cooper & Holgersen, 2016; Dervley et al., 2017; Drapeau et al., 2005; Thomas, Phillips & Blaine, 2015). Although challenging, this helped participants make sense of why they offended (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; Drapeau et al., 2005). Exploring this provided participants with a sense of relief and greater acceptance of their own difficult experiences (Cooper & Holgersen, 2016; O'Halloran et al., 2016; Williemson et al., 2016).

> "… it was kind of a relief. Immediately, it's like a brick in your stomach that just crumbles. And that meant a lot to me" (Williemsen et al., 2016, p.163)

Participants valued having space to explore their experiences, even if this appeared unrelated to their offending (Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). This process of self-discovery created feelings of empowerment and beliefs that one could change (Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016; Williams, 2004). Participants valued having access to support when exploring their difficulties, which encouraged them to continue sharing their experiences (Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Williemson et al., 2016). This safe space encouraged participants to view themselves and their future more positively, suggesting understanding oneself is key to promoting desistance from reoffending.

> "I found out all about myself … not just about what I done, but I found out about myself in other ways, which made me think and made me be a better person, be a more giving person than I used to be" (Thomas, Phillips & Blaine, 2015, p.312).

Having opportunities to understand oneself was considered beneficial in reducing reoffending through improving individual wellbeing. This is consistent with the Good Lives Model (GLM; Ward & Brown, 2004) which suggests awareness of underlying reasons for offending can identify alternative, more socially acceptable methods to meet one’s needs (Barnao, Ward & Roberston, 2016). Participants felt better able to recognise warning signs to reoffending through the development of a deeper understanding of themselves, increasing the likelihood of them engaging in alternative activities to offending (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015).

Theme 2: Motivation and engagement in therapy

Although only four studies included over-arching themes related to this concept (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Drapeau et al., 2005; Williams, 2004), an additional three studies referred to motivation for therapy in separate themes (O’Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). Several motivators for therapy were described including wanting to understand why they offended, to address negative affect believed to have contributed to their offending, and as a means to prevent future offending (Cooper & Holgersen, 2016; O’Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016; Williams, 2004). A desire to desist from offending motivated participants, enabling them to overcome any challenges associated with engaging in therapy.

> “I think I would have gone through fire in order to not do this [commit sexual offences] again” (Cooper & Holgersen, 2016, p. 705)

Initial motivators for therapy were not considered enough to ensure participants continued to meaningfully engage in therapy. Feeling safe was integral to promote active participation (Cooper & Holgersen, 2016; Drapeau et al., 2005; O’Halloran et al., 2016; Williams, 2004), whilst perceiving threats limited willingness to engage (Williemson et al., 2016; Williams, 2004). Factors promoting perceptions of safety included having easily accessible support throughout, trusting therapists, and perceiving they would not be judged for their disclosures (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Drapeau et al., 2005; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016; Williams, 2004).

Some participants described having ulterior motives for engaging in therapy, such as gaining early release from prison or transferring to a less threatening environment (Drapeau et al., 2005; Williams, 2004). This could suggest a lack of intrinsic motivation for therapy, which is typically associated with a decreased likelihood of positive therapeutic outcomes being achieved (Lord, 2016; Wakeling et al., 2005). Participants valued having the freedom to choose whether they started therapy (Drapeau et al., 2005; Thomas, Phillips & Blaine, 2015; Williams, 2004); with those who felt pressured to engage reporting increased resistance to the therapeutic process (Drapeau et al., 2005; Thomas, Phillips & Blaine, 2015; Williams, 2004).

> “If they force me to do something, I just don’t do it. I want it to come from me, not them. So I wanna do therapy because I want to and not because they want me to. I want this to be my thing” (Drapeau et al., 2005, p.103).

Theme 3: Group versus individual therapy

Of the seven studies that contributed to this theme, all made reference to group therapy (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; Drapeau et al., 2005; O’Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). Five studies described group therapy as positive (Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). This was attributed to having shared experiences with others (Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016), which reduced feelings of being judged or threatened for their offences (Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015). Observing others receive positive feedback for sharing their experiences encouraged others to do so too (Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Williemson et al., 2016). This was important in enacting change and promoting meaningful engagement in therapy (Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016).

> "I was amazed by it [the sharing], for such, the offending and even in my own case to be able to for the first time ever to be able to speak and feel comfortable…" (O'Halloran et al., 2016, p.326)

Group therapy allowed participants to offer support to others, providing them with a sense of purpose and improved self-esteem (Dervley et al., 2017; Thomas, Phillips & Blaine, 2015). Sharing their therapy journey with others ameliorated feelings of loneliness that existed prior to their offending (Cooper & Holgersen, 2016; Dervley et al., 2017; Williemson et al., 2016). Connecting with others was described as advantageous within five studies, as it enabled participants to develop positive relationships with other adults (Cooper & Holgersen, 2016; Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). This was considered an alternative to sexually engaging with children (Cooper & Holgersen, 2016; O'Halloran et al., 2016), suggesting developing relationships in group therapy can reduce reoffending. The value of peer relationships suggests the mutual understandings and shared experiences can promote therapy engagement.

> "… but actually to talk about it in front of the others was fine … we all sort of gelled really well… nobody here was going to judge anyone as we'd all done similar things" (Dervley et al., 2017, p. 52).

Those who criticised group therapy attributed this to a dislike of mixing with other offenders (Colton, Roberts & Vanstone, 2009; Drapeau et al., 2005). Participants described being "different" to the other group members, suggesting a more individualised approach was beneficial for them. Group size was considered important as large groups could be intimidating and limited the opportunities participants had to share their experiences (Colton, Roberts & Vanstone, 2009; Drapeau et al., 2005). Both studies were conducted in prison populations and referred to being targeted due to the nature of their offences. Their dislike for group therapy could, at least partly, be due to a fear of being recognised as a "child sex offender" and being assaulted by others due to this.

> "I see myself as not a high-risk sex offender, but there I will be exposed to … high risk sex offenders, and then I am thinking … perhaps that is not the sort of situation I want to be in" (Colton, Roberts & Vanstone, 2009, p. 329).

Theme 4: The therapist's role

Three studies identified themes related to the therapist (Drapeau et al., 2005; O'Halloran et al., 2016; Williams, 2004), yet two additional studies made reference to this in alternative themes (Colton, Roberts & Vanstone, 2009; Williemson et al., 2016). Therapists played an important role in supporting participants to meaningfully engage in therapy (Drapeau et al., 2005; O'Halloran et al., 2016; Williams, 2004). Participants were more likely to be open and honest when they trusted their therapists (Drapeau et al., 2005; Williams, 2004). This occurred when therapists were perceived as being non-judgemental, caring, genuine and respectful (Drapeau et al., 2005; O'Halloran et al., 2016; Williemson et al., 2016; Williams, 2004). Being unable to trust therapists limited participants' willingness to participate in therapy (Drapeau et al., 2005; Williams, 2004), thus suggesting the therapeutic relationship plays an important role in promoting treatment engagement.

> "I believe the relationships I had with therapists and corrections officers had a direct effect on my success or perceived failure in therapy" (Williams, 2004, p.155).

Participants valued their interactions with therapists (Drapeau et al., 2005; O'Halloran et al., 2016; Williams, 2004; Williemson et al., 2016), with some viewing SOTPs as ineffective based on the limited contact they had with their therapist (Drapeau et al., 2005). Therapists were valued if they were encouraging and recognised the participant's effort in therapy (O'Halloran et al., 2016; Williams, 2004). It was important that therapists acted as an authority figure in therapy to promote the smooth running of the SOTP (Drapeau et al., 2005; Williemson et al., 2016), including ensuring there was clearly defined structure to therapy to foster a sense of predictability.

> "The good thing about the program is that it's to the point. We know what's going on and what's next. For example I know that I have to talk about my things at a given session. And I know that others have to do it too and that the therapist will make sure that I get a chance to talk" (Drapeau et al., 2005, p. 104).

Therapists who misused therapeutic concepts, such as suggesting participants were distorting the truth if they voiced conflicting opinions to therapists, were viewed negatively (Drapeau et al., 2005), particularly as this was contradictory to participants' desire for empathy and understanding (Drapeau et al., 2005; O'Halloran et al., 2016; Williams, 2004). Appropriate challenge is considered a core component of many SOTPs (Yates, 2015; Yates & Kingston, 2016), suggesting how therapists do this needs consideration. Participants valued being treated as individuals as those who felt "pigeon-holed" were more likely to experience negative affect and disengage (Colton, Roberts & Vanstone, 2009; Williams, 2004). This prevented participants from feeling judged, encouraging meaningful engagement in therapy (Drapeau et al., 2005; Williams, 2004).

> "It was more – be yourself and do what you need to do – not you are pure evil and scum of the earth so tell us this!" (Williams, 2004, p.156).

Theme 5: Moving forwards

Engagement in therapy offered participants a "second chance" at life following their offences (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). The focus placed upon developing coping strategies and relapse prevention skills supported participants to not reoffend (Colton, Roberts & Vanstone, 2009; Dervley et al., 2017; Williemson et al., 2016). Greater awareness of precipitating factors to offending enabled participants to be better able to recognise warning signs to offending, meaning their risk of recidivism was reduced.

> "It (SOTP) has given me ways to deal with situations in the future, coping strategies, prevention" (Colton, Roberts & Vanstone, 2009, pp. 327-328).

Engaging in therapy helped participants to develop a more positive sense of self (Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015), reducing the shame that acted as a barrier to help-seeking previously (Dervley et al., 2017; Thomas, Phillips & Blaine, 2015). Given that shame was described as a precipitating factor to offending (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; Drapeau et al., 2005; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016), increased self-compassion could be an important factor in reducing reoffending in child sexual offenders. Therapy enabled participants to feel better able to connect with others (Colton, Roberts & Vanstone, 2009; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016) and encouraged them to confront underlying factors that contributed to their offending (Dervley et al., 2017; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016). Therapy gave participants hope for the future and provided them an alternative to living with the label of being “just a sex offender” (Cooper & Holgersen, 2016; Dervley et al., 2017; Thomas, Phillips & Blaine, 2015).

> “You get help to see that you are something more than a criminal sex offender … you get help to see that you can do something about it. You can get out of it” (Cooper & Holgersen, 2016, p.706).

Engaging in therapy promoted positive perceptions of one’s future (Colton, Roberts & Vanstone, 2009; Cooper & Holgersen, 2016; Dervley et al., 2017; O’Halloran et al., 2016; Thomas, Phillips & Blaine, 2015; Williemson et al., 2016), yet one study reported negative experiences (Drapeau et al., 2005). This study detailed feelings of hopelessness, attributed to the unpredictability of their therapy (Drapeau et al., 2005). Further limitations of SOTPs were described as the need to repeat therapy for it to be effective in promoting positive change (Thomas, Phillips &

Blaine, 2015). Two studies suggested SOTPs lacked ecological validity as they did not have clear links to the real lives of offenders (Colton, Roberts & Vanstone, 2009; Drapeau et al., 2005). This also referred to the unrealistic evaluations of the effectiveness of risk management plans. Both studies were based within prison populations, in which risk-management strategies will naturally be limited due to having no exposure to children.

> “What can you prove in here? Nothing. Because out there is where the trouble is. Believe me. That’s where children are. Out there you have got to prove it. In here you can take it all and mean nothing because there are no children” (Colton, Roberts & Vanstone, 2009, p.332).

One study did not refer to the impact therapy had on their perceived futures (Williams, 2004). This could be partly attributed to participants in this study not yet completing therapy and so may not have felt ready to think of their future.

Table 5. Development of superordinate themes from preliminary themes reported in the included studies

Preliminary themes from themes reported by the authors of the studies	Key theme: First iteration	Key themes: Final iteration	Superordinate themes: First iteration	Superordinate themes: Final iteration	Contributing studies
I didn't understand myself, I found out all about myself	Not knowing about oneself, not knowing why, lack of understanding	Understanding why one offended, knowing underlying reasons	Awareness of one's precipitating factors to offending	Learning about oneself and others	Colton, Roberts & Vanstone (2009) Cooper & Holgersen (2016) Derveley et al. (2017) Thomas, Phillips & Blaine (2015) Williemsen et al. (2016);
Why did I do it?					
Existential learning	Understanding the bigger picture, factors that contribute to offending				
Victim empathy	Understanding impact on victim, responsibility of crimes	Understanding others, increasing interpersonal skills	Accepting of responsibility, increased understanding of contributing factors to offences, awareness of people		
Altruism	Understanding of others, happiness for others				
Self-empowerment	Learning about oneself, self-generated change through learning	Removing denial, acceptance, insight			
I lived in a fantasy world, where everything was okay	Removing denial, understanding offences, accepting responsibility				
Choosing the La Macaza programme	The choice to enter therapy, initial	Choosing to begin therapy, choice	Choice as motivating	Motivation and engagement in	

and the choice to enter therapy	motivations for therapy			therapy	Colton, Roberts & Vanstone (2009) Cooper & Holgersen (2016) Drapeau et al. (2005) Williams (2004)
Why I started going to therapy					
The treatment setting	How the treatment setting influences engagement	The treatment setting influences motivation,			
Differences in program motivational climate					
Motivation and response to treatment	Motivation and engagement with therapy				
Past experiences with therapy	Previous experiences impact motivation	Challenges of engagement in therapy	Factors impacting engagement		
Hardships of treatment	Difficulties, challenges of treatment as impacting on motivation				
Nobody knew any of my secrets, that [therapy] was the first time I got to tell my story	Opportunity to share story, gain support, explore past experiences, gaining relief from sharing	Group as a space to share experiences, similarities amongst peers, sense of purpose	Ability to share in group, opportunities to give/receive support	Group versus individual therapy	Colton, Roberts & Vanstone (2009) Derveley et al. (2017) Drapeau et al. (2005) O'Halloran et al. (2016) Thomas, Phillips & Blaine (2015) Williemsen et al. (2016)
Catharsis					
Open communication					
Imparting information	Ability to support others, offer advice				
Universality	Sharing experiences with others, developing				
Imitative behaviour					

Group cohesion	interpersonal relationships				
The group became a family for me	Group as supportive, important relationships, safe space				
The group					
Group size	Size of group increase threat, limited time to explore experiences, factors related to disengagement	Limitations of group therapy, reduced opportunities			
Negative contributions towards therapy					
Group versus individual treatment	Benefits of group, benefits of 1:1 support, limited time to explore experiences	Impact of group on relationships, developing relationships	Development of relationships with others (good and bad)		
Therapist contributions	Therapists response to clients, contributions to therapy, differences in therapists	Therapists participation in therapy as important	How the therapists act as important, responsibility for safety	The therapist’s role	Cooper & Holgersen (2016) Drapeau et al. (2005) O’Halloran et al. (2016) Williams (2004)
Therapist response					
Differences in professionals’ openness towards clients					
The therapists	Characteristics of therapists, facilitating openness, trust	Trust of therapists vary on characteristics shown			
Offender trust of therapists and staff members	Trust as important, perceptions of safety, perceived threats				
The pros/cons of structuring the programme	Therapist responsibility to structure programme, ensure client	Therapist responsibility in the group	Responsibility of group structure		
Content, structure of					

therapy	contributions,				
It just stripped away all the lies, all the manipulation					
Previous and current relationships with others	Group relationships as important, opportunity to develop new relationships				
Looking to the future	Looking forwards	Improved perception of one's future, a new start	Hope for one's future	Moving forwards	Colton, Roberts & Vanstone (2009); Cooper & Holgersen (2016); Derveley et al. (2017); Drapeau et al. (2005); O'Halloran et al. (2016); Thomas, Phillips & Blaine (2015) Williemsen et al. (2016)
Instilling Hope	Having a sense of hope				
I'm very ashamed of what I've done. This treatment has really helped, gave me a second chance	Second chance from therapy				
Making changes and progress in therapy	Therapeutic progress	Continued progress in therapy, recognition of the progress made	Progress from therapy, limitations to therapy		
Continued risk of recidivism	A need to continue therapy skills				
Strategies for desistence					
Therapy as life					

Discussion

This review synthesised qualitative data on the experiences of SOTPs from the perspective of child sexual offenders. Individuals described various reasons for engaging in SOTPs initially, which were based upon intrinsic (e.g. to desist from offending) and extrinsic motivations (e.g. early release from prison). Choosing to engage in SOTPs due to extrinsic motivators may increase the likelihood of superficial engagement, ultimately reducing the efficacy of therapy (Drapeau et al., 2004). Those who feel pressured into attending therapy are less likely to achieve positive therapeutic outcomes due to this (Dhuffar & Griffiths, 2014; Ospal, Kristensen, Vederhus & Clausen, 2016). This highlights the importance of an individual's readiness for therapy and brings to question how effective SOTPs are if they are a condition for one's release or probation licence.

Factors that promoted motivation to engage were attributed to the ability to share one's experience without judgement and having a sense of purpose by offering support to others. Feeling accepted and useful can negate against the shame participants described regarding their offences. Reducing shame can prevent the use of defensive strategies, such as denial, minimising or justifying offences (Marshall, Marshall & Ware, 2009), which are important predictors of reoffending (Wright & Schneider, 2017). Whilst theories of deterrence suggest individuals need to feel shame to not re-offend (Benson, Alarid, Burton & Cullen, 2011), there is a lack of empirical support for this theory (Blagden, Lievesley & Ware, 2017). Furthermore, participants in this review suggested shame acted as a barrier to meaningful engagement, suggesting this would impact negatively on the effectiveness of therapy.

Developing positive relationships with adults through group therapy was valued and acted as an alternative to offending against children. Given that child sexual offenders are often rejected by society (Ricciardelli & Moir, 2013; Waldram, 2007), group SOTPs offer participants a safe space to seek support and explore their offences without reprisal. Without access to effective support, individuals are at risk of being isolated and feeling less able to help-seek, increasing the likelihood of reoffending (Blagden, Mann, Webster, Lee & Williams, 2018). This suggests an advantage in offering group therapy to increase the effectiveness of SOTPs, although there are limited studies exploring the efficacy of 1:1 SOTPs with this population (Looman, Abracen & Di Fazio, 2014). It is therefore unclear whether 1:1 therapy would be comparably different to group intervention.

One of the most valued aspects of SOTPs by participants was having the opportunity to understand why they offended, with some citing this as a key motivator for their continued engagement in therapy (Colton et al., 2009; Cooper & Holgersen, 2016; Derveley et al., 2017; Drapeau et al., 2005). This is consistent with research exploring the therapy experiences of offenders against adults (Collins, Brown & Lennings, 2010; Grady & Brodersen, 2008), suggesting this is a similar need across a range of sexual offending populations. Making sense of why one offended helped participants to view themselves more positively, particularly if reasons for offending were influenced by factors not in their control (e.g. mental-illness, trauma, and abuse). This can act as a buffer against the painful label of "child sex offender" becoming a central component of the individual's identity (Digard, 2010; Ievins & Crewe, 2015), enabling a sense of hope for a more positive life. This is similar to self-narrative changes reported in the desistence literature (Maruna, 2001; 2004), aiming to replace cognitions of "bad person who did bad things" to "good person who did a bad thing". Exploring their abuse histories was considered important, particularly as child sexual offenders are more likely to have experienced abuse in childhood when compared to other offender groups (Craissati, McClurg & Browne, 2002). Addressing abuse histories should be included in SOTPs for child sexual offenders, particularly as understanding one’s own abuse histories can improve insight into their offending behaviours (Walji et al., 2013).

Understanding what contributed to offending behaviours is associated with improved relapse prevention skills (Carnes, 2013; Maruna, 2004). This enables greater recognition of precipitating factors to offences, enabling the individual to utilise coping-strategies to prevent reoffending. Understanding one’s offending behaviours can increase empathy for victims, due to having a better insight into the true impact of offences (Collins et al., 2010; Walji et al., 2013). Increased victim empathy is considered an important tool in promoting cognitive and emotional changes in sexual offenders (Walji et al., 2013), reducing recidivism.

The therapist was deemed responsible for creating a non-threatening environment, so participants felt safe and motivated to continually engage in SOTPs. Therapists perceived to be non-judgemental, empathic and caring enabled participants to feel supported to meaningfully engage in therapy (Drapeau et al., 2005; Marshall et al., 2002), similar to characteristics deemed important for the development of the therapeutic alliance in the wider literature. Participants indicated that professionals viewed as harsh or uncaring impacted negatively on their motivation in therapy, giving support to the belief that compassionate care is integral for providing effective support (Sinclair et al., 2016).

Given that the therapist can impact the efficacy of SOTPs, attention must be paid to the impact of working with child sexual offenders on the professionals. This is particularly so as emotional hardening is associated with therapists working with sexual offenders (Moulden & Firestone, 2007), making it increasingly challenging to develop the positive therapeutic relationships needed to reduce recidivism (Lombardo & Eyre, 2011; Scheela, 2001). Exposure to distressing details of offences can adversely impact therapists (Way, VanDeusen, Martin, Applegate & Jandle, 2004), leading to beliefs that rehabilitating sexual offenders is extremely challenging (Bach & Demuth, 2018). This can have a negative impact on a therapist's pride, motivation, and satisfaction in their work (Hunsaker, Chen, Maughan & Heaston, 2015), making it harder for therapists to see a purpose in their work. Inadvertently this may reduce the sense of safety and compassion participants require to engage meaningfully in therapy, particularly as a sense of meaning in one's occupation can protect against potential negative affect associated with work.

Strengths and limitations

This review adhered to ENTREQ guidelines (Tong et al., 2012) and studies were critically appraised using the CASP quality framework to ensure credibility. All studies were deemed to be either moderate or strong quality, with Cooper & Holgersen (2016) providing clear evidence for each criterion. Five studies lacked evidence for one criterion, mainly the relationship between participant and researcher (Dervley et al., 2017; O'Halloran et al., 2016; Thomas, Phillips & Blaine, 2015). Whilst ratings were not used to exclude studies, it is noted that two studies failed to clearly acknowledge ethical considerations that may have impacted their research (Colton, Roberts & Vanstone, 2009; Williemsen et al., 2016). All studies presented clear research aims, appropriate methodology and methods of data collection. Four key electronic databases were searched to allow for a comprehensive search process to identify relevant literature relevant literature. This review is the first of its kind to specifically explore child sexual offenders' experiences of SOTPs. Whilst the use of qualitative synthesis is associated with some controversy in the literature, due to difficulties in making generalisations between context dependent studies (Bearman & Dawson, 2013), the use of meta-syntheses has been recommended within psychiatric and psychological research (Lachal, Revah-Levy, Orri & Moro, 2017). This approach can provide a more comprehensive understand and interpretation of qualitative findings to improve global understandings of important qualitative phenomena (Lachal et al., 2017).

This review is skewed to the experiences of males, accounting for over 99% of the participant sample where participant sex was reported. Generalising findings to female offenders is not advised, particularly as understanding female sexual offending through male sexual offending theories has been criticised (Cortoni & Gannon, 2016; Harris, 2010; Williams, Gillespie, Elliott & Eldridge, 2019).

This review highlights the scarcity of research exploring the therapy experiences of child sexual offenders, so this review only consists of a small number of studies. Further qualitative research will contribute to understanding what factors contribute to SOTPs being effective in reducing risk, particularly as quantitative research is inconsistent regarding the effectiveness of SOTPs for child sexual offenders currently. The decision to only include peer-reviewed studies may have led to a bias in the data reviewed, potentially leading to important, relevant studies being missed. Whilst this is considered a limitation, only including peer-reviewed studies was deemed appropriate to increase confidence in the quality of studies included, improving reliability of findings reported.

Whilst all participants had offended sexually against children, they differed in the specific offences committed, the therapeutic modality experienced and where in their treatment they were. Although overarching themes aimed to capture this range of experiences, this degree of heterogeneity may have led to the specific context of experiences being missed. A more homogenous sample could improve understanding of how different therapeutic modalities influence SOTPs effectiveness, yet identified themes were observed across different studies regardless of the modality used. The challenge of establishing a purely homogeneous sample based on the current literature is acknowledged, as there is not currently enough research to ensure a comprehensive review is achieved if focusing upon specific points in treatment.

Several studies referred to exploring experiences from participants that had already engaged in SOTPs previously. It was unclear whether this was repetition of the same therapy programme, thus meaning it is difficult to separate which experience the participant was referring to.

Clinical implications

Participants valued peer relationships within SOTPs, due to benefiting from having shared understandings with one another. This was important to encourage meaningful engagement in therapy, and to reduce recidivism. Opportunities for peer support should, therefore, be emphasised within SOTPs. This is particularly so as having opportunities to support others helped participants to develop a more positive sense of self, something unlikely to be achieved in 1:1 therapy. Having sense of purpose and achievement through being able to offer support reduced reoffending risk as it allowed participants to develop a more pro-social and fulfilling life (Mallion & Wood, 2020). This is akin to the Good Lives Model (GLM), a strengths-based approach to offender rehabilitation that aims to support individuals in living more meaningful lives (Ward & Brown, 2004). Offering peer support may be more important for child sexual offenders, given that they often have limited opportunities in the community due to societal rejection (Ricciardelli & Moir, 2013).

Given the challenging nature of SOTPs, such as increased vulnerability through confronting offences and abuse histories, ongoing assessment of the wellbeing of participants could identify whether additional support alongside SOTPs is required (Walji et al., 2013). Failure to support participants experiencing negative affect could lead to therapy “drop-outs” or reduced meaningful engagement (Serran & Marshall, 2006), leading to sustained or increased risk.

Participants in this review needed to feel safe before to meaningfully engage in SOTPs, citing the therapist as a significant contributing factor to this. Given that therapists working with sexual offenders can be negatively impacted by their work (Moulden & Firestone, 2010), it is important that the wellbeing of the therapists is supported, to ensure they are able to continue providing effective and compassionate care. Effective supervision and support can ameliorate symptoms of burn-out (Coffey & Coleman, 2001). For some therapists who work with sexual offenders, being able to easily access personal therapy helped them to feel better able to cope with the consequences of their work (Kadambi &Truscott, 2004). For others, this meant access to support from members of their team (Clarke & Roger, 2002), particularly as fearing judgement for one's profession acted as a barrier to seeking external support (Kottler & Markos, 1997). Services should therefore aim to maintain relationships between professionals within the service to ensure this support remains effective. Improving these relationships can be achieved through implementation of reflective groups, including Schwartz rounds. Schwartz rounds are evidence-based forums that allowing professionals from a range of different disciplines the opportunity to discuss and reflect on the emotional aspects of their work (Reed, Cullen, Gannon & Knight, 2015).

Future research

Many studies included in this review excluded those who denied their offences. This resulted in findings being skewed toward those accepting responsibility for their offending; limiting the accuracy of the reported SOTP effectiveness. Given that denial and offence minimisation is considered to increase the risk of reoffending (Marshall, Fernandez, Hudson & Ward, 1998; Schneider & Wright, 2004), understanding the experiences of those who deny offences can provide important insight into what factors, if any, are beneficial in promoting offence confrontation. Participants in forensic or prison populations were more likely to express negative perceptions of SOTPs. These participants were less likely to express feelings of safety in engaging in SOTPs, and feared retribution from others due to the nature of their crimes. Further research could explore what factors promote feelings of safety and explore whether individualised therapy may increase meaningful engagement within this population.

Participants in this review referred to relationships with other professionals, in addition to their therapist. Negative interactions with others could influence their motivation to engage, particularly if they deemed others to be punitive or uncaring. This suggests that participants' wider relationships can impact SOTPs engagement, indicating more attention should be paid to these professional groups. This is particularly so as "frontline staff" spend more time with clients compared to therapists yet receive less training and supervision to manage challenges associated with their work (Potter et al., 2010). Understanding how "frontline staff" experience working with sexual offenders is important to prevent any challenges to participants meaningfully engaging in SOTPs, as the effectiveness of SOTPs can rely on the positive support of non-therapy professionals (Ware, Galouzis, Hart & Allen, 2012).

Conclusion

Participants appeared to value being part of a group, although this was dependent upon them feeling safe to engage with others in therapy. Group therapy offered participants' opportunities to share their experiences without feeling judged, aided by the shared understandings created by having similar experiences to one another. Participants valued having the opportunity to "give back", through offering support and advice, and helped them to identify ways to live a more pro-social and meaningful life. This increased a sense of purpose in one's self, deemed important in encouraging participants to desist offending in the future. This was aided by enabling participants to have hope for their futures, providing them with an alternative to living under the label of being a “child sex offender”. The therapist was considered to play an important role in promoting participants continued engagement in therapy, even when this could be challenging. It is therefore imperative that effective support is provided to therapists supporting child sexual offenders to ensure they can continue providing high-quality care associated. Compassion and support provided by the therapist can promote meaningful engagement needed to increase the likelihood of reoffending risk being reduced.

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Appendices

Appendix 1-A: Author guidelines

Instructions for authors

About the Journal

Journal of Sexual Aggression is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

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Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

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Appendix 1-B. CASP (2018) quality checklist

Study 1: Child sexual abusers' views on treatment: A study of convicted and imprisoned adult male offenders (Colton, Roberts &Vanstone, 2009)

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	Clearly identifies that there is a gap in the literature (e.g. offenders' perspectives of treatment). This was cited as important to inform the development of future treatment for child sex offenders (CSO)	1
2	Is a qualitative methodology appropriate?	Qualitative method was appropriate as it focused upon the lived experience of CSO in regards to treatment for their offences.	1
3	Was the research design appropriate to address the aims of the research?	There is a lack of information to provide a rationale for the research design used. Interviews were used for data collection, but not clear what form this took (e.g. semi-structured/structured/open). Makes reference to key themes, but there are no details regarding what methods were used to identify these key themes.	0
4	Was the recruitment strategy appropriate to the aims of the research?	There is information regarding how participants were recruited, including why not all participants who had volunteered were included in the study.	1
5	Was the data collected in a way that addressed the research issue?	Data was appropriately collected for the purpose of the study (e.g. interviews), although further details about this are not present. It is not clear as to whether there was a topic guide used and other information (e.g. length of interviews, whether they were audio recorded) is not present.	1
6	Has the relationship between the researcher and participants been	There is no information regarding the relationships between the researcher and the participant.	0

	adequately considered?		
7	Have ethical issues been taken into consideration?	There is no explicit mention of the ethical approval for this study. Whilst participants were asked to volunteer for the study, there is no information regarding what information was shared about the purpose or process of the study and whether consent forms were used.	0
8	Was the data analysis sufficiently rigorous?	There is no information regarding how the data was analysed other than “key themes” were identified. It is not clear how these key themes were developed.	0
9	Is there a clear statement of findings?	There is evidence of an adequate discussion of the findings, including information regarding literature that is in support and in contrast with results from this study. The discussion identifies implications for clinical practice/future research. The findings/discussion clearly relate to the aims of the research (e.g. CSO’s experience of treatment).	1
10	How valuable is the research?	There does not seem to be any mention current practice or policy, although the discussion does make reference to how the study’s findings “fit in” with the current literature base. There is brief mention to future research (e.g. how treatment participation could create negative affect and how this warrants further examination, and also for similar research given how little exists in the literature base).	1

Study 2: Treatment experiences of child sexual offenders in Norway: A Qualitative study (Cooper & Holgersen, 2016).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	There is a clear statement of aims of the research (e.g. first-person perspectives of CSO are scarce so there is a gap in the literature). Clearly states the aims are to explore the factors that were experienced as useful in therapy.	1
2	Is a qualitative methodology appropriate?	Qualitative methodology is appropriate in order to gain the first-person experiences of CSO in therapy. Details regarding the rationale for the methodology are given (e.g. describe and reflect upon the subjective experiences), making it clear why thematic analysis was used.	1
3	Was the research design appropriate to address the aims of the research?	Information is provided regarding the rationale for the research design, including information as to why thematic analysis was used to analyse data. Further information is provided as to why phenomenological in-depth interviews were used to collect the data.	1
4	Was the recruitment strategy appropriate to the aims of the research?	There is information regarding how participants were selected and how the identified participants were deemed appropriate for the study. Information about where participants were recruited from was documented, although little information was detailed about how participants were selected. Participation was voluntary	1
5	Was the data collected in a way that addressed the research issue?	There is detailed information regarding how data was collected (e.g. interviews, audio-recorded). There is information about why the process was changed for one participant in relation to the audio-recorder failing, and how this was managed (e.g. extensive notes immediately after). Information is provided by the nature of questions asked (e.g.	1

		open) and provides information about the types of questions asked.	
6	Has the relationship between the researcher and participants been adequately considered?	There is reference to the need to take into account the relationship between the interviewer and informant during the interview, as well as how the interviews may impact on the participants (e.g. reminders of offences). The study provides information how this was managed (e.g. being treated with respect and non-judgement).	1
7	Have ethical issues been taken into consideration?	There is a section included in the study that is dedicated to ethical considerations. This includes who provided ethical approval for the study, how the authors ensured informed consent was obtained (e.g. participant information sheets) and making it explicit that participation in the study was voluntary, as well as having no impact on the participant’s treatment.	1
8	Was the data analysis sufficiently rigorous?	The section on data analysis clearly demonstrates the process of data analysis, including transcription and the emergence of themes. The study also referred to the importance of reflecting on identified themes in relation to the researcher’s bias	1
9	Is there a clear statement of findings?	There is a clear statement of finding, outlining the themes identified and using participant quotes to demonstrate the presence of the themes. There is adequate discussion about the evidence for and against the researcher’s arguments, with findings having clear links with the original research question.	1
10	How valuable is the research?	The discussion section of the study clearly demonstrates how each theme “fits-in” with the existing literature. It also makes reference to how this research may influence clinical practice, particularly in regards to identifying factors that promote treatment effectiveness.	1

Study 3: Themes in participant feedback on a risk reduction programme for child sexual exploitation material offenders (Dervley, Perkins, Whitehead, Bailey, Gillespie & Squire, 2017)

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	Clearly stated aims (e.g. to evaluate the community treatment programme for CSO). It also makes reference to how these aims will potentially help to inform alternative programmes in the future (e.g. its utility).	1
2	Is a qualitative methodology appropriate?	Qualitative methodology is appropriate as the aims of the study were to gain the personal feedback of CSO's regarding their treatment experiences.	1
3	Was the research design appropriate to address the aims of the research?	Information is provided regarding how the methodology was deemed appropriate, giving a clear rationale for why thematic analysis was used. It also provides information regarding how participants were recruited and how data was collected.	1
4	Was the recruitment strategy appropriate to the aims of the research?	Provides information about how participants were recruited for the study (e.g. recruitment letters, consenting, self-selected sample)	1
5	Was the data collected in a way that addressed the research issue?	Indicates that interview schedules were devised and included information about what these schedules included. Interviews were audio recorded and the length of interviews is also noted. Additional persons were interviewed (e.g. partners, parents, programme staff), although this sample is not included in the meta-synthesis.	1
6	Has the relationship between the researcher and participants been adequately considered?	There is little information present regarding the influence of the researcher on participants. It does make reference to the interviews being conducted by non-programme staff to prevent social desirability in responses.	0
7	Have ethical issues been taken into	There is a section regarding ethics in this study. This includes how ethical approval	1

	consideration?	was obtained and what considerations were given based upon the sensitive nature of the study. Information sheets and consent forms were provided. It is also documented that participants were informed they could leave the study at any time.	
8	Was the data analysis sufficiently rigorous?	The “analytic technique” section clearly demonstrates how data was analysed, providing clear information regarding the steps taken.	1
9	Is there a clear statement of findings?	There is a clear statement of findings, of which includes participant quotes to support the themes identified. It also makes reference to times when conflicting opinions were present. The discussion section demonstrates how the findings from this study are supported by previous research.	1
10	How valuable is the research?	There is a section regarding directions of future research that explicitly states how additional research can “build-upon” the findings from this study. This also includes information regarding the clinical impact of this study, indicating how treatment programmes may be improved in future.	1

Study 4: What sex abusers say about their treatment: Results from a qualitative study on pedophiles in treatment at a Canadian penitentiary clinic (Drapeau, Körner, Granger & Brunet, 2005).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	Aims of the study are clearly reported (e.g. lack of research in this area). Gives rationale for why hypothesis was not present (e.g. in order to be exploratory)	1
2	Is a qualitative methodology appropriate?	Qualitative methodology is appropriate in order to get the lived experiences and perceptions of CSO engaging in therapy	1
3	Was the research design appropriate to address the aims of the research?	The rationale for the study is outlined, as are the reasons for the use of semi-structured interviews and comparative analysis. This allowed CSO to share their experiences, in keeping with the aims of the research	1
4	Was the recruitment strategy appropriate to the aims of the research?	Participants recruited were appropriate to the aims of the study (e.g. CSO who had engaged in therapy for their offences). There was little information provided regarding how the participants were recruited, other than they engaged in the specific programme being explored.	1
5	Was the data collected in a way that addressed the research issue?	Data was collected using semi-structured interviews, with a clear rationale being reported for this method. Information regarding the process around interviews is documented (e.g. length of interviews, audio recorded, and transcription) is documented.	1
6	Has the relationship between the researcher and participants been adequately considered?	There is information regarding how the interviewer’s qualifications and affiliations were made known to participants prior to their interviews in order to promote informed consent	1

7	Have ethical issues been taken into consideration?	As above (informed consent is briefly acknowledged). There is no further information regarding how ethical approval was sought	0
8	Was the data analysis sufficiently rigorous?	Information is provided regarding why the method of analysis was chosen and how the analysis was conducted. There is evidence that more than one researcher contributed to the analysis to reduce researcher bias impacting theme development.	1
9	Is there a clear statement of findings?	Findings are clearly outlined in the results section, including the inclusion of tables to demonstrate theme development. Participant quotes are used to demonstrate the validity of themes identified. This includes when there was disagreement between participants. Findings are related to the aims of the study	1
10	How valuable is the research?	This study highlights the need for additional research and how it can be applied to clinical practice. Findings are discussed in relation to existing research and theories.	1

Study 5: Exploring client and therapist experiences of sexual offender intervention: Developing a model of "significant events" (O'Halloran, O'Reilly, Travers, Quinn, Stack, Cartin, Finnegan & Ewart-Boyle, 2016).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	The purpose of the research is reported, including the rationale as to why the aims of the study are necessary (e.g. identifying significant events in therapy to improve service development and future interventions)	1
2	Is a qualitative methodology appropriate?	Qualitative methodology is appropriate given the aims of the study were to identify what the effective factors of therapy were considered to be. This suggests a need for qualitative methodology as it is dependent upon individual's experiences/perceptions. There is a quantitative aspect to this study, which was not included in the meta-synthesis.	1
3	Was the research design appropriate to address the aims of the research?	There is discussion of the research design used, including how data is collected and how data is analysed	1
4	Was the recruitment strategy appropriate to the aims of the research?	Participants were recruited based upon their involvement in sexual offence programmes. It is noted that participation was voluntary, and participants were invited to participate in the interviews based upon random selection	1
5	Was the data collected in a way that addressed the research issue?	Data collection was clearly reported, both for the qualitative and quantitative aspects of the study. Data was collected via interviews, with information being documented about how these were conducted	1
6	Has the relationship between the researcher and participants been	There is no information regarding the relationships between interviewer and participants reported.	0

	adequately considered?		
7	Have ethical issues been taken into consideration?	Ethical approval was sought for this study and was documented in the "write-up". There is also an ethical approval section within the procedure component of the study, demonstrating how informed consent was obtained.	1
8	Was the data analysis sufficiently rigorous?	There is a rationale for the data analysis used. Emerging themes are supported by participant quotes within the results section. There is evidence of contradictory data being taken into account.	1
9	Is there a clear statement of findings?	Findings are clearly presented and are discussed in relation to the existing research. This includes how research is supported by previous findings, as well as identifying the limitations of the study	1
10	How valuable is the research?	There is a lot of discussion regarding the implications of this research in regards to future research, clinical practice and service evaluations.	1

Study 6: Psychotherapy experiences of perpetrators of child sexual abuse (Thomas, Phillips & Blaine, 2015).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	There is a section entitled “purpose of the study” that clearly outlines the aims of the study (e.g. meaning of psychotherapy experiences). Prior to this, rationale for the study is provided (e.g. qualitative studies regarding this population are limited), indicating a gap in the literature	1
2	Is a qualitative methodology appropriate?	The purpose of the study is to explore the experiences of CSO who attend psychotherapy. Qualitative methodology enables this to be captured by gathering their first-person perspectives.	1
3	Was the research design appropriate to address the aims of the research?	The method section provides information as to the design of the study, including clearly defined rationale for this. This includes reference to previous research to further demonstrate the appropriateness of the design.	1
4	Was the recruitment strategy appropriate to the aims of the research?	There is some information regarding how participants were recruited, including being provided information regarding the study by their therapists. Although not explicitly stated, it appears as though participants volunteered to engage in the research. This is due to therapists being unaware of who participated in the study.	1
5	Was the data collected in a way that addressed the research issue?	Method of data collection was appropriate considering the aims of the research (e.g. participants were CSO and had engaged in therapy). Participants were provided with information regarding the study and were able to volunteer to participate.	1
6	Has the relationship between the researcher and participants been	There is no reference to the relationship between the researcher and the participants	0

	adequately considered?		
7	Have ethical issues been taken into consideration?	Makes reference to the ethical considerations needed when conducting secondary analysis. Ethical consideration was given to therapists providing potential participants information regarding the study, and how this was managed (e.g. therapists were not informed whether participants chose to engage in the study)	1
8	Was the data analysis sufficiently rigorous?	The data-analysis section provides in-depth information regarding the analysis used, and the rationale for this. There is a clear process of how data was collected and analysed described in this section. Previous research is used to support the decisions made regarding data-analysis methods.	1
9	Is there a clear statement of findings?	Findings are clearly outlined, and participant quotes are used to support the identified themes. There is a discussion regarding how the findings are supported by previous research, as well as how findings may be conflicting with what has previously been reported. There is also reference to the strengths and limitations of the research	1
10	How valuable is the research?	The research describes implications for future research, as well as how it can be applied to improve clinical practice. This includes how sex offender treatment programmes can be improved to promote efficacy.	1

Study 7: Sexual offenders’ perceptions of correctional therapy: What can we learn? (Williams, 2004).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	The aims of the research were described (e.g. to give voice to sex offenders who had engaged in sex offence programmes). The rationale for this is outlined within the introduction section.	1
2	Is a qualitative methodology appropriate?	The methodology used was an open-ended questionnaire and so appears akin to a structured interview. This was deemed appropriate as it allowed participants to share their experiences, whilst ensuring their responses remained focused on the research aims	1
3	Was the research design appropriate to address the aims of the research?	The research design was considered appropriate, supported by research to demonstrate their rationale for its use within this study.	1
4	Was the recruitment strategy appropriate to the aims of the research?	The inclusion criteria for participants are described within the “participants” section of the study. This includes why participants were selected, and how they were informed of the study in order to volunteer for it.	1
5	Was the data collected in a way that addressed the research issue?	Data is collected in a way that addresses the research issue, enabling participants to share their experiences of therapy. There is reference to the participants being given a choice regarding data collection, indicating the chosen method was the preferred option of participants.	1
6	Has the relationship between the researcher and participants been adequately considered?	The author acknowledged their position as a psychotherapists and program director and how this could have influenced the study. Benefits and limitations of this dual-role are explored in the research, and how it could have influenced responses.	1

7	Have ethical issues been taken into consideration?	The dual-role of the author is considered and how this may impact responses Participants were given a choice in how data was collected to enable them to have some autonomy with how they share their experiences. Obtaining informed consent is reported	1
8	Was the data analysis sufficiently rigorous?	The process of data-analysis is described within the “data analysis” section of the study. This includes how the data was analysed and the rationale for why this was deemed appropriate. How themes were developed from the data is also documented.	1
9	Is there a clear statement of findings?	Participant quotes are used to support the identified themes This includes how different participants may have disagreed in regards to different topics. The research is discussed in regards to the wider literature base, and existing polices or procedures.	1
10	How valuable is the research?	There is reference to how the findings can inform how those working with sexual offenders may work (e.g. needing to be reflective of their attitudes, beliefs), although there is limited discussion about what could be done to improve practice or research.	0

Study 8: “Simply speaking your mind, from the depths of your soul”: Therapeutic factors in experiential group psychotherapy for sex offenders (Williemsen, Seys, Gunst & Desmet, 2016).

Question		Comments	Score
1	Was there a clear statement of the aims of the research?	Aims are clearly stated within the introduction section of the study (e.g. to elicit feedback regarding the most helpful aspects of therapy)	1
2	Is a qualitative methodology appropriate?	Qualitative methodology is appropriate given the focus on exploring the perceived helpful factors of therapy by offenders.	1
3	Was the research design appropriate to address the aims of the research?	The authors make reference to the rationale behind the research design used, relating this to the aims of the research (e.g. being interested in participant feedback). This provided reason for why alternative methodology was not used	1
4	Was the recruitment strategy appropriate to the aims of the research?	There is limited information regarding how participants were recruited, other than they had completed the treatment program.	0
5	Was the data collected in a way that addressed the research issue?	Semi-structured interviews were used. Information regarding what types of questions were asked is detailed in the study. The process of the interviews was explained, included when, where and how long interviews lasted.	1
6	Has the relationship between the researcher and participants been adequately considered?	There is no reference made to the relationship between the researcher and participants	0
7	Have ethical issues been taken into consideration?	There is no information provided regarding ethical approval, or other ethical considerations taken into account when conducting this research	0
8	Was the data analysis sufficiently	There is information regarding why the data was analysed in the way that it was (e.g.	1

	rigorous?	Yalom's), including how this approach was modified to address the limitations of the model used. This enabled contradictory data to be taken into account, such as the participants not sharing experiences related to some aspects of the model	
9	Is there a clear statement of findings?	There is adequate discussion of the evidence for and against the researcher's arguments including how this compares to existing literature. The findings are discussed in relation to the aims of the research, ensuring this remains the focus of the study.	1
10	How valuable is the research?	The study makes reference to future research and provides implications for clinical practice. Findings are discussed in relation to the relevant research base.	1

Chapter 2: Research Paper

Nursing professionals’ experiences of working with sexual offenders who have a learning disability

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Abstract

Background: Professionals supporting sex offenders with learning disabilities (SOwLD) can experience challenges in providing compassionate care, despite this being a core component for effective intervention. Research has paid little attention to "frontline" staff, such as nursing professionals, despite this group having the most contact with patients and the least support**.** **Objectives:** To explore nursing professionals' experiences of working with SOwLD, to identify the challenges and benefits associated with this work. **Method:** Semi-structured interviews were conducted with 8 nursing professionals. Interpretative phenomenological analysis was used to analyse the data. **Results:** Two superordinate themes were identified; 1) Becoming Janus and 2) The pervasive influence. Professionals felt better able to cope with job demands if they could access support. Informal support was preferred by professionals, particularly due to the use of dark humour. Understanding patients' histories was important to prevent offence focus and to aid compassionate care. **Conclusions:** Professionals have positive and negative experiences of their work. Ensuring varied support mechanisms are available to nursing professionals is integral to negate against stressors and compassion-fatigue. Implications for practice are considered.

Key words: Nursing professionals, compassion-fatigue, learning disabilities, sexual offences

Introduction

Individuals with sexual offending histories can pose significant challenges to professionals involved in their care (Duwe & Goldman, 2009; Kadambi & Truscott, 2004). Reasons for this have been attributed to being exposed to disturbing offence details (Slater & Lambie, 2011), creating difficulties in professionals' abilities to exhibit empathy or warmth to their patients (Marshall et al., 2003). Given that caring relationships are a central component in forensic nursing (Encinares, McMaster & McNamee, 2005); such difficulties may inhibit the development of positive therapeutic relationships needed to achieve this. In addition to these professional challenges, those working with sexual offenders may experience challenges in their personal lives also. This may include disruption to personal relationships, increased hyper-vigilance or suspiciousness of others and increased risk of using alcohol as a coping mechanism (Moulden & Firestone, 2007). Given that these difficulties develop as a direct result of one's work, it has been labelled "the cost of caring" (Figley, 1995). Although this label is typically applied to those working with trauma survivors, there is increasing evidence of its relevance to those working with sexual offenders (Baum & Moyal, 2020). This is due to greater levels of negative affect and stress being reported in those working with this population, particularly when compared to other professionals who do not work with sexual offenders (Lee, Wallace, Puig, Choi, Nam & Lee, 2010). Exposure to high levels of stress can lead to professionals experiencing emotional hardening; reducing their ability to feel compassion for their patients. This is an important consideration given that coping strategies rooted in compassion are suggested to better enable professionals to respond to their patients' needs, whilst effectively maintaining their own wellbeing (Hammarström, Häggström, Devik & Hellzen, 2019).

Compassion and compassion-fatigue

Compassion is deemed integral to providing quality care by patients, professionals, and policy makers (Department of Health, 2008; Flocke, Miller & Crabtree, 2002; Paterson, 2011; Sinclair et al., 2016). Providing compassionate care can improve the likelihood of positive outcomes being achieved (Norcross, 2002), and professionals reporting greater abilities in managing stressors (Gilbert, 2010; MacBeth & Gumley, 2012). Maintaining compassionate care can be challenging for those who are required to demonstrate high levels of empathic engagement with individuals in distress or exhibiting challenging behaviours (Figley, 2002). This is relevant for those working with sexual offenders due to the requirement to manage strong emotions regarding distressing information or behaviours (Way, VanDeusen, Martin, Applegate & Jandle, 2004). This suggested emotional labour, described as the requirement to regulate one's true emotion to display an organisationally appropriate reaction (Zapf, 2002), can act as precipitating and perpetuating factors to professionals' experiences of compassion-fatigue (Melvin, 2015; Sorensen & Iedema, 2009).

Compassion-fatigue describes a response to intense work stressors (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski & Smith-MacDonald, 2017), leading some professionals to feel they are "running on empty" (Boyle, 2011). This can impact the quality of care provided to patients by impeding the development of therapeutic relationships (Lombardo & Eyre, 2011; Najjar, Davis, Beck-Coon, & Carney-Doebbeling, 2009). Certain environments can increase the vulnerability to compassion-fatigue, including feeling worthless and being disillusioned with one's work (Figley, 1995; Stamm, 2010). This is relevant for those working with sexual offenders, given the belief that this population are difficult to rehabilitate successfully (Bach & Demuth, 2018). This may cause practitioners to question their purpose, deemed necessary for professionals to be motivated and satisfied with their work (Hunsaker, Chen, Maughan, & Heaston, 2015; Perry, 2008). This may explain why professionals working with this population are at an increased risk of experiencing anxiety, depression, and negative impacts on their personal relationships (Clarke & Roger, 2002; Way, VanDeusen, Martin, Applegate & Jandle, 2004).

Sexual offenders with learning disabilities

Working with certain populations, such as people with learning disabilities (PwLD), is associated with increased stress in some professionals (Innstrand, Espnes, & Mykletum, 2002). Sexual offenders with learning disabilities (SOwLD) are, therefore, considered particularly challenging for professionals (Clare & Murphy, 1988; Mosher, 2010).This has been attributed to perceptions that PwLD are less in control of sexual offending behaviours than others (MacKinlay & Langdon, 2009). Whilst it is suggested that those working with SOwLD are more likely to have positive perceptions of this population than others (Day, Boni, Hobbs, Carson, Whitting & Powell, 2014; Steans & Duff, 2018), there is little information available on how this is achieved or maintained. Most emerging research with this group has focused upon the experiences of the victim or perpetrator, with less attention being given to the role of the "helper" (Bach & Demuth, 2018).

The impact on nursing professionals

The existing literature has been criticised for the lack of research exploring the specific experiences of professionals working with SOwLD (Sandhu, Rose, Rostill-Brookes & Thrift, 2012). Much of this research focuses upon the experiences of psychotherapists or psychologists who deliver treatment programmes, with little attention being paid to "frontline staff", such as nurses or support workers. This is pertinent given that this professional group spend the most time with patients, with these relationships being considered key in predicting therapeutic success (Norcross, 2002; Serran & Marshall, 2010). Nursing professionals receive the least amount of training and supervision to manage the emotional sequelae of their work (Potter et al., 2010), which may increase their vulnerability to compassion-fatigue. Further research is required to better understand the experiences of nursing professionals who work with SOwLD. This is important given that research exploring the subjective accounts of working with sexual offenders is lacking (Elias & Haj-Yahia, 2017), specifically in regard to practitioners who are required to meet the "moment-to-moment" needs of patients that nursing professionals are expected to do. Understanding the potentially positive aspects of this work may identify what factors motivate practitioners to work in this field (Kadambi & Truscott, 2006), offering insight into valuable coping strategies used by this professional group.

Aims

This study aims to explore the experiences of nursing professionals who work with SOwLD to identify factors that may influence the presence of compassion-fatigue.

Method

Design

A qualitative research design was used to gain insight into nursing professionals' experiences of working with SOwLD. As nursing teams are typically comprised of nurses and support workers, both job roles have been included in this study. This is to ensure that important experiences are not missed, particularly as the experiences of "front line" workers' who work with SOwLD is lacking. Semi-structured interviews were conducted, utilising a topic guide to collect the data (Appendix 2-B). Topics included challenges and benefits of working with SOwLD, perceptions of support, coping strategies and areas requiring improvement. Interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009) was used for data analysis. IPA is an appropriate method of data analysis as it enabled detailed exploration of an individual's experiences, whilst simultaneously acknowledging that the research is engaged in a double-hermeneutic when making sense of that individual's sense making (Smith et al., 2009).

Ethical approval

Sponsorship and ethical approval were granted by Lancaster University (Ref: FHMREC18105). HRA approval and NHS research and development approval were also granted (IRAS ID: 264142)

Participants and recruitment

Participants were recruited from a forensic learning disability (FLD) service within the UK. All participants worked from the same hospital site and were recruited from the secure and community teams of the FLD service. The research advert was sent to ward-managers and team leaders by the principal investigator, encouraging distribution to relevant others (e.g. nurses, support workers). It was made clear that decisions to participate in the study would not be shared with others. This was to reduce the potential for perceived coercion to participate in the study given the advert was distributed by lead professionals within teams. This was managed by emphasising anonymity throughout the research process and no identifiable information being shared.

Those interested in participating in the study were asked to email the main author directly. Nine participants expressed interest in participating, but only eight were interviewed. This was due to research activity being suspended by the R&D department of the research site in response to the Covid-19 pandemic prior to the last interview being arranged. This was explained to the individual, who was accepting of this. Participants' characteristics are detailed in Table 1.

Collected data was deemed rich and robust enough to allow for appropriate analysis using IPA. IPA studies typically utilise small samples to ensure there is detailed exploration of participants' experiences, enabling the identification of subtle similarities and differences between each participant's accounts (Smith et al., 2009). This considered the complexity of human experiences (Smith et al., 2009), relevant to the topic of working with SOwLD.

Interviews were arranged at times preferable for participants, ensuring the least disruption to their working day. Rooms within the FLD service were booked by the main author to reduce the likelihood of individuals being identified as participants in this study. Participants were asked to read the participant information sheet and were given time to ask questions they may have had regarding the research process. Participants were asked to read and sign consent forms before audio-recording commenced for the purpose of the interview.

Data collection

Interviews were conducted between January and February 2020. All interviews were conducted by the main author within private rooms of the FLD site. Interviews were audio-recorded using an encrypted digital dictation device and lasted up to one hour.

Using a semi-structured approach enabled participants the opportunity to discuss matters salient to them (Horton, Macye & Struyven, 2004), allowing for a more detailed account of participants' true experiences. Having this flexibility allowed for a greater breadth of data to be collected (Horton et al., 2004). This was important given the lack of current research exploring the experiences of nursing professionals working with SOwLD as it reduced the risk of important understandings being missed.

Data analysis

IPA is an appropriate method of analysis for this study due to its focus on personal meaning and sense-making within a particular context (i.e. FLD services) for people who share a particular experience (e.g. nursing professionals working with SOwLD; Smith et al., 2009). Using an IPA approach allowed the researcher to acknowledge how their own sense-making could impact the interpretation of participants' responses.

Interviews were transcribed verbatim by the main author. All identifiable information was removed to promote anonymity. IPA was conducted in line with guidance provided by Smith et al. (2009). This included following the six stages: 1) The transcript was read and re-read several times to ensure familiarity with the data.; 2) Initial noting was undertaken to identify key concepts or experiences described by the participant; 3) Emergent themes were developed through reflection and developing an understanding of the notes; 4) Superordinate themes were developed by searching for connections across emergent themes for each participant; 5) Repeating the process with the next transcript and 6) Looking for patterns across the cases to identify the overall themes described by the participant sample.

This process was completed separately for each participant to remain in keeping with IPA's idiographic commitment. It is acknowledged that the author could have been inevitability influenced by what they had read before when completing the above process for each participant. Following this process systematically improved the likelihood of rigour being achieved (Smith et al., 2009). Given the double hermeneutic component of IPA, it is acknowledged that other researchers may interpret the data differently (Shaw, 2010). This is considered an inevitable bias within IPA (Smith et al., 2009).

Quality and reflexivity

Yardley's principles for qualitative research (Yardley, 2000) were followed to assure the quality of the analysis. This includes sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. This was achieved by the main author completing a reflective diary after each interview and through the transcription and analysis of each transcript to demonstrate a clear process of learning and interpretation (Vicary, Young & Hicks, 2017). The use of a reflective diary enabled recognition of potential bias, limiting the impact of pre-existing assumptions on theme-development. This was aided by discussions with the research team.

Additional considerations

The main author previously worked at the FLD service and so had existing relationships with some participants. Continued reflection on how these relationships may have influenced the information shared within the interviews was undertaken. This was supported by discussions within research supervision. Previous research has consistently highlighted the risk of compassion-fatigue in health services (Gerard, 2017), leading it to be a considered a top concern for services and policymakers (Newdick & Danbury, 2015; Slatten, Carson & Carson, 2011). Having this awareness, including one’s own experience of working with SOwLD, could have impacted the process of theme interpretation and development within this research; particularly in “looking for” the presence of this phenomena. To prevent this occurring, the main author kept a reflective diary so potential biases could be recognised. Discussions were also facilitated with the research team to ensure the main author’s interpretations were grounded in the data, rather than potential underlying expectations.

Findings

Two superordinate themes were identified: 1) Becoming Janus and 2) The pervasive influence. Both themes encompassed sub-themes, which are presented in Table 2. Examples of theme development are presented in Appendix 2-C.

Theme 1: Becoming Janus – "You just think 'right', and you put your head in the game"

This theme represents how professionals are required to maintain compassionate care, despite exposure offending behaviours or details that can interfere with their ability to develop therapeutic relationships. All participants voiced needing to remain aware of past offending to manage risk, whilst simultaneously focusing on the patient in the present moment to provide compassionate care. Having these contrasting focuses is akin to the depiction of Janus in Roman mythology. Janus was described as having two faces; one looking backwards and the other looking forwards, and so appears related to participants' experiences within this study.

> "You're going into that sort of push and pull, push and pull all the time … it's quite – sometimes it can be quite difficult" (Participant 5; Nurse).

> "This is how I deal with things, and see what's in-front on me… you've always got to keep things in the back of your mind and make sure like you know why you're here" (Participant 8; Support worker).

This represented a "push and pull" between focusing on the present moment with their patients and being mindful of their past. The need to maintain compassionate care whilst simultaneously managing risk demonstrates the paradoxical nature of forensic nursing. It appears this was difficult for participants to navigate, suggesting challenges in holding conflicting perceptions of their patients. This indicates that being "Janus" involved regularly switching from one view (e.g. present focus) to another (i.e. past focus) rather than attempting to encompass both perceptions simultaneously.

Offence exposure

Participants described becoming emotionally numb when repeatedly exposed to offence details and behaviours. This did not mean participants lacked emotional reactions to their work, as many described feelings of disgust, fear, anger, and hopelessness, but rather suggested the impact of this had diminished over time. This suggests emotional numbing is a natural consequence of working with SOwLD.

> "I think I'm quite desensitised to things [offences] like that … I think it can still shock and you just think … "I can't believe someone has actually done that", but … you just think "right" and you put your head in the game and you don't get attached to certain things" (Participant 6; Support worker)

Emotional numbing appeared to be associated with a conscious effort to distance themselves from patients' offences. The need to have their "head in the game" could indicate an attempt to disconnect from their personal feelings towards patients to be effective as a professional. This personal-professional dialect was described by other participants.

> "I think anybody who hears about sexual offences … you always feel like sort of quite repelled by that, but in the same breath you've got to be professional about it. You know that it is part of your job" (Participant 3: Support worker)

This suggests distancing from emotional responses is an expected component of this work, even if this appears counterintuitive to "normality". Loss of perceived "normality" in emotional reactions could lead some professionals to question their own mental health, particularly when this signified a change from what they once experienced.

> “You just sort of get used to seeing things, hearing things and it doesn’t seem to bother you anymore and then you think; Is that normal? Should I be feeling like that, or should I be like really upset?” (Participant 1: Support worker)

Working with SOwLD created sadness and frustration, particularly when the very nature of their patients’ offences acted as barriers to them progressing in the future.

> “I think it’s sad because you kind of think no one would ever support their discharge out of hospital really… it can be frustrating” (Participant 7: Nurse)

> “He’s never going to move on and that, for me, that’s really frustrating … no one should have to spend their life in hospital” (Participant 3: Support worker)

Participants mirrored the hopelessness of their patients, suggesting a degree of transference when working with SOwLD. Given that helping people improve is a fundamental aspect of being a nursing professional; being unable to achieve this can create uncomfortable dissonance between what they believe they should be doing (e.g. rehabilitation) and what they can realistically achieve (e.g. containment). This was exacerbated if continued efforts to support patients did not result in meaningful changes, leading to cynicism or resentment towards their patients, themselves, and their service.

> “And you know for a fact that some of them, given half the chance … they will reoffend. I have seen clients come back here three or four times (Participant 2: Support worker).

Therapeutic relationships

Participants needed to understand patients' histories to develop therapeutic relationships with them. Gaining deeper understanding of patients' lives enabled professionals to view them with greater compassion, particularly if patients had experienced abuse themselves.

> "… someone with a learning disability that's been abused themselves … they may just think it's normal to some extent, and haven't necessary been brought up with the rules that it's not" (Participant 7: Nurse)

Knowing this patient's history enabled the participant to make sense of what contributed to their offending. As this patient's experiences (e.g. being abused) were outside their control, this could have made it easier for professionals to view them as more deserving of care. This is suggested as it is seen as more socially acceptable to give care to victims, rather than perpetrators, of abuse (Richards &McCartan, 2018); thus enabling professionals to justify their work. This is particularly so given that professionals often described being judged for their work by others.

It is suggested this patient offended due to a lack of opportunities to learn about "right and wrong", rather than because they were inherently evil. This enabled the participant to view their patient as someone capable of change, important for professionals to accept offences as part of patients' histories rather than being a defining feature of that person. Compartmentalising offences was deemed necessary, as a focus on offence details was a barrier to the development of positive therapeutic relationships. Some participants felt it important to meet the patient before learning about their offences to reduce this risk.

> “[I] know their offences; know their history before I’ve even seen what this patient looks like. I think that just automatically puts a picture of them in your head (Participant 4: Nurse)

Being unable to control when they heard patients’ histories made it challenging for participants to overcome the underlying judgements they had towards those individuals. This undermined how the participant wished to manage their job-demands, creating a loss of control in practising what was effective for them. This mirrors the lack of control patients have in dictating when and who they share their stories to, potentially disadvantaging patients as they are judged for past events rather than who they may be now. Although delivering compassionate care was considered easier when offences were not known, professionals still needed to know offence details to effectively manage risk.

> “I actually see what is in front of me … and I know you have to be really, really aware of what these people are capable of, but I actually treat each individual as an individual” (Participant 8: Support worker)

This example indicated a professional’s need to balance offence awareness, whilst also maintaining a present-focused view of patients. This was important to deliver compassionate care, indicating the dual role of forensic nursing professionals. Balancing risk management and compassion indicates a “push-pull” aspect to this work, causing some professionals to experience cognitive dissonance that led them to question their own identity.

> “I would think ‘oh my God, this poor woman has had this horrific life’, but then actually in her day-to-day life you couldn’t even take her to a shop because she

> was too highly risky around children … it was like you were two completely different people" (Participant 4: Nurse).

Theme 2: The pervasive influence – "It does have that knock-on effect"

This theme represents the far-reaching impact that working with SOwLD can have on professionals. The likelihood of professionals seeing value or purpose in their work was influenced by the actions of others, including patients, management, and other services. Professional and personal impacts were described, indicating how professionals' overall lives have been influenced by their work.

Impact of others

All participants stated their work provided them with job-satisfaction, yet few provided specific examples of this. This may reflect the limited progress often observed in forensic services, as well as the challenges in sourcing community placements for SOwLD. Many participants acknowledged the lack of "big changes" in their work but placed greater emphasis on the significance of seemingly small signs of progress in their patients instead.

> "Seeing little bits of progress that they make everyday gives you that little bit more job satisfaction. You think you have achieved something with them" (Participant 1: Support worker).

For this participant, this appears to be beneficial in helping them develop a sense of purpose in their work. It was important not to dismiss the cumulative effect of these small changes when working with SOwLD, seemingly allowing professionals to maintain in their role when progress was considered infrequent. When patients were deemed ready to progress, it was frustrating when they were prevented from doing this. This was attributed to the stigmatising attitudes towards sexual offenders, meaning opportunities for patients were limited.

> “[He] is constantly being pulled back and forth: transition, not transition, transition, not transition … and he’s just like ‘well what’s the point? Because I am never getting out’. So, he just doesn’t care” (Participant 6: Support worker).

This example demonstrates the parallel process of hopelessness in the patient and the professional, and the counterintuitive nature of some forensic services. The participant suggests that barriers to moving-on may exacerbate risks as it reduces patient motivation and hope. Risk-aversive practice appears unfair to this participant, indicating how this undermines the very purpose of their job.

> “It basically scares the life out of them and they think ‘oh I shouldn’t have been that open’… the minute we clamp down, they clamp shut and they start telling us what we want to hear” (Participant 5: Nurse).

Risk-aversive practice within teams can lead to negative perceptions of their colleagues and is considered ineffective as it increases superficial engagement in patients. This makes it harder for professionals to do their jobs as patients are less likely to be honest regarding their risk. Lack of communication between teams also posed challenges for professionals, particularly if they were not aware of the rationale behind important decisions regarding patients. This created a sense of distrust between staff and management, increasing negative perceptions of the service on a whole. Professionals would question the service’s actions, particularly if they appeared contradictory to its purpose (e.g. to provide care and rehabilitation).

> “If the trust are making decisions that you don’t think are going to benefit the patients, then you start thinking ‘well what’s the point?’ … you go into your intervention with patients and you think with that same attitude” (Participant 3: Support worker).

This example demonstrates transference of hopelessness with the service to hopelessness when providing patient care. Decisions made by the service could undermine participants’ professional identities, making it more challenging to see a purpose in their work. Feeling unsupported by the service created difficulties in offering support to patients, suggesting a risk of becoming stuck in a “vicious cycle” of feeling unsupported to provide support.

> “It just takes away, I think, the caring nature of our hospital because we just think well the managers don’t care, why should we? (Participant 4: Nurse).

This was amplified for some participants when decisions regarding patient discharge did not appear to be based upon the best interests of patients, but rather due to political pressures.

> “There are always pressures to get people out, sometimes it is regardless as to whether you think they should be going out or not … it is frustrating when that happens because you then kind of doubt the service that you work for” (Participant 7: Nurse).

This suggests cynicism towards the service when responding to external pressures instead of focusing on the needs of individual patients. These decisions appear to undermine the fundamental purpose of providing person-centred care, questioning the purpose of rehabilitation services if readiness to “move-on” is not the reason for patient discharges. When this occurs, professionals can describe a very reductionist view of their roles.

> ““If you’ve done your job and you’ve done it to the best of your ability … it’s about managing risk” (Participant 5: Nurse)

Lack of involvement in decisions made about patient care creates challenges in a person’s professional identity, reducing it purely to managing risk. It appears that this participant separates their job from the wider service (e.g. “your job”, “your ability”); suggesting this may be an attempt to distance oneself from decisions they do not agree with. It also indicates how professionals feel separate to their service, rather than a team working towards a shared goal. This may partly account for why accessing informal support within teams was more valued by participants. For many, this took the form of “dark humour”.

> “There is some dark humour that’s used. Like you have to, like nothing that is offensive to the patient, but sometimes you’ve just got to do that. That’s a way to get it out” (Participant 7: Nurse).

> “[There is] a bit of a sick humour that goes alongside people that work in forensics… we see some really horrendous things” (Participant 4: Nurse)

Dark humour is a stress-relief, reducing the emotional labour associated with their work by given them an outlet for potentially suppressed emotions. “Have to” and “got to” suggests dark humour is a necessity when supporting SOwLD, allowing professionals to minimise the severity of their experiences so they can continue in their roles. This is particularly so as dark humour was described when discussing frustrations at lack of perceived meaningful engagement or when risk incidents occurred. Participants feared judgement for their use of dark humour, which may indicate an acknowledgement of the challenges they experience in maintaining compassionate perceptions of patients when faced with challenging experiences. Fearing judgement was described as a barrier to seeking alternative, more formalised support, particularly when people did not have trusting relationships with others.

> “I think it’s the environment … who’s around and how they may interpret what you’re saying because I think we all need that safe space” (Participant 4: Nurse).
>
> “I think sometimes when you’re feeling, it’s quite personal, like if you feel you’ve done a bad job … and it is usually linked to something that you have always thought about yourself like ‘I knew I was useless’… I think it’s not something you can then talk about at work” (Participant 7: Nurse).

These participants feared that their perceived shortcomings would be exposed if they sought formalised support. Feeling vulnerable reduced opportunities for underlying worries to be addressed, thus increasing the reliance on needing to “vent” to manage stressors. When professionals had opportunities to develop trusting relationships with others from different teams or disciplines, it increased their access to support. This was deemed advantageous in helping professionals to problem-solve difficulties.

> “If I only spoke to people on the wards, I would only get experiences from people on wards… I can then speak to people within a psychology team that brings a different response or, you know … it just makes you think differently” (Participant 4: Nurse).

Some participants valued how different perspectives widened their thinking, suggesting an acknowledgement that professionals can be limited when constrained to one interpretation. The description of thinking differently appears positive and indicated awareness that rigid thinking is not always beneficial to them or their patient's wellbeing. Exposure to different perspectives appears to contribute to professional's development, enabling them an escape from becoming in stuck in only having one view.

Impact on one's personal life

It was important for participants to maintain clear boundaries between home and work to prevent their personal life being negatively impacted. Whilst many denied having difficulty in achieving this balance, many participants described changes in how they related to others, parented their children, and viewed themselves because of their work. This contradiction could suggest there is a difference between how participants believe they should be coping with how they actually cope. This may represent a fear of being judged negatively, particularly as the change in how participants' viewed others appeared to correlate with increased self-consciousness about their resulting thought-processes.

> "[I speak to] my sister or a friend … just to kind of get whether I'm overreacting or not. Because I think that's the worry; is it me overreacting or is it actually I'm right and she [daughter] shouldn't be doing the stuff that she's asking (Participant 4: Nurse).

For this participant, their work had altered their core-beliefs regarding the trustworthiness of others and ultimately the safety of the world we live in. Other participants echoed this, particularly when patients did not conform to the stereotype of what a sex offender was perceived to be.

> "When I first met him [patient] I thought, 'what a lovely guy him' and then they told me his offence and it shocked me … I remember thinking, if I was out in the

> community, I would have no problems trusting him … so yeah it has affected my trust" (Participant 3: Support worker).

These experiences created hyper-vigilance within participants' personal lives, leading participants to constantly assess for the presence of risk. This was not only applicable to the actions of others, but also in how participants' made sense of their own behaviours.

> "I had went to [the] park with my dog. I just felt so uncomfortable… because there are kids there and I just felt dirty 'cos I was walking around (Participant 2: Support worker).

This example demonstrates how a seemingly innocent event (e.g. walking the dog) could create a fear or guilt response in the individual, indicating the insidious way that this work could infiltrate how participants made sense of their own and others' behaviours.

Discussion

Findings from this study provide insight into the complex challenges experienced by nursing professionals who work with SOwLD. It was important for professionals to see a purpose and value in their roles, yet this was reduced when patient progress was deemed slow or infrequent. Whilst PwLD are expected to need more time, patience, and adaption to meet the same therapeutic goals as others, this could be frustrating for professionals if they felt their efforts had been in vain. This was exacerbated when patients were prevented from progressing, even when deemed ready and safe to do so, due to the lack support from other services. Whilst this is partly attributed to the stigmatising attitudes towards sex offenders, it also highlights the lack of appropriate placements and awareness of this specific population within the wider healthcare system (Douds & Bantwal, 2011). This appears contradictory to the purpose of Transforming Care (Department of Health, 2012), a governmental driver to reduce inpatient stays for PwLD by increasing community provisions.

Being prevented from seeking opportunities to progress can reduce self-autonomy, leading people to feel hopeless and helpless regarding their future (Harris, Walfield, Shields & Lerourneau, 2016), inadvertently perpetuating offence cycles (Levenson & Cotter, 2005; McMackin, Leisen, Cusack, LaFratta & Litwin, 2002). Participants found this challenging as repeated barriers to progression could reduce patient motivation and in turn lead professionals to experience reduced purpose, satisfaction, and motivation in their work. This is consistent with symptoms of compassion-fatigue (Hunsaker et al., 2015; Perry, 2008), suggesting that the wellbeing of nursing professionals who support SOwLD is impacted by the attitudes and structuring of wider services.

Access to effective support and resources can reduce the negative impact that work challenges have on professionals (Bakker & Oerlemans, 2016). Participants in this study reported fewer negative effects in response to work challenges when they had a wider range of support available to them, such as interdisciplinary involvement, team support and effective supervision. Similar to findings from MacDonald, Clarbour, Whitton & Rayner (2017), the ability to access these resources could be dependent upon additional organisational demands related to staffing levels. Reduced or changing staff-teams could limit the time or opportunities professionals had to access support due to the need to prioritise patient contact for safety reasons. This gives support to the Job-Demands and Resources model (JD-R; Bakker & Demerouti, 2007), which suggests job demands (e.g. patient contact, assessing risk, offence exposure) and availability of resources (e.g. supervision, support) can influence the overall wellbeing of professionals (Bakker, Demerouti & Sanz-Vergel, 2014).

The JD-R model suggests professionals are more likely to be negatively impacted when the demands of their job outweigh their ability to access effective resources (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Working in forensics services can be emotionally demanding (Kessler et al., 2010), yet working with SOwLD can amplify these demands due to exposure to disturbing offence details or behaviours (Slater & Lambie, 2011). One of the most challenging demands associated with this work was the need to balance awareness of patient risk, through knowing offences, whilst simultaneously needing to distance oneself from offences to develop positive therapeutic relationships. This juxtaposition of roles means professionals need to manage their emotional reactions to offence details to provide compassionate care (Beryl, Davies & Völlm, 2018). When barriers to resources exist, exposure to such job-demands can increase the risk of compassion-fatigue occurring (Flarity, Nash, Jones & Steinbruner, 2016). This may lead professionals to become emotionally numb and apathetic towards their work (Sinclair et al., 2017), which were experiences described by some participants in this study. Those that did not share these experiences reported easier access to effective support. This provides support to literature suggesting access to readily available resources can negate against job-demands (Bakker, Demerouti & Sanz-Vergel, 2014), reducing the experience of compassion-fatigue within emotionally demanding roles.

A commonly cited coping mechanisms was using dark humour. Dark humour was valued for enabling professionals to manage the emotional impact of their work, yet they were often concerned about judgement for this. Similar concerns were raised by professionals within high-secure services (Beryl, Davies & Völlm, 2018), indicating this fear of judgement may be consistent across forensic services. Consistent with existing research, professionals felt unable to seek support for work challenges within their personal lives (Coates & Jones, 2018) due to being questioned or judged for their work. This may account for why they placed a strong emphasis on utilising informal support, especially dark humour, given its association with increased camaraderie and a sense of belonging (Christopher, 2015).

Dark humour is a contentious issue within psychology, particularly as it is suggested to lead to the dehumanisation of those that are the subject of the joke (Ferguson & Ford, 2008). Given the stigma associated with sex offenders generally (Tewksbury, 2012), dark humour may act as a barrier to professionals providing compassionate care by reinforcing stigmatising attitudes. Participants in this study, however, suggested this was not the case. For these professionals, dark humour enabled them to minimise the severity of their experiences so they could continue working positively with their patients. These findings are consistent with research indicating dark humour to be effective in enabling professionals to persevere with challenging work (Young, 1995; Beryl et al., 2018; Cain, 2012). This may explain why dark-humour is also observed in emergency professionals and palliative-care staff (Buchanan & Keats, 2011; Charman, 2013; Mills, Wand & Fraser, 2018), suggesting it to be commonplace within emotionally demanding professions. Reasons for this may be attributed to its utility in helping professionals manage intense emotional reactions to continue providing high-quality care (Regehr, Goldberg & Hughes, 2002; Wright, Powell & Ridge, 2006). Dark-humour appeared more likely to be used when access to other support systems are limited, given that many citing its use also described barriers to formalised support.

Barriers to engaging in formalised support, such as clinical supervision, were attributed to a fear of being judged negatively for disclosing their true thoughts and feelings. This fear or distrust of others reduces professionals' abilities to access available support (Puffett & Perkins, 2017). Clinical supervision is an important factor in protecting staff wellbeing in forensic services (Davies, 2015), but feeling unable to engage in this meaningfully can limit the reflective space staff should have to make sense of their experiences. This may account for why participants frequently referred to questioning themselves if they did not feel safe to engage in this process. Furthermore, feedback was predominately seen as negative by professionals, with few describing experiences of being praised for their work. When positive feedback was received, it was associated with increased psychological safety within supervisory relationships (Scheepers, van der Goor, Arah, Heineman & Lombarts, 2018). When managers can improve the work-environment by providing such feedback and support, it can reduce staff stress and dissatisfaction (Bakker & Oerlemans, 2016), suggesting staff wellbeing can be maintained by implementing such "top-down" solutions. This is supported by professionals in this study who reported being more negatively impacted by offence exposure when a lack of organisational support was perceived. This had an impact on patient care, as this made it harder for professionals to look beyond offence histories to deliver compassionate care.

Effective supervision can reduce the risk of professionals experiencing compassion-fatigue when working with complex or challenging populations (Hatcher & Noakes, 2010; Sinclair et al., 2017). Whilst supervision is unable to remove the risk of professionals being exposed to distressing experiences, it can help reduce the psychological impact this has on staff (Bell, Hopkin & Forrester, 2019). For supervision to be effective, the relationship between the supervisee and supervisor needs to be built on trust and empathy (Howard, 2008). This can promote an individual's sense of psychological safety in supervision (May, Gibson & Harter, 2004); increasing feelings of safety to be open regarding any difficulties they may have (Edmondson, 1999; Newman, Donohue & Eva, 2017; Tynan, 2005).

Clinical implications

Given nursing professionals' preference for informal support within teams, services should aim to maintain this to ensure it remains effective in negating against work-demands. Offering staff "away days", such as time away from the work environment, can maintain team-cohesiveness (DiMeglio et al., 2005). This allows nursing professionals protected time for reflective practice, enabling them to make sense of their experiences in a safe environment (Mosher, 2010). This may be difficult to achieve within the hospital setting, given the unpredictability of forensic services meaning nursing professionals may be needed to respond to unexpected incidents. The difficulty in implementing this is acknowledged, given the ongoing shortages of ward-based staff (Simoens, Villeneuve & Hurst, 2005; The Commission on Acute Adult Psychiatric Care, 2015).

Multidisciplinary (MDT) working was deemed beneficial but was not always achieved. MDT working can promote the facilitation of risk assessment and management plans to better support complex groups (Grant & Lusk, 2015). Encouraging collaboration across the MDT can reduce professionals questioning themselves, or blaming themselves, as there is a greater focus on shared responsibility and decision making across the service (Grant& Lusk, 2015). Regular input from different disciplines strengthens MDT working, increasing access to more varied support for staff (Goodrich, 2011; Reed et al., 2015). This can be aided by the facilitation of regular formulation meetings for all teams in the service, where members of the MDT can share their specific knowledge and experience of patients. This results in a better understanding of the patient through the communication of different perspectives (Beryl et al., 2018; Davies et al., 2013), enabling for more informed decisions regarding patient care being made. Given that formulation meetings act as preventative rather than reactive support mechanism (Beryl et al., 2018), this can contribute to a more satisfied, confident, and well workforce. Moreover, this is in keeping with many policy drivers (e.g. Transforming Care), highlighting the importance of MDTs to meet the complex needs of FLD populations (Bubb, 2016; Department of Health, 2012).

Support workers have the most direct contact with patients yet are often considered a lesser priority for training or development opportunities (Mosher, 2010). Professionals in this study expressed a desire for more support, specifically in keeping safe mentally. Whilst there is a lack of formalised training specific to working with SOwLD (Epps, 2003), providing education regarding supporting PwLD and challenging behaviour has been valued (Taylor, Keddie & Lee, 2003). Self-care training, such as mindfulness, can empower professionals to feel more confident in managing their job-demands (MacDonald et al., 2016). This is associated with reduced stress and improved job-satisfaction (Hülsheger, Alberts, Feinholdt, & Lang, 2013). Offering development opportunities to nursing professionals helps them feel more appreciated and valued by their service (Mosher, 2010). This enables professionals to feel that their efforts are appreciated, particularly as observing positive progress in patients can be infrequent.

Professionals believed they were not valued by management when important decisions regarding patient care were not communicated across teams. Clearer communication of changes to policies, procedures or organisational change is needed, particularly to avoid professionals feeling as “pawns” rather than people to their organisations (Mosher, 2010). When decisions are clearly communicated, including the rationale behind changes, it fosters better two-way communication between frontline and managerial staff. This can be achieved through the implementation of “Circles of support”, a strengths-based initiative to support patients to make desired changes in their life (Moulster, Amey, Gregson, Johnson & Nobbs, 2006; Rowlands, 2001). This not only encourages patient involvement in decisions regarding their care, it also requires input from those central to the patient’s support-network (e.g. nursing professionals). This initiative ensures that nursing staff remain aware and involved in important decisions regarding patient care, increasing a sense of purpose and value in their role.

Strengths and limitations

This research has provided insight into the experiences of nursing professionals who work with SOwLD, currently a gap in the literature (Sandhu et al., 2012). It has demonstrated how challenges associated with working with this specific population can be ameliorated by having access to varied support, feeling valued and having an ability to understand patient histories. Eight participants were recruited for this study, enabling for a detailed case-by-case analysis as required for IPA (Smith et al., 2009). The number of males and females within the sample were relatively balanced, reducing the risk of findings being skewed to one gender. This is also the case with job-roles, with similar experiences from nurses and support-workers being reported.

Participants had been in post for approximately fourteen years on average and so findings are biased towards the experiences of more established professionals. Understanding the perspectives of professionals newer to their post would determine whether similar experiences would be shared, particularly as professionals in this review described a sense of "getting used to it" in their work. The perspectives of temporary or bank-staff were not included and so the experiences of this specific professional group are missed. This is important given that many of the coping strategies and resources described by participants were dependent upon developing positive relationships with others and having in-depth understanding of patients. Participants were recruited from a single hospital, reducing the reliability of generalising findings to alternative sites. Regardless of whether this sample is fully representative of nursing professionals who support SOwLD, it does provide insight into what factors play an important role in influencing professionals' satisfaction with their roles. This insight is important to understanding what helps staff maintain in their roles, as well as how they manage or overcome challenges associated with working with SOwLD. Further research should be conducted to ascertain whether similar findings are observed within different services.

Future research

This study highlighted that team closeness and in-depth understandings of patients' histories were important in managing challenges in working with SOwLD. It is argued that this is more easily achieved when staff have time to develop relationships with others, of which can be challenging for agency or bank-staff. Exploring how this staff group experience working with

SOwLD can help identify what factors make their roles more or less challenging, as well as how support systems can be improved overall. This is important given the increased use of agency staff within secure services (The Commission on Acute Adult Psychiatric Care, 2015), suggesting this research is needed.

Most professionals in this study had been in their roles for over seven years and so their experiences are likely to reflect those who have been able to adapt or manage the challenges of working with SOwLD. Future research could explore experiences of those who left the service to ascertain what factors contributed to their departure. This would provide valuable insight into what could be done to promote the retention of forensic staff. Given that the World Health Organisation (WHO) have estimated there to be a shortage of 9,000,000 nursing professionals (WHO, 2016), it is likely to be a long-standing issue and so more consideration needs to be given to how staff wellbeing is protected to reduce low-staffing.

The lack of community opportunities for SOwLD was frustrating for participants, particularly if patients were prevented from progressing due to risk-averse practice or stigmatising attitudes of others. Exploring the attitudes or experiences of working with SOwLD in other services could provide insight into how to overcome these challenges, including what support may need to be implemented to ensure this is resolved. This is particularly important considering Transforming Care has been criticised for demonstrating little progress since its implementation (Taylor, McKinnon, Thorpe & Gilmer, 2017).

Conclusion

Working with SOwLD can have a strong emotional impact on nursing professionals, particularly as they try to balance the need for compassionate care with risk awareness. Access to informal support, including dark humour, can help ameliorate the challenges associated with one’s work. Mixed opinions existed regarding the effectiveness of more formalised support, with this appearing dependent upon whether professionals felt they could trust and were valued by supervisory staff. When professionals have access to a wider range of support systems, this can reduce the likelihood of compassion-fatigue being experienced and can promote satisfaction with one’s work.

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Tables

Table 1. Participant characteristics

Number of participants	Participant sex	Mean age (years)	Job role	Mean time in role (years)
8	5 females 3 males	45.2 (Range: 29-60)	3 Nurses 5 Support-workers	11.28 (Range:0.75-20)

Table 2. Themes

Sub themes	**Superordinate theme**
Offence exposure	Becoming Janus
Therapeutic relationship	
Impact of others	The pervasive influence
Impact on one’s personal life	

Appendices

Appendix 2-A: Author guidelines

The international, multi-disciplinary Journal of Learning Disabilities (JLD) publishes articles on practice, research, and theory related to learning disabilities (LD). Published bimonthly.

Types of Manuscripts

JLD encourages the submission of quantitative and qualitative manuscripts of different orientations (e.g., ethnographic, interpretative, narrative, voices). Several types of manuscripts are typically accepted by the journal. In all categories, tables and figures are included in the page limitations; therefore, authors are strongly encouraged to use them sparingly.

A **special series** is composed of several different articles on a given topic by various authors. It is conceptualized and coordinated by an author with extensive experience and expertise in a specific area. Individuals who wish to guest edit a special series should first contact the journal editorial office to ascertain interest in the topic.

Feature articles are selected based on the content's importance to the field of learning disabilities. They may be extensive literature reviews, theoretical papers, or nonempirical position papers. Length: 30 to 40 typewritten, double-spaced pages.

Research articles are data-based manuscripts that report original research. Studies may investigate characteristics of the population or intervention effectiveness. In regards to research study design, please refer to Parker's discussion of research validity in the December 1990 JLD issue. All research articles must provide a comprehensive description of study participants and procedures. Please refer to the Council for Learning Disabilities' minimum standards for the description of participants in LD research in JLD 26:4 (April 1993). For single-subject designs, authors are referred to Wolery and Ezell's discussion in JLD 26:10 (Dec. 1993). When small sample sizes are involved, authors should consult such references as Statistical Strategies for Small Sample Research (Hoyle, 1999). Length: 20– 30 typewritten, double-spaced pages.

Reports are nonempirical discussions of practices or issues in the field. Length: no more than 20 typewritten, double-spaced pages.

Intervention articles are overviews of successful physiological or psychoeducational interventions that can be replicated with other individuals with LD. Interventions can occur in school and community settings, clinics, hospitals, homes, or employment sites. Sample size is usually small. Length: 20–25 typewritten, double-spaced pages.

Forum articles are general discussions on various key issues in the field. They can be (a) reactions to articles that have been printed in the journal or (b) on any topic pertinent to LD. Length: 10–15 typewritten, double-spaced pages.

Letters to the editor that involve reaction to material appearing in JLD or to an issue in the field of LD are encouraged and are published as space permits. Length: no more than 3 double-spaced, typewritten pages. No tables, figures, or footnotes. Letters are subject to editing and condensation by the editorial staff.

Acceptance Criteria

Initial consideration of a manuscript will depend upon (a) the relevance and usefulness of the content to the readership; (b) how the manuscript compares to other articles dealing with similar content on pertinent variables (e.g., sample size, research design, review of literature); (c) clarity of writing style; and (d) the author's adherence to APA guidelines (see next section). The editor suggests that authors review the American Psychological Association Science Directorate Statement on the Disclosure of Test Data (www.apa.org/science/disclosu.html) and Electronic Reference Formats Recommended by the American Psycho- logical Association (www.apastyle.org/elecref.html).

Manuscript Preparation

Guidelines specified in the Publication Manual of the American Psychological Association (6th edition, 2010) should be followed. Pay particular attention to the sections concerning guidelines for non- sexist language, avoiding ethnic bias, and disabilities.

General

1. Authors must submit a SEPARATE TITLE PAGE FILE with (1) article title; (2) first name, middle initial, and last name of each author, with highest academic degrees; (3) names of institutions to which each author is affiliated, along with complete addresses AND e-mail addresses; and (4) any acknowledgments, financial disclosure information, author notes, and/or other text that could identify the authors to reviewers.

2. Format: 8½ × 11 in. paper; 1-in. margins; double spacing, left alignment, Times New Roman, 12-pt. type. Include title and abstract.

3. Heads: Do not use small capital letters.

4. Place figures in separate files. Tables may appear at end of main text file. Tables should be double-spaced; please use Word's table functions. All tables and figures must be cited in text.

5. Use tab key and centering functions for head alignment, paragraph indents, and so forth. DO NOT USE THE SPACE BAR.

6. Use endnotes sparingly. Number with Arabic numerals starting with 1 and continuing through the article. Example: (see Note 1). NO footnotes.

Artwork

Figures must be production-ready. Because most art will be reduced to fit, use bold type that is large enough to be reduced and still be readable, and make sure rules/tick marks are at least 1 pt. Acceptable electronic formats for art: TIFF, EPS, Word, or Excel. For scans/photos, download the SAGE Image Resolution Guidelines from the Instructions & Forms link at http://mc.manuscriptcentral.com/jld. If you have trouble when loading Excel files, copy and paste them into a Word document.

Permissions

Obtaining written permission for material such as figures, tables, art, and extensive quotes taken directly—or adapted in minor ways—from another source is the author's responsibility, as is payment of any fees the copyright holder may require. Permissions often take a considerable amount of time to be granted; start the request process early. Material taken from software or from the Internet also requires obtaining permission. Authors can download a Permissions Request form at https://mc.manuscriptcentral.com/jld (Instructions & Forms Link under Resources head). Read any per-missions carefully to make sure that the language is broad enough to allow publication in all formats, including electronic and print. Failure to obtain permission will result in either removal of the particular item or pulling the article from the journal issue.

Manuscript Submission

Submit electronically: https://mc.manuscriptcentral.com/jld Log in, or click the “Register Here” option in top right corner if you are a first-time user. Once logged in, click on Author Center. Have the following available before starting submission: manuscript files, including separate title page; all coauthors’ full names and e-mail addresses; # of figures, # of tables, # of manuscript pages. Click the “Submit a Manuscript” link and follow the submission steps. A guide is available on the main page under “Resources,” User Tutorials.

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Appendix 2-B: Topic guide

Study title: Nursing professionals' experience of working with sexual offenders who have a learning disability

Opening information

- Introduce self and re-cap aims of the research
- Advise participant approximately how long interview should take (i.e. up to 1 hour)
- Ask participant if they have any questions prior to beginning (check consent)
- Remind participant not to disclose personal information about clients and details of potential offences

Background information

The aim of these questions is to gain demographic information about the participants (i.e. job title, length of time in role). These questions aim to understand more about why participants may choose to work with sexual offenders who have a learning disability, as well as explore why people may choose to take a 'break' from this line of work if applicable. This may help to identify potential motivating factors for working with sexual offenders who have a learning disability, as well as factors that may reduce this.

- What is your role?
- How long have you worked with this client group?
- Why did you choose a career working with sexual offenders who have a learning disability?
- Have there been any points during your career working with sexual offenders when you left the role? If so, why was this?

Main interview questions

1. The impact of working with sexual offenders who have a learning disability

These questions aim to explore more generally the impact that working with this client group can have on mental health professionals. This will help to understand how participants make sense of their experiences of working with this client group and the impact this may have on their therapeutic work

Question: How has your work with sexual offenders impacted upon you?

- What aspects of the role led you to have those feelings?
- Has this impacted upon your ability to work therapeutically with sexual offenders who have a learning disability? If yes, how?
- How have you managed these feelings and what support was available for you?
- How do you make sense of your work with this client group?

2. Challenges

These questions aim to establish what the particular challenges participants experience in their work with this client group. These questions may be helpful in exploring what the difficulties are associated with working professionally with sexual offenders who have a learning disability and what coping strategies professionals use to negate against this.

Question: What aspects of working with sexual offenders who have a learning disability is the most challenging?

- Why do you think this is?
- How have you coped with these challenges?
- Do you think there is anything that may help you in the future if these challenges happened again?
- Are there any other challenges? If yes, what are these?

3. Benefits

This question aims to explore what the potential benefits of working with sexual offenders may be. This can provide important information as to what helps participants maintain in their role.

Question: What are the benefits of working with sexual offenders who have a learning disability?

- Have these benefits supported you to maintain in your role?
- If so, how/why?

- What do you value the most from your work with sexual offenders who have a learning disability? If yes, what is this?
- What aspects of your job do you most enjoy? Why?

4. Support

These questions aim to establish what coping strategies participants use in order to continue in their role, as well as what support they think is valuable in helping them achieve this.

Question: What type of support is available to you in relation to your work with sexual offenders with a learning disability?

- If this effective? Why?
- What coping strategies do you utilise?
- What do you think helps to prevent professionals experiencing negative affect from working with this client group?

Closing the interview

These questions aim to allow the participant to discuss anything that they feel is important in relation to this research that may not have been covered within the interview. This will hopefully reduce the likelihood of pertinent information being missed.

Final questions

Question: If there anything else you want to discuss that you think is important for this research to capture?

Question: Do you have any questions you would like to ask me about this research?

Advise participant what will happen next (i.e. transcribing, initial coding of transcript, summary of results) and remind participant they will have an opportunity to comment on findings if they so wish.

Thank interviewee for their time.

Appendix 2-C. Example of theme development

Participant	Step 1: Initial notations	Step 2: Developing emergent themes	Step 3: Connects across participants	Step 4: Higher order interpretation
Participant 1: **“It might have affected the way I look at the patient and sometimes thinking ‘Oh’, you know, you can sometimes feel quite disgusted looking at them but you need to get past that and work with them”**	Offence details can impact how one looks at the patient creating feeling of disgust. Appears to be a need to acknowledge this in order to manage it (prevents rupturing relationship?)	Disgust at patients Overcoming emotional reactions Impact of knowing offence details	**Offence Exposure** Emotional impact Offence exposure Offence Vs. Person Desensitisation Distancing from offences **Therapeutic relationship** Understanding patient history Knowing the patient first Importance of understanding the patient Balancing past and present Compassion through understanding Need to be risk aware Understanding history increases empathy Work with the person Person first	**Becoming Janus** “You just think ‘right’ and you put your head in the game”
Participant 2: **“It did for me with that client. That’s why, like I say, I started reading less and less. And I said I’ll just judge everybody on the day, exactly the same and I still try and maintain that now”**	A sense that offence details can make it hard to view patients with compassion. This participant made an active decision to not read offence details to prevent this happening again. Perhaps distancing oneself from the offence is beneficial to conducting their role?	Distancing to maintain in role Offences vs. relationships Impact of offences Offences vs. compassion		
Participant 3: **Cos I think if you based every patient based on**	Knowing offence histories can be challenging. There seems to be an emphasis on	Offence exposure Impact of offences Person first Distancing from		

their offences, it would be an incredibly difficult place to work so I think you just … you meet the patient, you build your relationship as if you knew nothing about them. Erm and I think that is probably the best way to go”	getting to know the person, even distancing oneself from their offences in order to do the job more easily. Suggestion that offence exposure is challenging	offences Offence impacts on relationships
Participant 4: **“I felt really sorry for her and it was awful, then I also had the other side of oh my god her offences are horrific and actually … it was like two totally opposing feelings for one person. It was awful”**	Conflicting emotions towards the same patient. A sense of “push and pull” on how one make sense of patients who have offended. Understanding patient history can create empathy, but this appears juxtaposed with the offences. A sense of this being very challenging for the professional	Conflicting emotions Understanding patient histories Empathy vs offences
Participant 5: **“Some people are – you question what have they had happen? Are people actually born paedophiles? I don’t know. But if it’s been generation after**	Knowing client history or own abuse histories can make it easier to understand offences and show empathy to them. Sense that people may question why people offend, indicating a need to make sense of patient	Empathy through understanding Seeing the patient as a whole Increased compassion through understanding Making sense of offences

generation then that makes sense. I almost feel sorry for them, because they didn't know any different and had they'd known, then that wouldn't have happened… possibly"	histories to overcome this	Patients as victims
Participant 6: **"Now I work with them and you forget what they've done. It's only when something will get mentioned in ward round, you know if they've been watching something or they were staring and you just think "oh gosh yeah". I just think you're just so used to them"**	A sense that professionals "get used to it" over time. This may indicate a sense of emotional-numbing or de-sensitisation to offences. Could also suggest that a focus on them now means that people forget about the offences?	Emotional numbing De-sensitisation to offences Distance from offences
Participant 7: **You know, it's like when you always work in like secure services, you like can't look at it as being like the offence first. Like you've got to look at the person first.**	Seems to be a suggestion that it is a requirement to focus on the person first in order to overcome the offences and do the job. Language used suggests this is an integral component of providing support to SOwLD. Doesn't say offence is	Person first Offence vs person Focus on the present Balancing past and present Work with the person

	forgotten, so could indicate a need to keep this at back of mind	
Participant 8: **“I er look at the person, I don’t look at what the crime was, okay? Erm obviously you are always aware of that – that never goes away, but I try and treat everyone as equal as I possibly can.”**	A need and perhaps desire to focus on the person in front of them, instead of their offences. This seems to be important in helping them maintain in the role. Offence history is not forgotten, so suggests this still lingers at back of mind. Perhaps an indication that to provide equal care, offence focus needs to be reduced	Offence vs. Person Offence awareness Person centred Equality in relationships Distance from offences Work with the person

Chapter 3: Critical Appraisal

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Word count: 3899 (excluding references)

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Abstract

In this critical appraisal, I outline the rationale for the terminology used and discuss the impact of using labelling language within research and healthcare services. The appraisal specifically explores the use of the terms “patient” and “sex offender”.

Critical appraisal introduction

Throughout the research process, I became increasingly aware of the prevalence of labelling language within the literature and within my own writings. This led me to explore whether the language I had chosen to use was appropriate, yet the inconsistent terminology used and the prevalence of labels within the wider literature did not make this any clearer. I decided it was important to reflect upon my language used within this critical appraisal to further explore the contentious issue of labelling within research and healthcare.

I consider myself to be very person-focused within my clinical work and would shy away from using labelling language; particularly when I was not aware of the preferences of the individual I was working with. Whilst writing this thesis, I found it challenging to achieve a non-labelling language when referring to individuals in receipt of forensic support for sexual offending behaviours. This was complicated by the specific populations I was referring to (e.g. “child sex offenders”, “sex offenders with learning disabilities”), particularly in maintaining specificity of the population being discussed and clarity in my writing. To manage this, I opted to use the most commonly used language represented in the literature. Although the labelling language is used throughout this thesis, I felt it important to reflect upon the impact of using such language within research and healthcare.

Finding the right terminology

The use of labels is argued to be commonplace within everyday language, enabling people to convey meaning and information without the use of superfluous words (Willis, 2018). Using labels in communication can help to identify and differentiate individuals based on the presence of key characteristics (MacMillan, 2016). This can include, but is not limited to, family roles, sexuality, gender, and occupation. When labels are deemed positive by the individual assigned them, it can have a positive impact on that individual's self-identity and sense of self (Gottfried, Estrada & Sublett, 2015). Not all labels are considered positive, however, and they are not always congruent to how individuals view themselves or how they wish to be perceived by others.

Research has suggested that certain labels can increase the risk of individuals experiencing stigma, discrimination and in some case, social exclusion (Bernburg, 2019; Kintzinger, 2008; Link & Phelan, 2001; Schultz, 2014). This has particular relevance for this thesis project given that criminal and mental-health labels are used (e.g. "patient", "sex offender", "child sex offender"). These labels are considered to be associated with increased risk of individuals experiencing stigma (Corker et al., 2016; Edwards & Mottarella, 2014), and so it is important that the rationale behind and impact of including these labels are explored. For ease of review, each label will be discussed separately.

Using the patient label

A variety of terms have been used to describe those who receive mental health services, including patient, client, service user, consumer and survivor (Fischer, Johnson-Kwochka, Firmin, Sheehan, Corrigan & Saylyers, 2020; Simmons, Hawley, Gale & Sivakumaran, 2010). This has led to inconsistent terminology being used within the literature base to describe the same or similar populations, thus making it difficult to assess which is the most appropriate term to adopt. This has been further complicated by different terminology being used by practice guidelines, including those provided by the British Psychological Society (BPS; 2017). This document makes reference to “service user” and “patient” throughout, suggesting these terms are somewhat interchangeable. Given this lack of clarity, it is unsurprising researchers have continued to debate what the most acceptable terminology is to describe those seeking health services (Christmas & Sweeney, 2016; Seeman, 2014; Wing 1997). Whilst it would be preferable to seek the preference of the individual the label is referring to; this was not possible within this project given the focus being on professionals. A decision was made to adopt the language used by this professional group, which was “patient”, to respect their chosen terminology.

Using the term “patient” has been criticised as it assumes a lack of individual autonomy and agency in the care or support that person receives (Shevell, 2009; Speed, 2006). Given that “patient” is suggested to infer a “done to” relationship between the individual and the professional (Neuberger & Tallis, 1999), it could inadvertently indicate a lack of collaborative care being offered. This reduced sense of collaboration between the individual and professionals is contradictory to the emphasis placed on the need for person-centred care (World Health Organisation, 2016), particularly as collaboration is deemed a key component in providing effective support (Brabban, Byrne, Longden & Morrison, 2017; Moise et al., 2018). The association between the term “patient” and potential passivity of that individual is longstanding within the literature (Neuberger & Tallis, 1999; Shevell, 2009; Speed,, 2006; Veatch, 1985; Wing, 1997). Despite the continued criticisms, the term “patient” persists as being cited as the most preferable term by individuals accessing healthcare services (Costa, Mercieca-Bebber, Tesson, Seidler & Lopez, 2019; Dickens & Picchioni, 2012; Ritchie, Hayes & Ames, 2000; Simmons, Hawley, Gale & Sivakumaran, 2010). This suggests that whilst this term can be problematic for some groups, such as researchers or professionals, it is deemed an appropriate and accepted term by those who are considered “patients”.

Reasons why individuals prefer the term “patient” are varied and may depend upon the individual preference of that person. It is suggested however, that the preference for “patient” may be attributed to the familiarity of this label (Christmas & Sweeney, 2016). This is consistent with research suggesting individuals tend to express a preference for language that is used within the service they are accessing (Heffernan, 2006; Thalitaya, Prasher, Khan & Boer, 2011), potentially suggesting this preference is attributed to a “better the devil you know” mentality. It may also suggest that individuals do not particularly care about what they are referred to, especially as it is unlikely they are directly referred to a “patient”, “client” or “service user” within their own correspondence and interactions with the service. Whilst not caring what term is used was reported by some participants in research by Simmons et al (2010), overall findings from this study demonstrated a preference for “patient”. This appeared, at least in part, to the negative associations participants had with other labels offered (Simmons et al., 2010). For example, the term “service user” has been deemed too similar to “user”, leading individuals to associate this with someone being addicted to drugs or someone taking advantage of others (Heffernan, 2006). The term “client” was associated with prostitution by some (Ratnapalan, 2009; Simmons et al., 2010) and was considered to signify a business relationship by others (Dickens, Lange, Picchioni, 2011).

Previous research has, however, suggested that using alternative labels, such as “client”, “service user” or consumer” can be more empowering to the individual accessing healthcare services than “patient” (Seeman, 2014). These alternative labels are suggested to represent increased perceptions of autonomy in the individual, evoking a sense of equality regarding healthcare decisions between the individual and the professional (Neuberger & Tallis, 1999). For some “clients” were associated with having a choice, whereas “patients” were not (Ratnapalan, 2009). Whilst using “clients” was deemed beneficial across healthcare services (McDonald, 2006; Seeman, 2014), this suggestion of equality in decision making is not always representative of the experience of those accessing certain healthcare services. This is particularly true of those receiving input from secure or forensic services, in which their engagement in services may not have been voluntary. For these individuals they may not have chosen to seek support, and in some cases may not believe they require support, and so suggesting they have power or control over their care experiences is not necessarily accurate. This could, therefore, suggest terms such as “clients” or “consumers” are not appropriate in such circumstances. This is especially so given that such labels are suggested to be important in reducing the power imbalance between the individual and service provider (Lloyd, King, Bassett, Sandland & Savige, 2001), yet being expected to engage in support that one does not want or initiate can be disempowering for the individual (Hart, 2004; Hughes, Hayward & Finlay, 2009). Using “client” when referring to those who are court-mandated to engage in services could be contradictory to what the term “client” was initially attempting to achieve (e.g. increased autonomy and equality between individuals and the professionals they seek support from). Similar criticisms of using the term "service user" have been shared in previous research, suggesting it did not accurately represent the lack of choice some individuals had in their involvement with forensic services (Dickens et al., 2011). This is relevant to the empirical study within this thesis; given the context is a forensic learning disability service. This may account for why professionals included in that study often referred to "patients" rather than using alternative labels.

The UK Royal College of Psychiatrists have attempted to establish some consistency in the terminology used for those accessing healthcare services, collectively agreeing to the use of the term "patient" (Christmas & Sweeney, 2016). This decision was attributed to attempts at creating a parity of esteem between physical and mental health services (Health and Social Act, 2012), with the term "patient" being commonly used within physical health settings. It was argued that using the same label for those accessing physical health and mental health services was an important step in reducing the stigma associated with mental health difficulties (Christmas & Sweeney, 2016). Although using alternative terms to "patient" are suggested to contribute to attempts to reduce this stigma, by attempting to empower the individual with this alternative term, it has been suggested that the very presence of these alternative labels may inadvertently maintain stigmatising perceptions of those accessing mental health support (Fischer et al., 2020). Reasons for this were attributed to the rarity of these labels being used within physical health settings, and so become specifically associated with mental health difficulties or forensic needs (Fischer et al., 2020). This may, at least in part, explain why those accessing inpatient services were more likely to express a preference for "patients" compared to other labels offered (Covell, McCorkle, Weissman, Summerfelt & Essock, 2007; Thalitaya, Prasher, Khan & Boer, 2011). Maintaining the same terminology used across all healthcare services may, therefore, promote perceptions that accessing mental health support is just as acceptable and necessary as those accessing physical health services. Despite this, inconsistent terminology is still used within different professional guidance including those published by the BPS, with the term “client” being used more frequently than any other label even when referring to persons with forensic needs (BPS, 2017).

Conclusion

In conclusion, there is ongoing disagreement regarding what the most appropriate terminology is to refer to those accessing healthcare services. It is acknowledged that whatever label is used can create different perceptions or expectations of that individual, and so it is important that researchers and professionals alike continue to reflect on the impact of the language they use. The term “patient” appears to be the most preferred term of individuals who are accessing healthcare services, including those within mental health and forensic services. This therefore suggests there is no need to remove the word “patient” when referred to those accessing both mental and physical health services. The label used should not, however, dictate the quality of care provided to that individual. Regardless of whether “patient”, “client”, “service user” or other labels are used, all individuals accessing mental-health services should be given the same opportunities to be involved in decisions regarding their care and support. When this is not possible, it is important any decisions made are done so with the best interests of that individual in mind to ensure the same high-quality and compassion care is provided regardless of what that individual may be labelled as. This will involve the service provider and professional being mindful of the preferred language of those they are providing care for.

The sex offender label

The decision was made to use the label of “sex offender” when referring to those who have displayed sexual offending behaviours within this thesis project. Reasons for this were attributed to this label being commonly used by many of the research papers contributing to the literature review and empirical study that forms this thesis. To ensure the terminology used remained consistent, it was deemed appropriate to adopt this label. For the purpose of the literature review, the more specific label of “child sex offender” was used. This was to ensure the review remained focused upon those who had offended against children, given that these individuals were the specific focus of this review. It is acknowledged, however, that the continued use of the label of “sex offender”, including “child sex offender”, within research has been criticised (Willis, 2018). This critical appraisal aims to acknowledge these criticisms and explore the impact on continuing to use “sex offender” within research and services.

Labelling in intervention programmes

The label of sex offender is prevalent within the current research base, as well as within services designed to offer interventions and support to those who have displayed sexual offending behaviours (Carich & Musack, 2015; Sawyer & Jennings, 2016; Willis, 2018). Some intervention programmes designed to reduce risk of sexual reoffending often adopt the label of sex offender in their title, leading to the acronym of SOTP (Sex Offender Treatment Programme) being widely understood and accepted by services working with this population. Whilst this demonstrates the normalisation of such labels within associated services, it is argued that clearly identifying intervention programmes as being for sexual offending behaviours may be counterintuitive to what these programmes are aiming to achieve (e.g. to reduce reoffending) (Willis, 2018). Involvement in an intervention programme that clearly identifies them as having committed sexual offences may reduce an individual’s desire to meaningful engage in such programmes, potentially due to a fear of being “found out”. A person’s readiness and safety to engage in treatment is considered important to promoting the likelihood of meaningful engagement (McMurran & Ward, 2010), which in this context could correlate with a continued risk of reoffending. This potential fear of being identified as a sex offender may be exacerbated in individuals accessing support within prison populations, where sexual offenders are suggested to be at an increased risk of violent assaults if their offences are known (Schwaebe, 2005; Spencer, 2009). The need to feel safe is often cited as a fundamental aspect to engaging in psychological intervention (Walji, Simpson & Weatherhead, 2014), enabling individuals an opportunity to explore factors that may have contributed to their offending (Blagden, Winder & Hames, 2016). Given the impact of being easily identified for one’s crimes due to the labelling in intervention programmes brings into question the utility of continuing to refer to individuals as sex offenders within treatment settings. This has led to the criticisms that continuing to define a person by the very behaviour they are attempting to change is counterproductive (Willis, 2018).

The stereotype of sex offenders

There are existing beliefs that sex offenders are deserving of the label given to them, particularly considering the longstanding impact that sexual abuse can have on victims (Merrick, Ports, Ford, Afifi, Gerhoff & Gorgan-Kaylor, 2017; Sumner et al., 2016), so the indefinite nature of this label can appear justified (Mingus & Burchfield, 2012). This may be reinforced by the perception that sex offenders are challenging, if not impossible, to rehabilitate successfully and are considered to be at a high-risk of reoffending (Katz-Schiavonne, Levenson & Ackerman, 2008; King & Roberts, 2017; Levenson, Brannon, Fortney & Baker, 2007). Despite this, recidivism rates for sexual offences are considered to be low, particularly when compared to other offending behaviours (Ducat, Thomas & Blood, 2009; Lonsway & Archambault, 2012; Mancini, 2013). The inconsistency in what is perceived and what is reported has been attributed to the media often providing sensationalised news stories related to sexual crimes, reinforcing stereotypical perceptions of sexual offenders and their suggested risk to wider society (Katz-Schiavone, Levenson & Ackerman, 2008; Quinn, Forsyth & Mullen-Quinn, 2004; Sample & Kadleck, 2008). This can lead sex offenders to be viewed as a homogenous group (Sample & Bray, 2006), despite the nature and context of their crimes having the potential to vary hugely. It is noted that this is not to suggest that certain sexual offending behaviours are deemed more acceptable that others, but rather to demonstrate how this can lead to stereotypical beliefs about recidivism risk and possibility for rehabilitation. This is particularly so given that the media tend to focus upon high-profile but rare cases (Corabian & Hogan, 2012; Ducat, Thomas & Blood, 2009), leading this to become the perceived norm of sex offenders by members of the public (Lowe & Willis, 2019). The stigmatising and stereotypical perceptions of those labelled as sex offenders can act as a barrier for society accepting that there is a potential for such individuals to change and lead pro-social lives (Maruna & LeBel, 2010).

The nature of sexual crimes means it can be challenging to see any positives in those who have committed such offences (Marshall & Marshall, 2017). This is consistent with Cognitive Dissonance theory (Festinger, 1957) in which it is uncomfortable for an individual to hold two conflicting ideas (e.g. a person convicted of sexual offences has positive qualities), thus leading to the alteration of one of those ideas to reduce discomfort (e.g. sexual offenders cannot be good in any way). Reluctance to see the potential for positive change in sex offenders can reinforce this stigmatising label, leading individuals to be continued to be judged by past behaviours regardless of any progress or positive contributions made to society. This suggests a person's ability to desist from offending is prevented by continuously being reminded of their past offences (Lowe & Willis, 2019), resulting in people convicted of sexual crimes being punished indefinitely for them (Mingus & Burchfield, 2012).

Whilst it is understandable to want to hold people accountable for their crimes, continuing to label someone by their past behaviour can create its own difficulties in regard to predicting ongoing risk. If an individual is consistently labelled and judged for past behaviours it can have a negative impact on their self-concept, potentially leading them to begin viewing themselves based on the attitudes or beliefs of others (Matsueda, 1992). For some this may not appear to be a problem in the context of sex offenders, particularly as some theories of deterrence suggest individuals need to feel shame to prevent them reoffending (Benson, Alarid, Burton & Cullen, 2011). Alternative research has, however, suggested that the label given to an individual can reinforce behaviours congruent to that label (Burger & Caldwell, 2003; Paternoster & Bushway, 2009). In this case it suggests continuing to refer to people as sex offenders can reinforce sexual offending behaviours. This is supported by Labelling theory (Becker, 1973) and the self-fulfilling prophecy theory (Merton, 1948); both of which suggest individuals are at risk of adopting behaviours that then confirms the legitimacy of the label given to them initially (Link & Phelan, 2013).

Whilst labelling theory has been criticised for not being a complete theory (Braithwaite, 1989), it was suggested to still provide important insight into how deviant behaviour is perpetuated as one part of a wider picture (Becker, 1973; Applebly, 2010). The suggestion that deviant labels may maintain deviant behaviours could, at least in part, be associated with the notion of learned helplessness (Seligman, 1973; 1975). For example, if individuals are continued to be seen and labelled as sex offenders, even if they desist from offending, it may lead them to feel unable to make positive changes. In some cases, this may lead individuals to think “what’s the point?”, reducing a desire to develop a more pro-social life if this will not change how they are perceived or treated by others. Adopting person-first language has been suggested to provide more neutral perceptions of individuals’ convictions of sexual crimes (Lowe & Willis, 2019), allowing people to move-past the restrictions that the label of sex offender may put on them. It is important to note that using alternative to the term sex offender is not to minimise or disregard their offences, but rather can act as an important acknowledgement of a person’s potential to change (Lowe & Willis, 2019).

Alternative labels

The continued use of the sex offender label can act as a barrier for individuals convicted of sexual crimes to reintegrate into the community safely and successfully (Lowe & Willis, 2019). This is demonstrated by research suggesting that individuals need stable housing, support and employment opportunities to reduce risk of reoffending (Göbbels, Ward & Willis, 2012), yet people do not want sex offenders in their community, workplace or properties (Burchfield & Mingus, 2008; Clark, 2007; Levenson et al., 2007). It is argued that using more neutral language, such as person who sexually offended or persons who committed crimes of a sexual nature, may encourage others to think of the person first, rather than seeing them as just another stereotypical offender (Lowe & Willis, 2019). Although studies comparing this neutral language with labelling language (e.g. sex offender) are minimal, studies that do exist suggested more punitive attitudes were present in cases were labelling language was used (Harris & Socia, 2016; Imhoff, 2015; Lowe & Willis, 2019). Although effect sizes for these studies were considered to be relatively small, it does provide important insight into how public attitudes and beliefs can be influenced by changing the labels used.

Conclusion

Using the term sex offender in research and within forensic services appears widely accepted, despite ongoing criticisms of the impact of this stigmatising label. Whilst an argument exists to use the label of sex offender to hold people accountable for the crimes, the indefinite nature of the label can inadvertently contribute to a risk of reoffending in this population. This is due to the sex offenders being viewed as pariahs to society, meaning this label can often act as a barrier to providing them with important opportunities deemed necessary to reduce reoffending. Moreover the sex offender label can lead individuals to behave in ways congruent to that label, such as sexual offending, meaning its inclusion in research and services may be inadvertently reinforcing the very stigma and risk that they are trying to reduce. Alternative labels, such as person-first language, have been recommended, although studies exploring the impact of such labels on public attitudes are still in their infancy. Further research exploring the impact of such labels would be beneficial as such labels enables the identification of potentially dangerous individuals yet may reduce barriers needed for those who have desisted from offending.

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Chapter 4: Ethics Section

Ethics Application for Research Paper:

Nursing professionals' experiences of working with sexual offenders with learning disabilities

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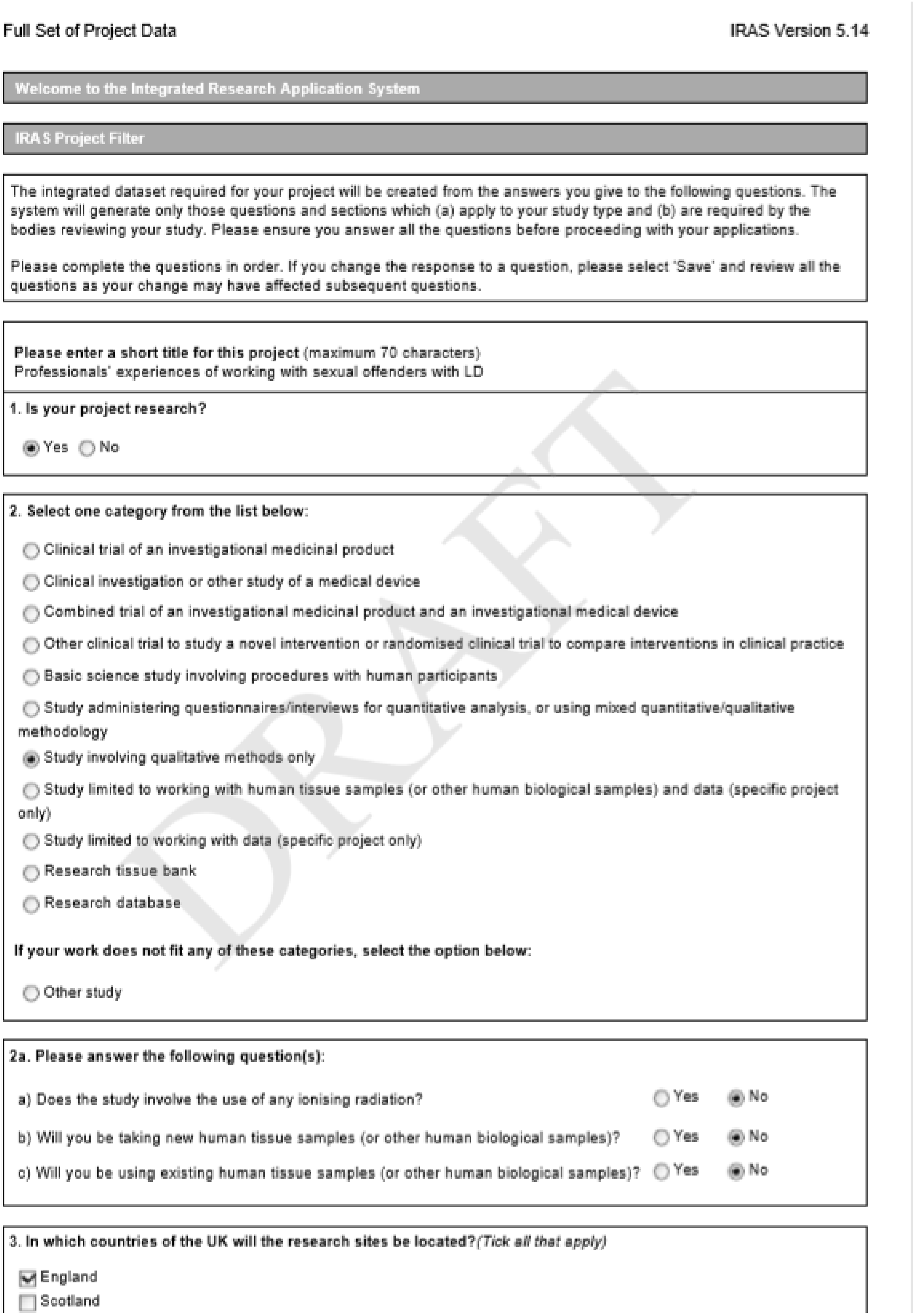
IRAS Application Form



Full Set of Project Data IRAS Version 5.14

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Professionals' experiences of working with sexual offenders with LD

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
● Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

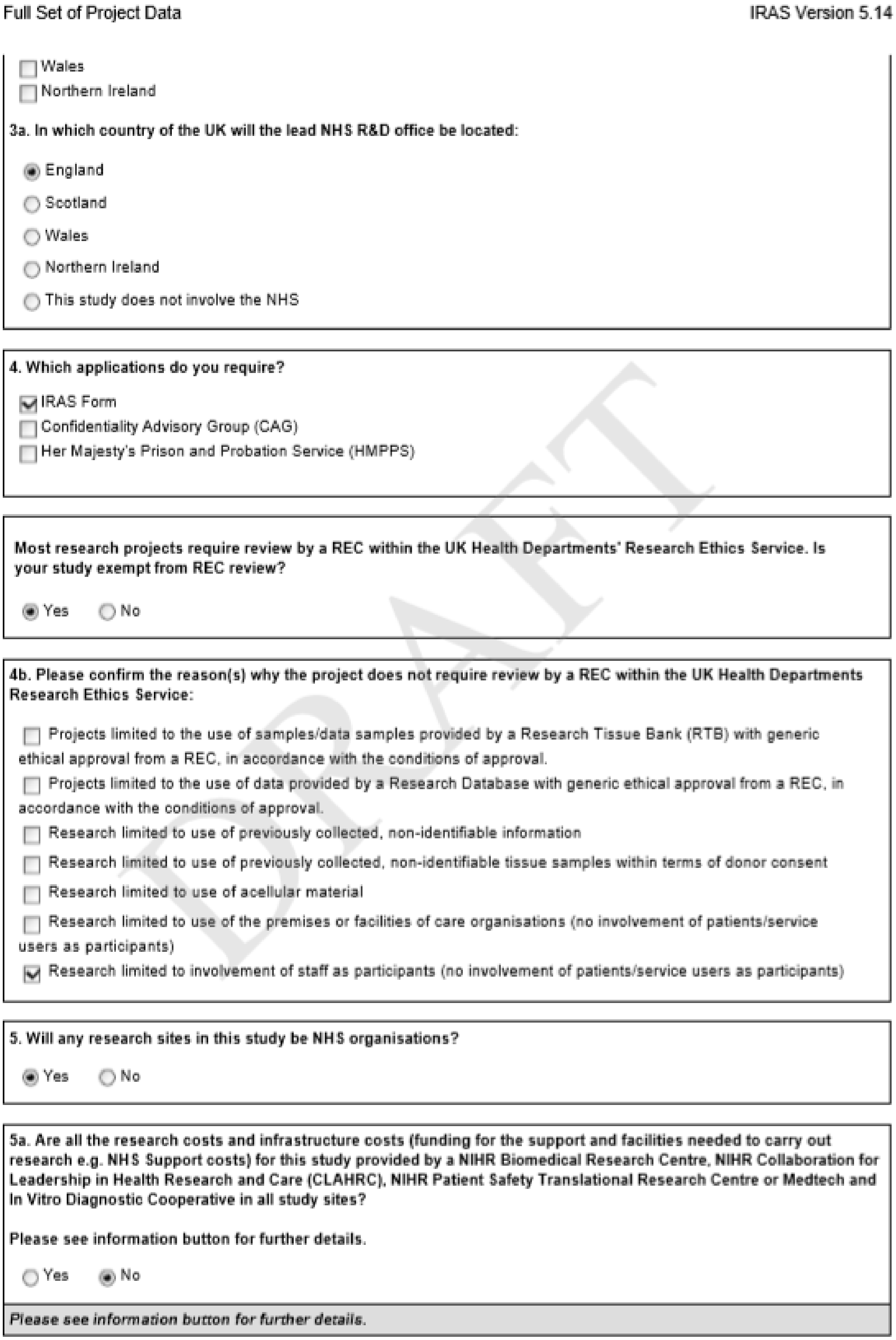
○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland



☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

● Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

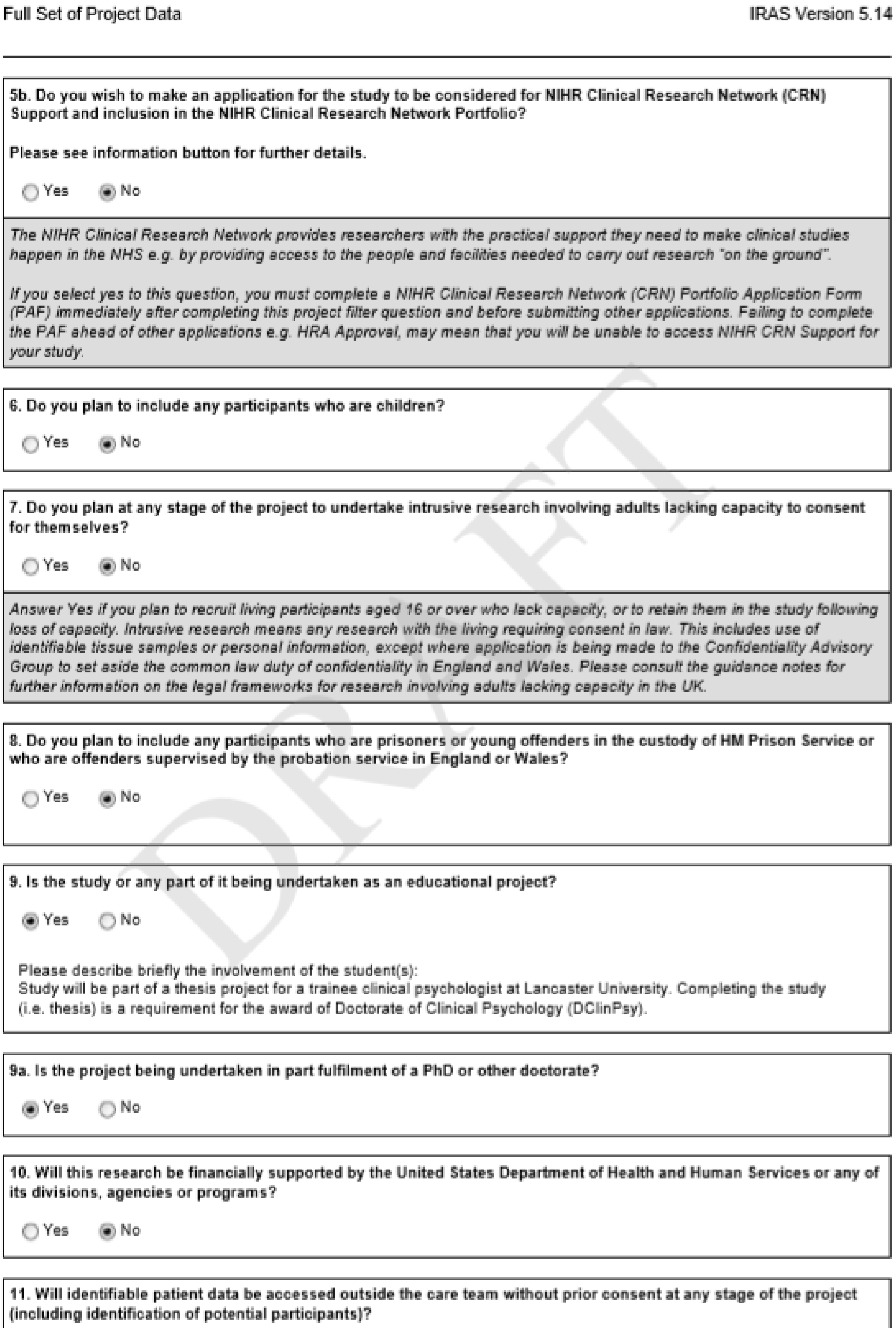
● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or Medtech and In Vitro Diagnostic Cooperative in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.



Full Set of Project Data IRAS Version 5.14

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Study will be part of a thesis project for a trainee clinical psychologist at Lancaster University. Completing the study (i.e. thesis) is a requirement for the award of Doctorate of Clinical Psychology (DClinPsy).

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

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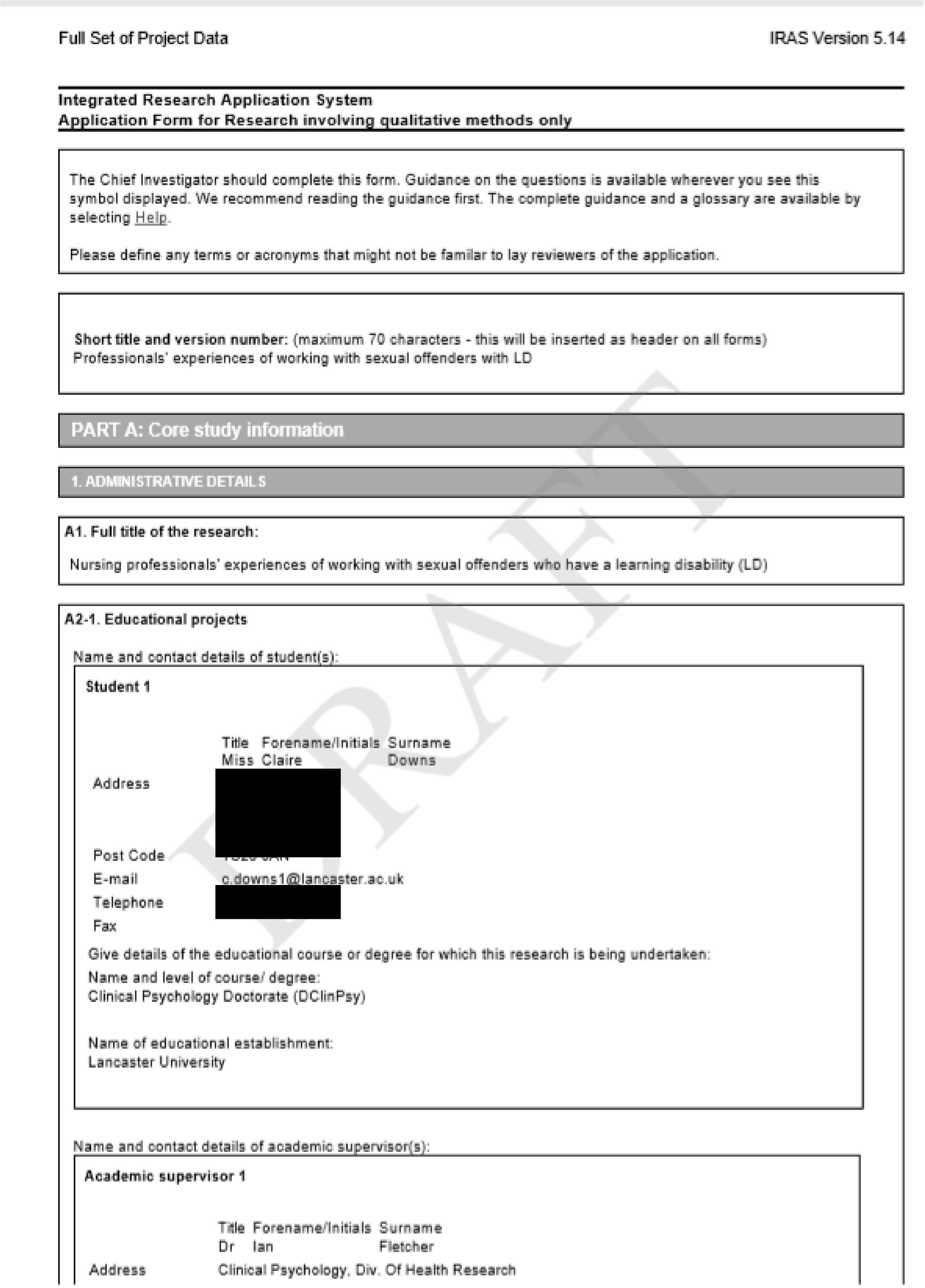
○ Yes ● No



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Integrated Research Application System
Application Form for Research involving qualitative methods only

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Professionals' experiences of working with sexual offenders with LD

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Claire	Downs

Address [redacted]

Post Code

E-mail c.downs1@lancaster.ac.uk

Telephone [redacted]

Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Clinical Psychology Doctorate (DClinPsy)

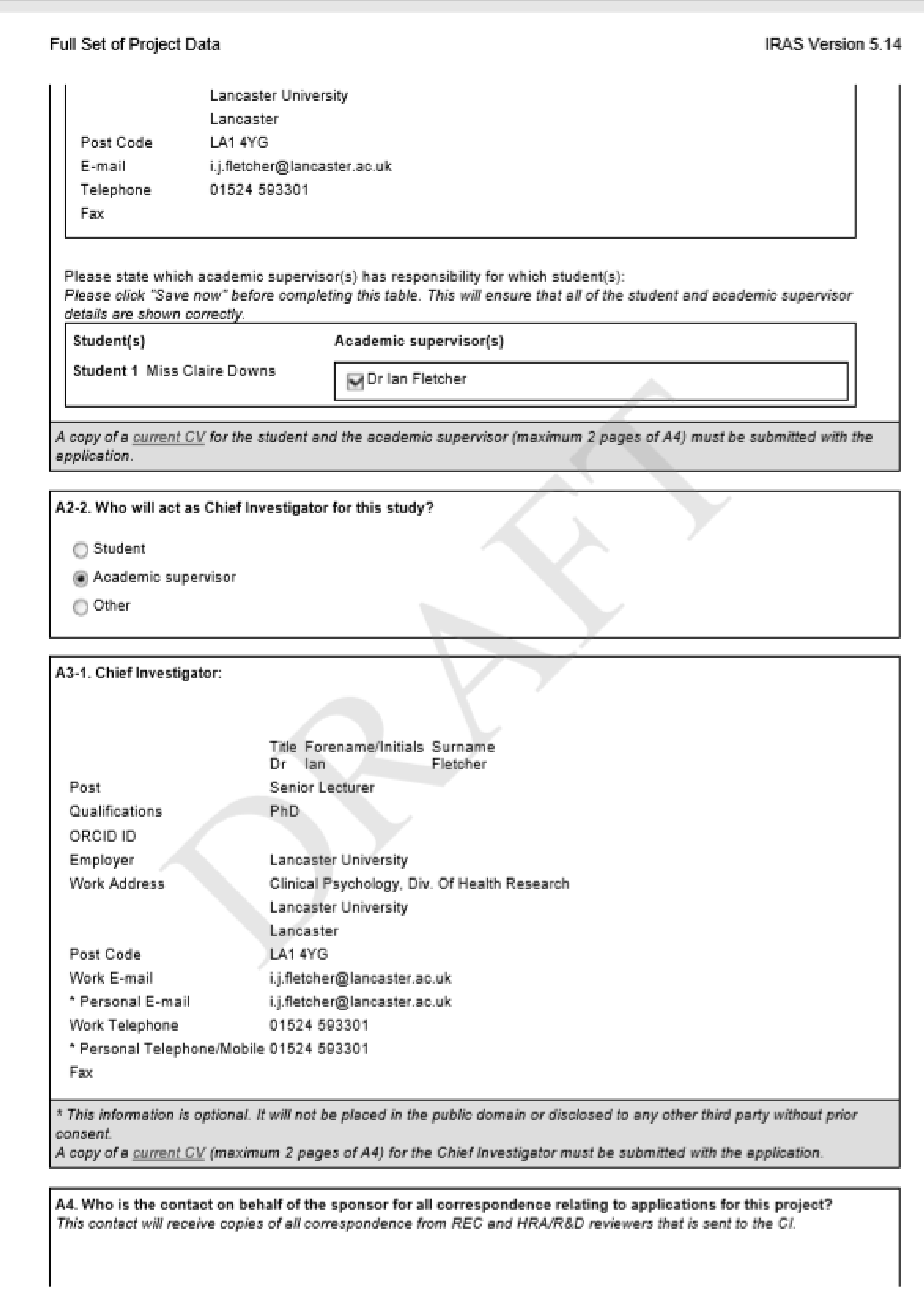
Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher

Address Clinical Psychology, Div. Of Health Research



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Lancaster University
Lancaster
Post Code LA1 4YG
E-mail i.j.fletcher@lancaster.ac.uk
Telephone 01524 593301
Fax

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Claire Downs	☑ Dr Ian Fletcher

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

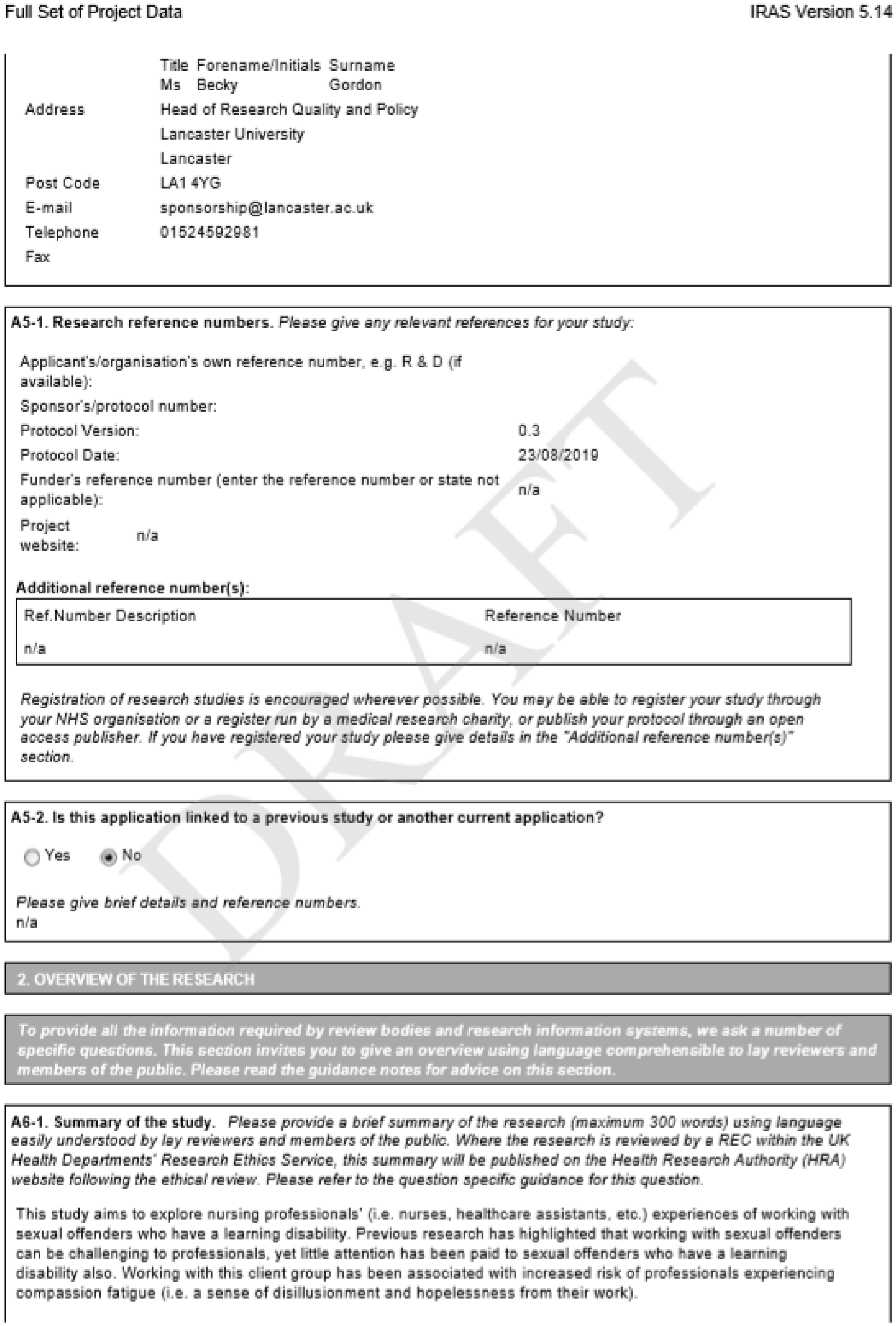
○ Student
● Academic supervisor
○ Other

A3-1. Chief Investigator:

Title Forename/Initials Surname
Dr Ian Fletcher
Post Senior Lecturer
Qualifications PhD
ORCID ID
Employer Lancaster University
Work Address Clinical Psychology, Div. Of Health Research
Lancaster University
Lancaster
Post Code LA1 4YG
Work E-mail i.j.fletcher@lancaster.ac.uk
* Personal E-mail i.j.fletcher@lancaster.ac.uk
Work Telephone 01524 593301
* Personal Telephone/Mobile 01524 593301
Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.



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Title	Forename/Initials	Surname
Ms	Becky	Gordon

Address	Head of Research Quality and Policy Lancaster University Lancaster
Post Code	LA1 4YG
E-mail	sponsorship@lancaster.ac.uk
Telephone	01524592981
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	
Sponsor's/protocol number:	
Protocol Version:	0.3
Protocol Date:	23/08/2019
Funder's reference number (enter the reference number or state not applicable):	n/a
Project website:	n/a

Additional reference number(s):

Ref.Number Description	Reference Number
n/a	n/a

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.
n/a

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This study aims to explore nursing professionals' (i.e. nurses, healthcare assistants, etc.) experiences of working with sexual offenders who have a learning disability. Previous research has highlighted that working with sexual offenders can be challenging to professionals, yet little attention has been paid to sexual offenders who have a learning disability also. Working with this client group has been associated with increased risk of professionals experiencing compassion fatigue (i.e. a sense of disillusionment and hopelessness from their work).

Focusing on nursing professionals is deemed important, as current literature has often focused upon the roles of psychologists and psychotherapists who are involved in offering interventions. Little attention has been paid to nursing, who often have the most direct contact with their patients, and of whom are less likely to receive supervision of training specifically designed to support them with working with this client group. As nursing shortages continues, particularly in relation to mental health and learning disability services, more needs to be done to understand how best support this professional group in order to reduce the risk of compassion fatigue being experienced and to ensure a high quality of care is maintained. This is deemed integral to reducing future risk of re-offending in sexual offenders with a learning disability. This research aims to identify what the emotional experiences of working with sexual offenders with a learning disability are, and explore how professionals may cope with the challenges associated with their work. It will also be beneficial to explore the positive aspects professionals perceive from their roles, as this may be important to identify what may reduce the likelihood of compassion fatigue occurring in this population. The study aims to interview up to 12 professionals to identify what the common experiences of this professional group are.

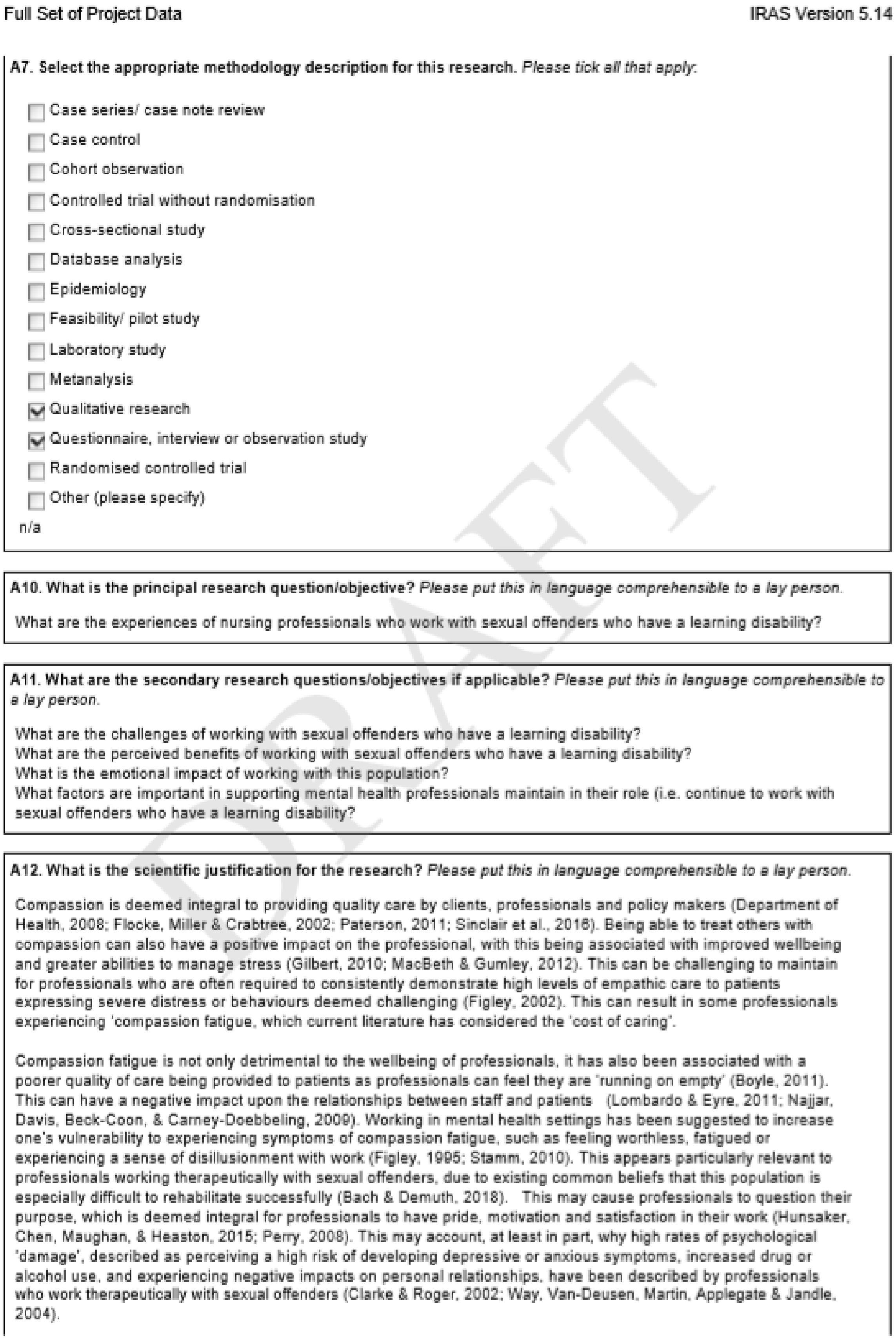
A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

- In an effort to maintain confidentiality, participants will have the opportunity to confirm willingness to participate anonymously through being asked to express their interest via an email directed to Claire Downs (doctoral student conducting the research). Claire will be responsible for confirming participation and coordinating with participants around logistics of interviews.
- Participants will be made aware that their involvement in the study will not be shared with anyone, including the research team
- The research team (Dr Rayner-Smith and Dr Fletcher) will only have access to anonymised transcripts of interviews. Audio data of interviews will not be shared with the overall research team
- As Dr Rayner-Smith (field supervisor) is employed in the same trust as one of the intended recruitment sites, there may be a small possibility that Dr Rayner-Smith could identify anonymised transcripts based upon their stories and experiences shared. In order to reduce this possibility, participants from this site will be asked whether they would prefer for their transcripts to only be shared with the research supervisor who has no links to the recruitment site.
- Quotes used in the writing up of the findings from the research will be anonymised.
- Any discussion regarding the data obtained from this research will only be facilitated once the data has been anonymised. The only exception to this will be if a participant causes the main researcher concern regarding their own or another's safety, in which case this may have to be discussed with supervisory team
- If participants disclose any information that raises concerns about their own or others' safety, then this will be shared with the research team in order to decide whether it will be necessary to break confidentiality and whether this requires sharing of the participant name to others. If it is agreed that concerns needs to be shared with others outside of the research team, then the principal investigator will share this with the participant's supervisor. Participants will be made aware of this limitation to confidentiality prior to starting the interview process. This will also be made explicit on the consent form and information sheet that they will be provided with.
-If any issues arise relating to the practice of Dr Rayner-Smith then this will be shared with their clinical supervisor within the Trust and with the research supervisor. Dr Rayner-Smith will not be informed of who raised any potential concerns, to maintain participant anonymity. Discussions with the academic supervisor (Dr Fletcher) as to whether it is necessary to name the individual raising the concerns to others (e.g. to Dr Rayner-Smith's supervisor). No discussion between the primary research and Dr Rayner-Smith will be facilitated regarding concerns raised about their practice if this does occur, to minimise the likelihood of Dr Rayner-Smith being able to identify the participant raising concerns.

If participants become distressed during the interview process, appropriate steps will be taken to manage this. Participants will be given the opportunity to have a break from the interview if they wish. It is possible that participants may not feel comfortable in continuing with the interview further, and so this would be respected and the interview terminated. Given that participants are recruited from NHS settings, they will be provided with information about Trust well-being services and other organisations that may be supportive for them. This will also be detailed on participant information sheets that they will be provided with.

3. PURPOSE AND DESIGN OF THE RESEARCH



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A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

n/a

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What are the experiences of nursing professionals who work with sexual offenders who have a learning disability?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

What are the challenges of working with sexual offenders who have a learning disability?
What are the perceived benefits of working with sexual offenders who have a learning disability?
What is the emotional impact of working with this population?
What factors are important in supporting mental health professionals maintain in their role (i.e. continue to work with sexual offenders who have a learning disability?

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Compassion is deemed integral to providing quality care by clients, professionals and policy makers (Department of Health, 2008; Flocke, Miller & Crabtree, 2002; Paterson, 2011; Sinclair et al., 2016). Being able to treat others with compassion can also have a positive impact on the professional, with this being associated with improved wellbeing and greater abilities to manage stress (Gilbert, 2010; MacBeth & Gumley, 2012). This can be challenging to maintain for professionals who are often required to consistently demonstrate high levels of empathic care to patients expressing severe distress or behaviours deemed challenging (Figley, 2002). This can result in some professionals experiencing 'compassion fatigue, which current literature has considered the 'cost of caring'.

Compassion fatigue is not only detrimental to the wellbeing of professionals, it has also been associated with a poorer quality of care being provided to patients as professionals can feel they are 'running on empty' (Boyle, 2011). This can have a negative impact upon the relationships between staff and patients (Lombardo & Eyre, 2011; Najjar, Davis, Beck-Coon, & Carney-Doebbeling, 2009). Working in mental health settings has been suggested to increase one's vulnerability to experiencing symptoms of compassion fatigue, such as feeling worthless, fatigued or experiencing a sense of disillusionment with work (Figley, 1995; Stamm, 2010). This appears particularly relevant to professionals working therapeutically with sexual offenders, due to existing common beliefs that this population is especially difficult to rehabilitate successfully (Bach & Demuth, 2018). This may cause professionals to question their purpose, which is deemed integral for professionals to have pride, motivation and satisfaction in their work (Hunsaker, Chen, Maughan, & Heaston, 2015; Perry, 2008). This may account, at least in part, why high rates of psychological 'damage', described as perceiving a high risk of developing depressive or anxious symptoms, increased drug or alcohol use, and experiencing negative impacts on personal relationships, have been described by professionals who work therapeutically with sexual offenders (Clarke & Roger, 2002; Way, Van-Deusen, Martin, Applegate & Jandle, 2004).

Working with certain populations, such as those with a learning disability, has also been associated with increased stress within professionals and compassion fatigue (Innstrand, Espnes, & Mykletum, 2002). As such, sexual offenders who also have a learning disability are considered to be of a particular challenge to both professionals and to services (Clare & Murphy, 1998). Reasons for this have been attributed to the need to adapt mainstream programmes to suit the specific needs of this client group (Harkins & Beech 2007), as well perceptions that those with an intellectual disability are in less control over their sexual offending behaviours than others (MacKinlay & Langdon, 2009).Although research has demonstrated that those work to support sexual offenders with a learning disability, such as mental health professionals, are more likely to have more positive or optimistic views of this population than other professions (Day, Boni, Hobbs, Carson, Whitting, & Powell, 2014), there is little information available on how this is achieved or maintained. It has been suggested that most emerging research focused upon this client group has focused upon experiences of the victim or the perpetuator, with less attention being paid to the role of the 'helper' (Bach & Demuth, 2018) and what the positive impact of working with sexual offenders may be.

Existing research has been criticised for lack of research exploring the specific experience of professionals working with sexual offenders with a learning disability therapeutically (Sandhu, Rose, Rostill-Brookes & Thrift, 2012), suggesting a gap in the literature presently. Moreover, the vast majority of this research has focused upon the experiences of psychologists or psychotherapists who deliver treatment programmes, with little attention being paid to 'frontline staff', such as nurses or healthcare assistants. This is particularly pertinent as this professional group are often the ones who spend the most time with clients, with these relationships and interactions being considered key in predicting therapeutic success (Norcross, 2002). This professional group, however, are argued to receive the least amount of training or supervision to manage the potentially negative emotional sequelae of their work (Potter et al., 2010), which may increase their likelihood of experiencing compassion fatigue as a result of their experiences. This therefore suggests a need for further research to better understand the experiences of this profession working therapeutically with sexual offenders who have a learning disability, particularly in regards to how professionals manage their emotional responses in this work setting. This is particularly important considering that research is lacking with subjective accounts of the impact of therapeutic interactions with sexual offenders (Elias & Haj-Yahia, 2017), specifically in relation to professional groups that are required to meet the 'moment-to-moment' needs of their clients as nursing professionals typically are expected to do. Understanding more about the potentially positive aspects of this work may help to identify the meaningful factors that motivate professionals to work in this field (Kadambi & Truscott, 2006), offering insight into what support or coping strategies are considered valuable by this professional group.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

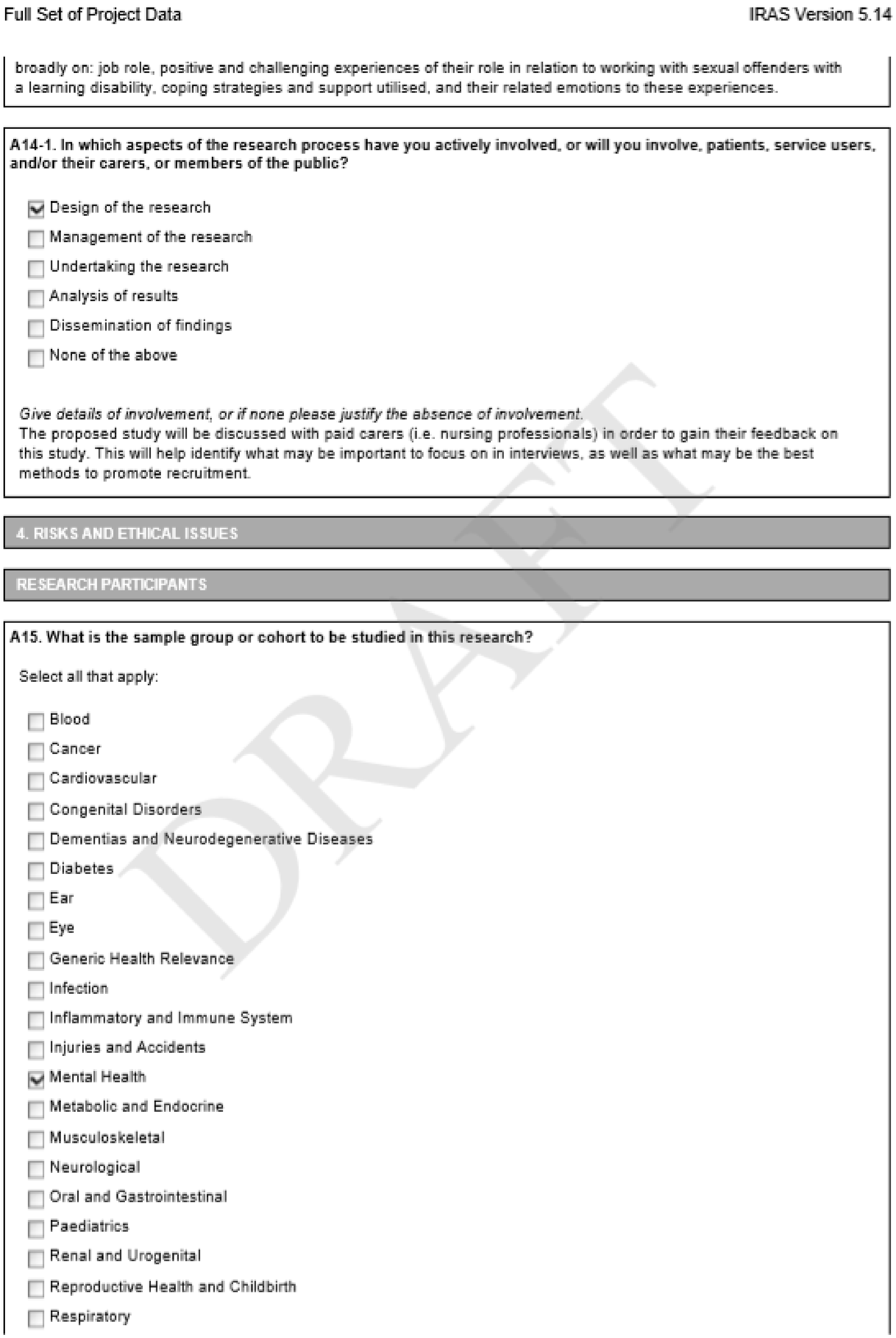
The study will be qualitative in nature, consisting of semi-structured interviews with participants lasting up to one hour. This approach should allow exploration of the experiences of professionals who work with sexual offenders who have a learning disability. An advert for the research will be sent by administration staff at their respective Trusts. All staff who are employed in the Trust will receive the email to prevent targeted identification of potential participants (i.e. nursing staff) to reduce any perceived pressure to participate. The advert will ask those interested in participating in the research to contact the primary researcher (Claire Downs) directly, who will disseminate the relevant participant information sheet dependent on which Trust the participant is employed at. There are different participant sheets for each site as they include contact details to service specific support services. It may also be possible for the advert for the research to be disseminated via the Trust intranet.

Those who express an interest in participating in the study by contacting the primary resarcher will be sent a participant information sheet. Those after they have read the information sheet will be asked to confirm their interest to the primary researcher via email. Interviews will then be arranged between the participant and the primary researcher. Participants will then be sent a copy of the consent form to ensure they have adequate time to read this prior to the interview being facilitated by Claire Downs.

Participants will be asked to provide written informed consent forms prior to commencement of the interview. This means participants will be asked to read and sign the consent form when first meeting the primary researcher for the interview. This will happen before participants are asked any questions about their experiences or are audio recorded. This will allow checking of their understanding about the nature of the study and the interview process before any data is collected.

Participants will be given the opportunity to ask any questions at this point. Particular areas to focus on and clarify for participants may be around the assurance of anonymity in reporting findings from the study, the secure storage and location of the interview data and the availability of the final report to participants and the service as a whole.

The interview will then be facilitated, lasting up to one hour. This can be facilitated at the participant's work address or via Skype. Participants will be reminded they are able to stop the interview at any time if they wish. Questions will focus



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broadly on: job role, positive and challenging experiences of their role in relation to working with sexual offenders with a learning disability, coping strategies and support utilised, and their related emotions to these experiences.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The proposed study will be discussed with paid carers (i.e. nursing professionals) in order to gain their feedback on this study. This will help identify what may be important to focus on in interviews, as well as what may be the best methods to promote recruitment.

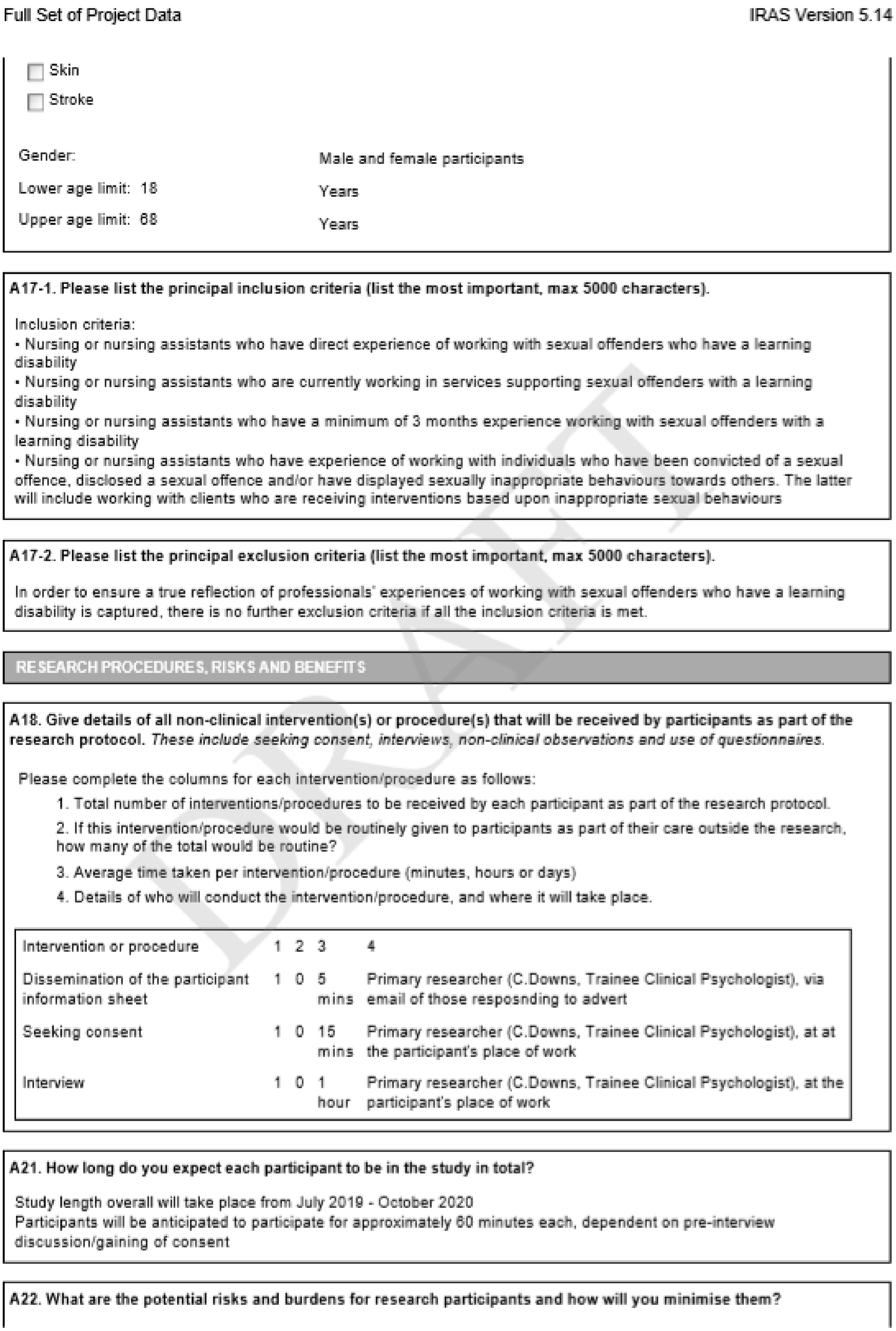
4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System
☐ Injuries and Accidents
☑ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☐ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth
☐ Respiratory



☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 68	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion criteria:
- Nursing or nursing assistants who have direct experience of working with sexual offenders who have a learning disability
- Nursing or nursing assistants who are currently working in services supporting sexual offenders with a learning disability
- Nursing or nursing assistants who have a minimum of 3 months experience working with sexual offenders with a learning disability
- Nursing or nursing assistants who have experience of working with individuals who have been convicted of a sexual offence, disclosed a sexual offence and/or have displayed sexually inappropriate behaviours towards others. The latter will include working with clients who are receiving interventions based upon inappropriate sexual behaviours

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

In order to ensure a true reflection of professionals' experiences of working with sexual offenders who have a learning disability is captured, there is no further exclusion criteria if all the inclusion criteria is met.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

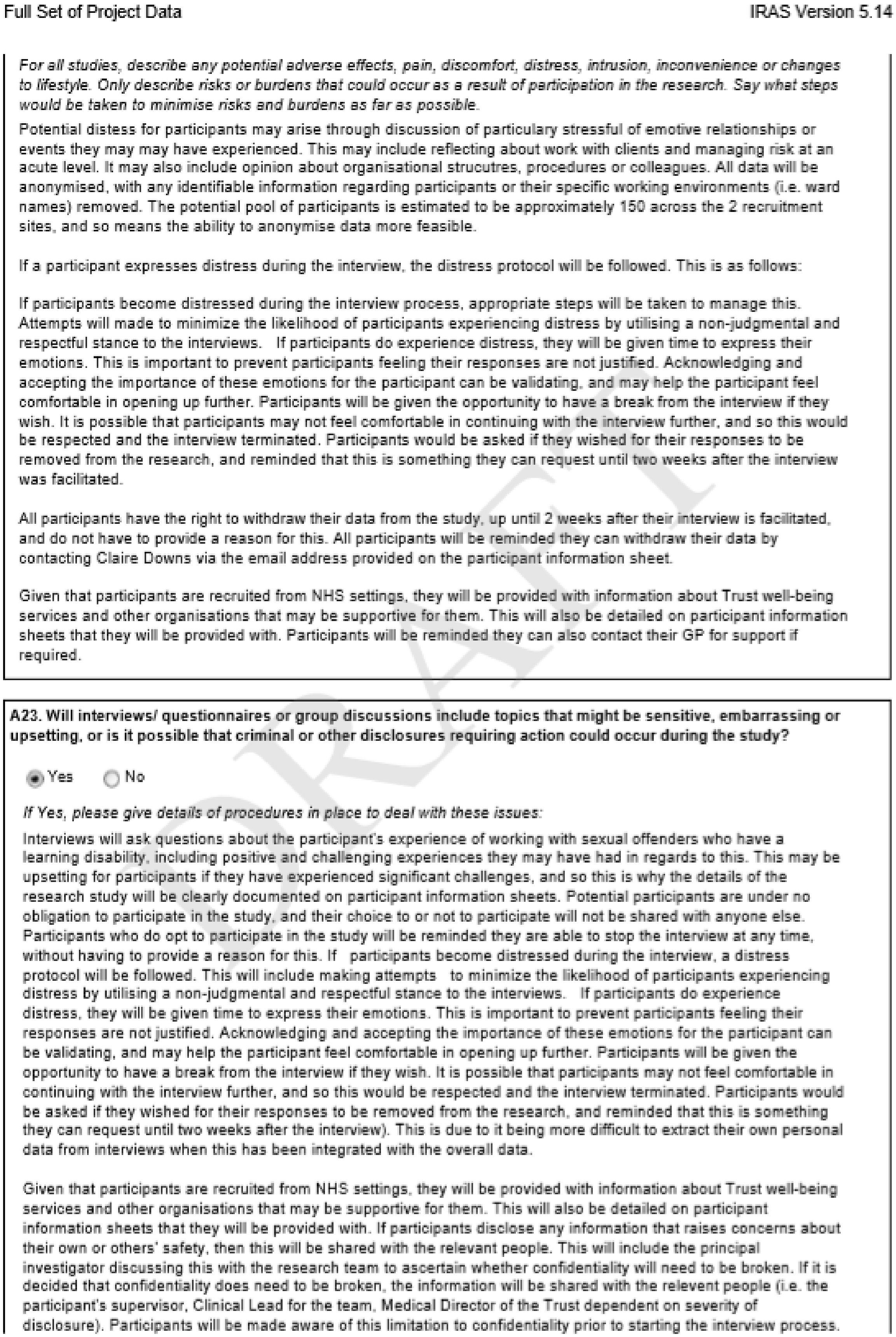
1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Dissemination of the participant information sheet	1	0	5 mins	Primary researcher (C.Downs, Trainee Clinical Psychologist), via email of those resposnding to advert
Seeking consent	1	0	15 mins	Primary researcher (C.Downs, Trainee Clinical Psychologist), at at the participant's place of work
Interview	1	0	1 hour	Primary researcher (C.Downs, Trainee Clinical Psychologist), at the participant's place of work

A21. How long do you expect each participant to be in the study in total?

Study length overall will take place from July 2019 - October 2020
Participants will be anticipated to participate for approximately 60 minutes each, dependent on pre-interview discussion/gaining of consent

A22. What are the potential risks and burdens for research participants and how will you minimise them?



For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Potential distess for participants may arise through discussion of particulary stressful of emotive relationships or events they may may have experienced. This may include reflecting about work with clients and managing risk at an acute level. It may also include opinion about organisational strucutres, procedures or colleagues. All data will be anonymised, with any identifiable information regarding participants or their specific working environments (i.e. ward names) removed. The potential pool of participants is estimated to be approximately 150 across the 2 recruitment sites, and so means the ability to anonymise data more feasible.

If a participant expresses distress during the interview, the distress protocol will be followed. This is as follows:

If participants become distressed during the interview process, appropriate steps will be taken to manage this. Attempts will made to minimize the likelihood of participants experiencing distress by utilising a non-judgmental and respectful stance to the interviews. If participants do experience distress, they will be given time to express their emotions. This is important to prevent participants feeling their responses are not justified. Acknowledging and accepting the importance of these emotions for the participant can be validating, and may help the participant feel comfortable in opening up further. Participants will be given the opportunity to have a break from the interview if they wish. It is possible that participants may not feel comfortable in continuing with the interview further, and so this would be respected and the interview terminated. Participants would be asked if they wished for their responses to be removed from the research, and reminded that this is something they can request until two weeks after the interview was facilitated.

All participants have the right to withdraw their data from the study, up until 2 weeks after their interview is facilitated, and do not have to provide a reason for this. All participants will be reminded they can withdraw their data by contacting Claire Downs via the email address provided on the participant information sheet.

Given that participants are recruited from NHS settings, they will be provided with information about Trust well-being services and other organisations that may be supportive for them. This will also be detailed on participant information sheets that they will be provided with. Participants will be reminded they can also contact their GP for support if required.

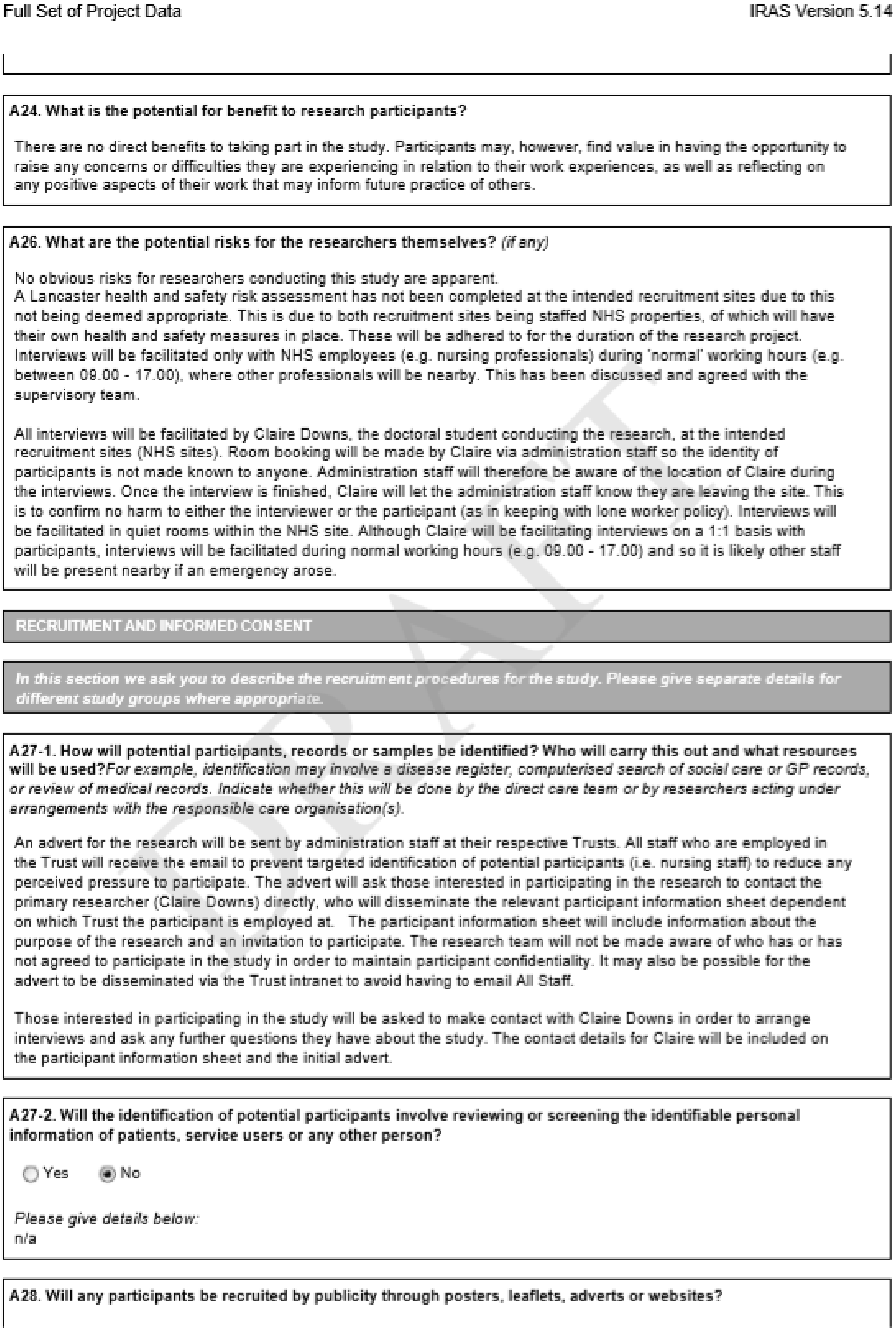
A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Interviews will ask questions about the participant's experience of working with sexual offenders who have a learning disability, including positive and challenging experiences they may have had in regards to this. This may be upsetting for participants if they have experienced significant challenges, and so this is why the details of the research study will be clearly documented on participant information sheets. Potential participants are under no obligation to participate in the study, and their choice to or not to participate will not be shared with anyone else. Participants who do opt to participate in the study will be reminded they are able to stop the interview at any time, without having to provide a reason for this. If participants become distressed during the interview, a distress protocol will be followed. This will include making attempts to minimize the likelihood of participants experiencing distress by utilising a non-judgmental and respectful stance to the interviews. If participants do experience distress, they will be given time to express their emotions. This is important to prevent participants feeling their responses are not justified. Acknowledging and accepting the importance of these emotions for the participant can be validating, and may help the participant feel comfortable in opening up further. Participants will be given the opportunity to have a break from the interview if they wish. It is possible that participants may not feel comfortable in continuing with the interview further, and so this would be respected and the interview terminated. Participants would be asked if they wished for their responses to be removed from the research, and reminded that this is something they can request until two weeks after the interview). This is due to it being more difficult to extract their own personal data from interviews when this has been integrated with the overall data.

Given that participants are recruited from NHS settings, they will be provided with information about Trust well-being services and other organisations that may be supportive for them. This will also be detailed on participant information sheets that they will be provided with. If participants disclose any information that raises concerns about their own or others' safety, then this will be shared with the relevant people. This will include the principal investigator discussing this with the research team to ascertain whether confidentiality will need to be broken. If it is decided that confidentiality does need to be broken, the information will be shared with the relevent people (i.e. the participant's supervisor, Clinical Lead for the team, Medical Director of the Trust dependent on severity of disclosure). Participants will be made aware of this limitation to confidentiality prior to starting the interview process.



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A24. What is the potential for benefit to research participants?

There are no direct benefits to taking part in the study. Participants may, however, find value in having the opportunity to raise any concerns or difficulties they are experiencing in relation to their work experiences, as well as reflecting on any positive aspects of their work that may inform future practice of others.

A26. What are the potential risks for the researchers themselves? *(if any)*

No obvious risks for researchers conducting this study are apparent.
A Lancaster health and safety risk assessment has not been completed at the intended recruitment sites due to this not being deemed appropriate. This is due to both recruitment sites being staffed NHS properties, of which will have their own health and safety measures in place. These will be adhered to for the duration of the research project. Interviews will be facilitated only with NHS employees (e.g. nursing professionals) during 'normal' working hours (e.g. between 09.00 - 17.00), where other professionals will be nearby. This has been discussed and agreed with the supervisory team.

All interviews will be facilitated by Claire Downs, the doctoral student conducting the research, at the intended recruitment sites (NHS sites). Room booking will be made by Claire via administration staff so the identity of participants is not made known to anyone. Administration staff will therefore be aware of the location of Claire during the interviews. Once the interview is finished, Claire will let the administration staff know they are leaving the site. This is to confirm no harm to either the interviewer or the participant (as in keeping with lone worker policy). Interviews will be facilitated in quiet rooms within the NHS site. Although Claire will be facilitating interviews on a 1:1 basis with participants, interviews will be facilitated during normal working hours (e.g. 09.00 - 17.00) and so it is likely other staff will be present nearby if an emergency arose.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

An advert for the research will be sent by administration staff at their respective Trusts. All staff who are employed in the Trust will receive the email to prevent targeted identification of potential participants (i.e. nursing staff) to reduce any perceived pressure to participate. The advert will ask those interested in participating in the research to contact the primary researcher (Claire Downs) directly, who will disseminate the relevant participant information sheet dependent on which Trust the participant is employed at. The participant information sheet will include information about the purpose of the research and an invitation to participate. The research team will not be made aware of who has or has not agreed to participate in the study in order to maintain participant confidentiality. It may also be possible for the advert to be disseminated via the Trust intranet to avoid having to email All Staff.

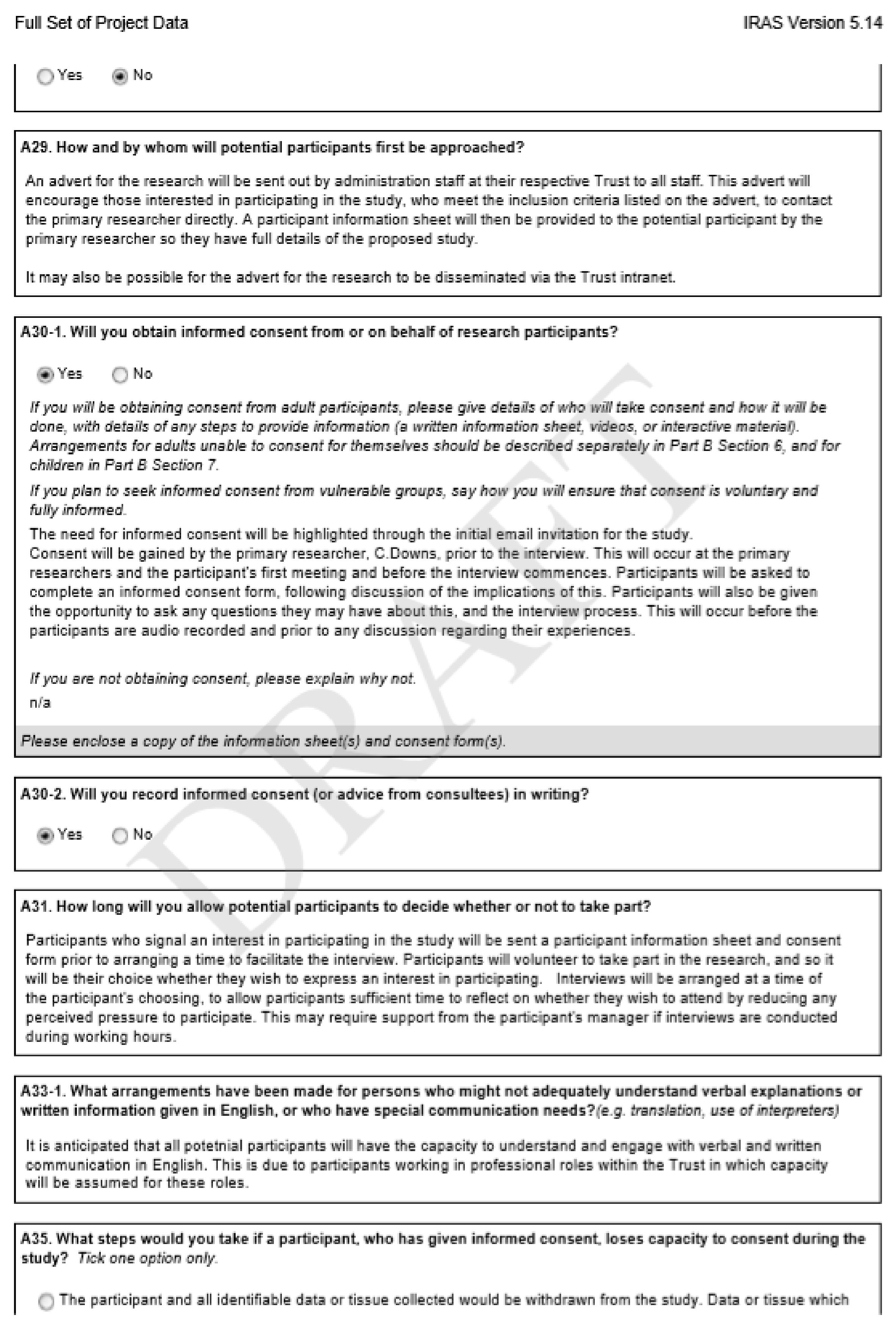
Those interested in participating in the study will be asked to make contact with Claire Downs in order to arrange interviews and ask any further questions they have about the study. The contact details for Claire will be included on the participant information sheet and the initial advert.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:
n/a

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?



○ Yes ● No

A29. How and by whom will potential participants first be approached?

An advert for the research will be sent out by administration staff at their respective Trust to all staff. This advert will encourage those interested in participating in the study, who meet the inclusion criteria listed on the advert, to contact the primary researcher directly. A participant information sheet will then be provided to the potential participant by the primary researcher so they have full details of the proposed study.

It may also be possible for the advert for the research to be disseminated via the Trust intranet.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

The need for informed consent will be highlighted through the initial email invitation for the study.
Consent will be gained by the primary researcher, C.Downs, prior to the interview. This will occur at the primary researchers and the participant's first meeting and before the interview commences. Participants will be asked to complete an informed consent form, following discussion of the implications of this. Participants will also be given the opportunity to ask any questions they may have about this, and the interview process. This will occur before the participants are audio recorded and prior to any discussion regarding their experiences.

If you are not obtaining consent, please explain why not.

n/a

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

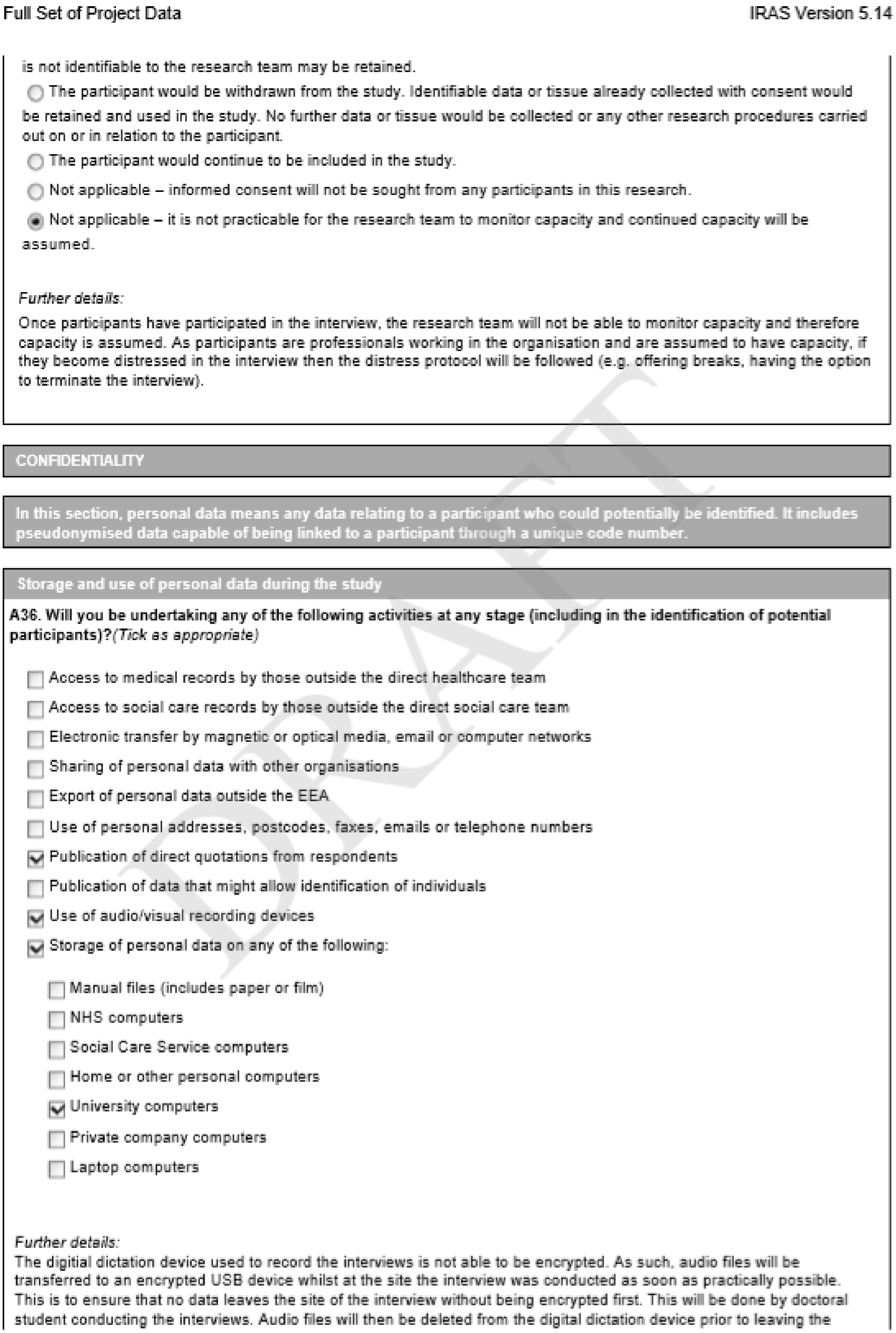
Participants who signal an interest in participating in the study will be sent a participant information sheet and consent form prior to arranging a time to facilitate the interview. Participants will volunteer to take part in the research, and so it will be their choice whether they wish to express an interest in participating. Interviews will be arranged at a time of the participant's choosing, to allow participants sufficient time to reflect on whether they wish to attend by reducing any perceived pressure to participate. This may require support from the participant's manager if interviews are conducted during working hours.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

It is anticipated that all potetnial participants will have the capacity to understand and engage with verbal and written communication in English. This is due to participants working in professional roles within the Trust in which capacity will be assumed for these roles.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which



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is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

● Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Once participants have participated in the interview, the research team will not be able to monitor capacity and therefore capacity is assumed. As participants are professionals working in the organisation and are assumed to have capacity, if they become distressed in the interview then the distress protocol will be followed (e.g. offering breaks, having the option to terminate the interview).

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

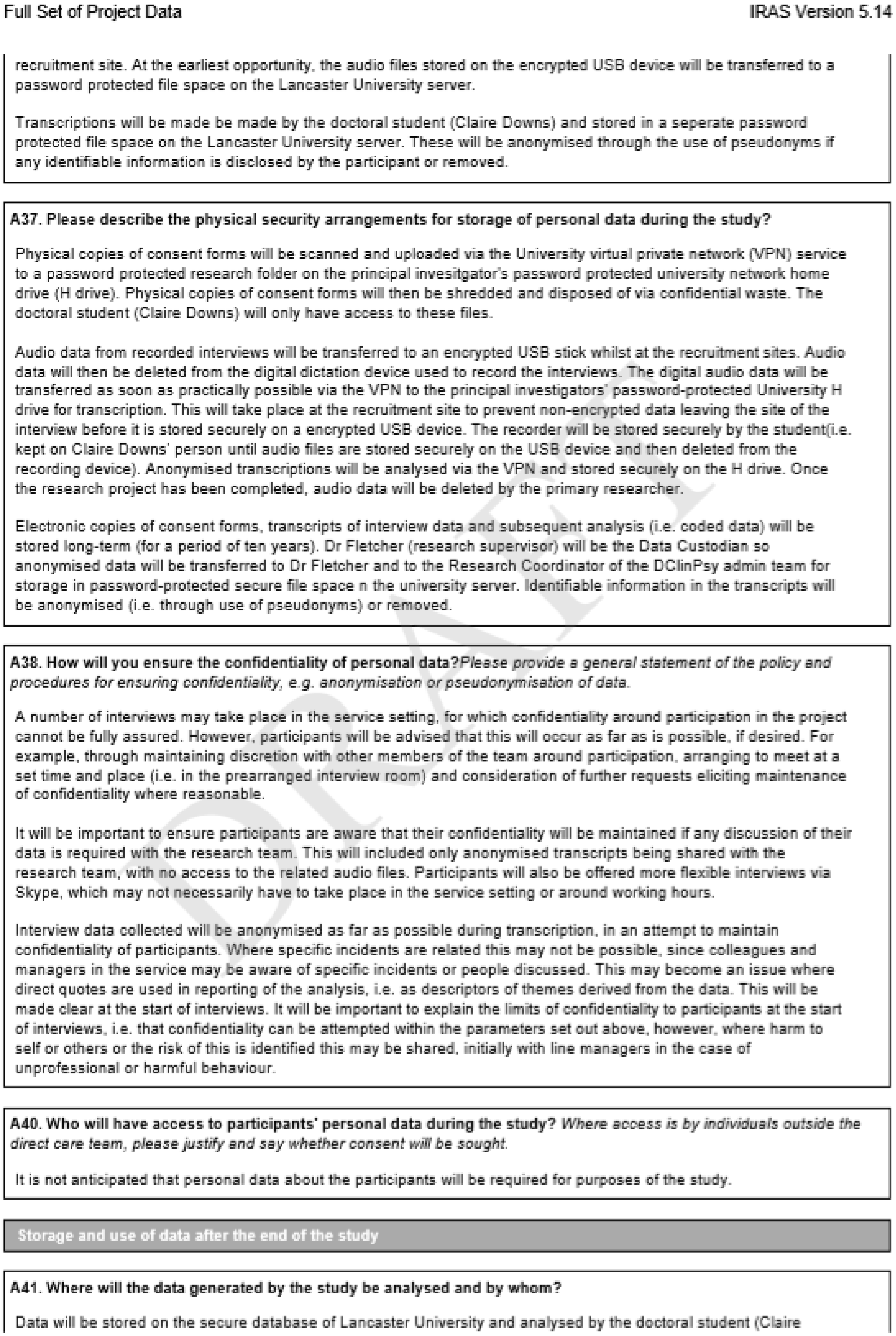
A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team
☐ Access to social care records by those outside the direct social care team
☐ Electronic transfer by magnetic or optical media, email or computer networks
☐ Sharing of personal data with other organisations
☐ Export of personal data outside the EEA
☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
☑ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
☑ Use of audio/visual recording devices
☑ Storage of personal data on any of the following:

  ☐ Manual files (includes paper or film)
  ☐ NHS computers
  ☐ Social Care Service computers
  ☐ Home or other personal computers
  ☑ University computers
  ☐ Private company computers
  ☐ Laptop computers

Further details:

The digitial dictation device used to record the interviews is not able to be encrypted. As such, audio files will be transferred to an encrypted USB device whilst at the site the interview was conducted as soon as practically possible. This is to ensure that no data leaves the site of the interview without being encrypted first. This will be done by doctoral student conducting the interviews. Audio files will then be deleted from the digital dictation device prior to leaving the



recruitment site. At the earliest opportunity, the audio files stored on the encrypted USB device will be transferred to a password protected file space on the Lancaster University server.

Transcriptions will be made be made by the doctoral student (Claire Downs) and stored in a seperate password protected file space on the Lancaster University server. These will be anonymised through the use of pseudonyms if any identifiable information is disclosed by the participant or removed.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Physical copies of consent forms will be scanned and uploaded via the University virtual private network (VPN) service to a password protected research folder on the principal invesitgator's password protected university network home drive (H drive). Physical copies of consent forms will then be shredded and disposed of via confidential waste. The doctoral student (Claire Downs) will only have access to these files.

Audio data from recorded interviews will be transferred to an encrypted USB stick whilst at the recruitment sites. Audio data will then be deleted from the digital dictation device used to record the interviews. The digital audio data will be transferred as soon as practically possible via the VPN to the principal investigators' password-protected University H drive for transcription. This will take place at the recruitment site to prevent non-encrypted data leaving the site of the interview before it is stored securely on a encrypted USB device. The recorder will be stored securely by the student(i.e. kept on Claire Downs' person until audio files are stored securely on the USB device and then deleted from the recording device). Anonymised transcriptions will be analysed via the VPN and stored securely on the H drive. Once the research project has been completed, audio data will be deleted by the primary researcher.

Electronic copies of consent forms, transcripts of interview data and subsequent analysis (i.e. coded data) will be stored long-term (for a period of ten years). Dr Fletcher (research supervisor) will be the Data Custodian so anonymised data will be transferred to Dr Fletcher and to the Research Coordinator of the DClinPsy admin team for storage in password-protected secure file space n the university server. Identifiable information in the transcripts will be anonymised (i.e. through use of pseudonyms) or removed.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

A number of interviews may take place in the service setting, for which confidentiality around participation in the project cannot be fully assured. However, participants will be advised that this will occur as far as is possible, if desired. For example, through maintaining discretion with other members of the team around participation, arranging to meet at a set time and place (i.e. in the prearranged interview room) and consideration of further requests eliciting maintenance of confidentiality where reasonable.

It will be important to ensure participants are aware that their confidentiality will be maintained if any discussion of their data is required with the research team. This will included only anonymised transcripts being shared with the research team, with no access to the related audio files. Participants will also be offered more flexible interviews via Skype, which may not necessarily have to take place in the service setting or around working hours.

Interview data collected will be anonymised as far as possible during transcription, in an attempt to maintain confidentiality of participants. Where specific incidents are related this may not be possible, since colleagues and managers in the service may be aware of specific incidents or people discussed. This may become an issue where direct quotes are used in reporting of the analysis, i.e. as descriptors of themes derived from the data. This will be made clear at the start of interviews. It will be important to explain the limits of confidentiality to participants at the start of interviews, i.e. that confidentiality can be attempted within the parameters set out above, however, where harm to self or others or the risk of this is identified this may be shared, initially with line managers in the case of unprofessional or harmful behaviour.

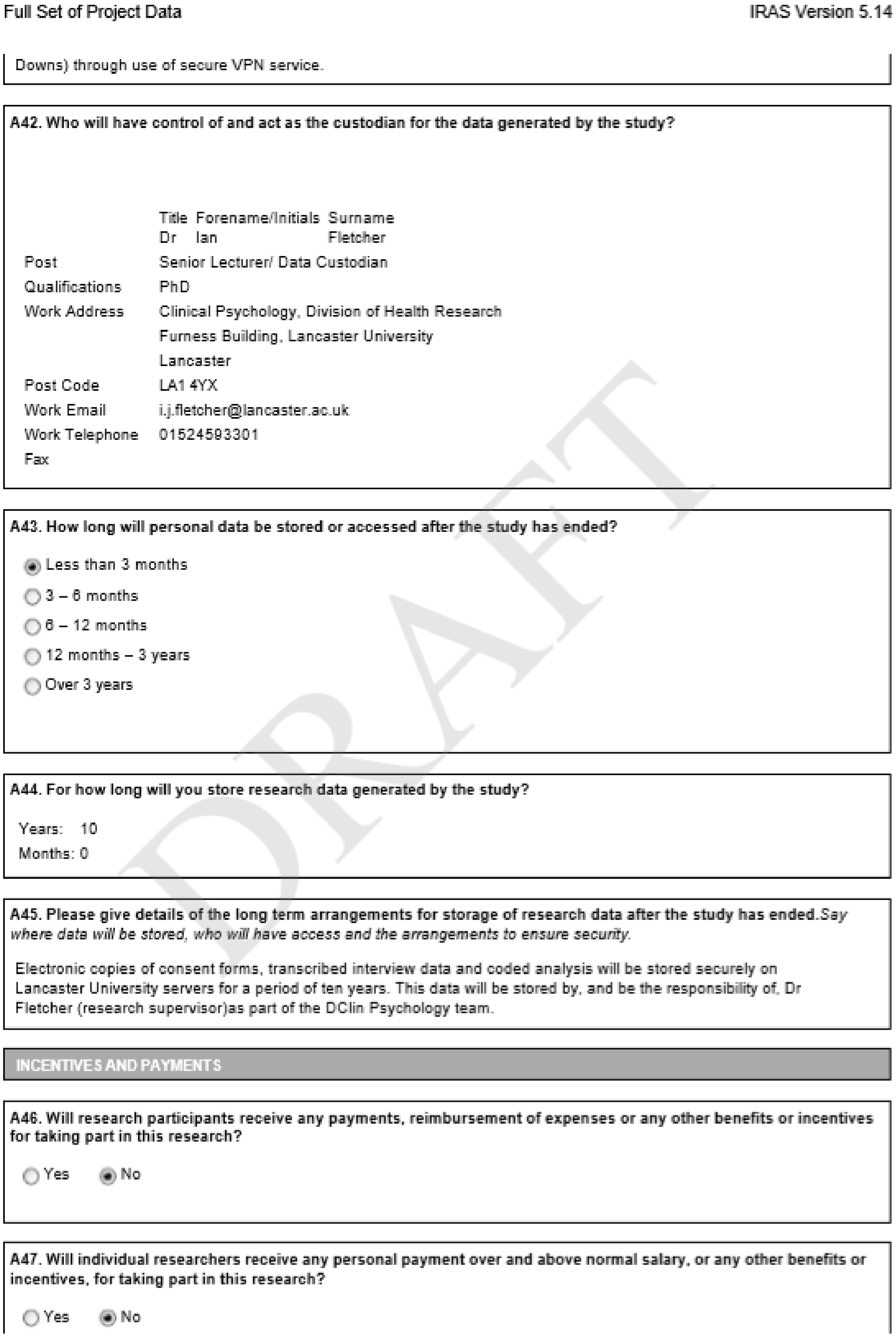
A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

It is not anticipated that personal data about the participants will be required for purposes of the study.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be stored on the secure database of Lancaster University and analysed by the doctoral student (Claire



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Downs) through use of secure VPN service.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title Forename/Initials Surname Dr Ian Fletcher
Post	Senior Lecturer/ Data Custodian
Qualifications	PhD
Work Address	Clinical Psychology, Division of Health Research Furness Building, Lancaster University Lancaster
Post Code	LA1 4YX
Work Email	i.j.fletcher@lancaster.ac.uk
Work Telephone	01524593301
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

● Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Electronic copies of consent forms, transcribed interview data and coded analysis will be stored securely on Lancaster University servers for a period of ten years. This data will be stored by, and be the responsibility of, Dr Fletcher (research supervisor)as part of the DClin Psychology team.

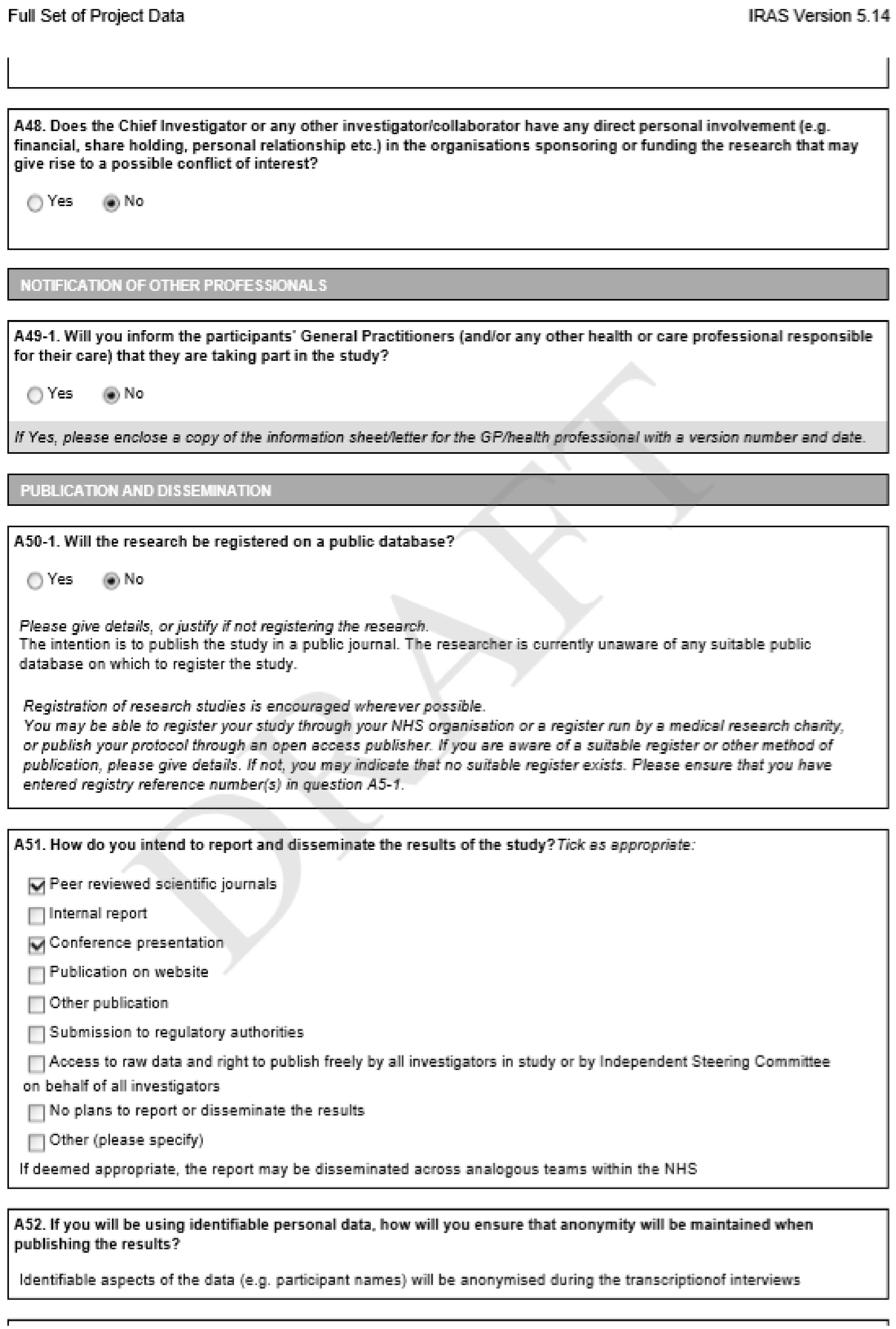
INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ● No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No



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A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.
The intention is to publish the study in a public journal. The researcher is currently unaware of any suitable public database on which to register the study.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

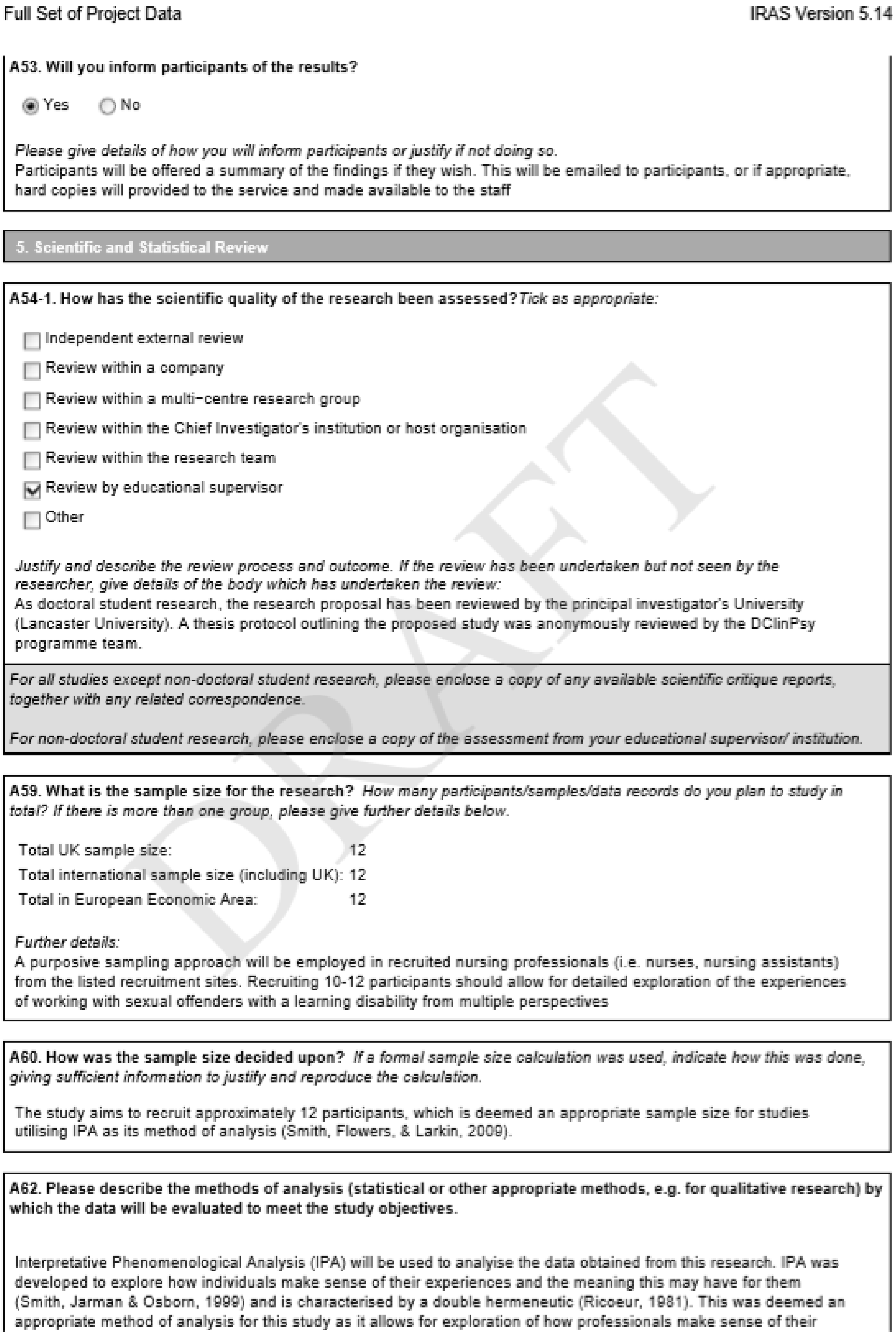
A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☐ Internal report
☑ Conference presentation
☐ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

If deemed appropriate, the report may be disseminated across analogous teams within the NHS

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Identifiable aspects of the data (e.g. participant names) will be anonymised during the transcriptionof interviews



A53. Will you inform participants of the results?

● Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be offered a summary of the findings if they wish. This will be emailed to participants, or if appropriate, hard copies will provided to the service and made available to the staff

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☐ Review within the Chief Investigator's institution or host organisation
☐ Review within the research team
☑ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
As doctoral student research, the research proposal has been reviewed by the principal investigator's University (Lancaster University). A thesis protocol outlining the proposed study was anonymously reviewed by the DClinPsy programme team.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	12
Total international sample size (including UK):	12
Total in European Economic Area:	12

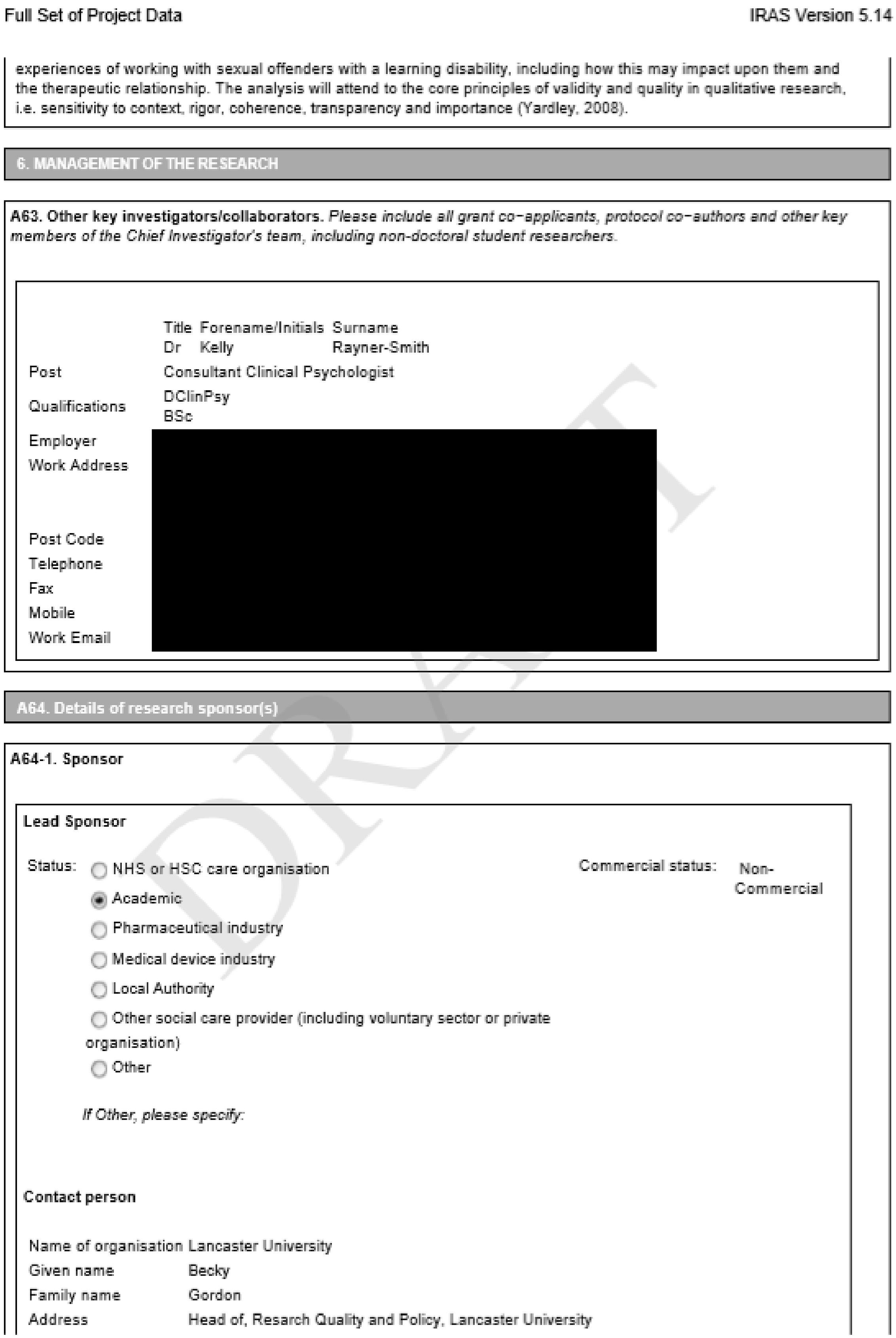
Further details:
A purposive sampling approach will be employed in recruited nursing professionals (i.e. nurses, nursing assistants) from the listed recruitment sites. Recruiting 10-12 participants should allow for detailed exploration of the experiences of working with sexual offenders with a learning disability from multiple perspectives

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The study aims to recruit approximately 12 participants, which is deemed an appropriate sample size for studies utilising IPA as its method of analysis (Smith, Flowers, & Larkin, 2009).

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Interpretative Phenomenological Analysis (IPA) will be used to analyise the data obtained from this research. IPA was developed to explore how individuals make sense of their experiences and the meaning this may have for them (Smith, Jarman & Osborn, 1999) and is characterised by a double hermeneutic (Ricoeur, 1981). This was deemed an appropriate method of analysis for this study as it allows for exploration of how professionals make sense of their



experiences of working with sexual offenders with a learning disability, including how this may impact upon them and the therapeutic relationship. The analysis will attend to the core principles of validity and quality in qualitative research, i.e. sensitivity to context, rigor, coherence, transparency and importance (Yardley, 2008).

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Kelly	Rayner-Smith

Post Consultant Clinical Psychologist
Qualifications DClinPsy
BSc
Employer
Work Address
Post Code
Telephone
Fax
Mobile
Work Email
[redacted]

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

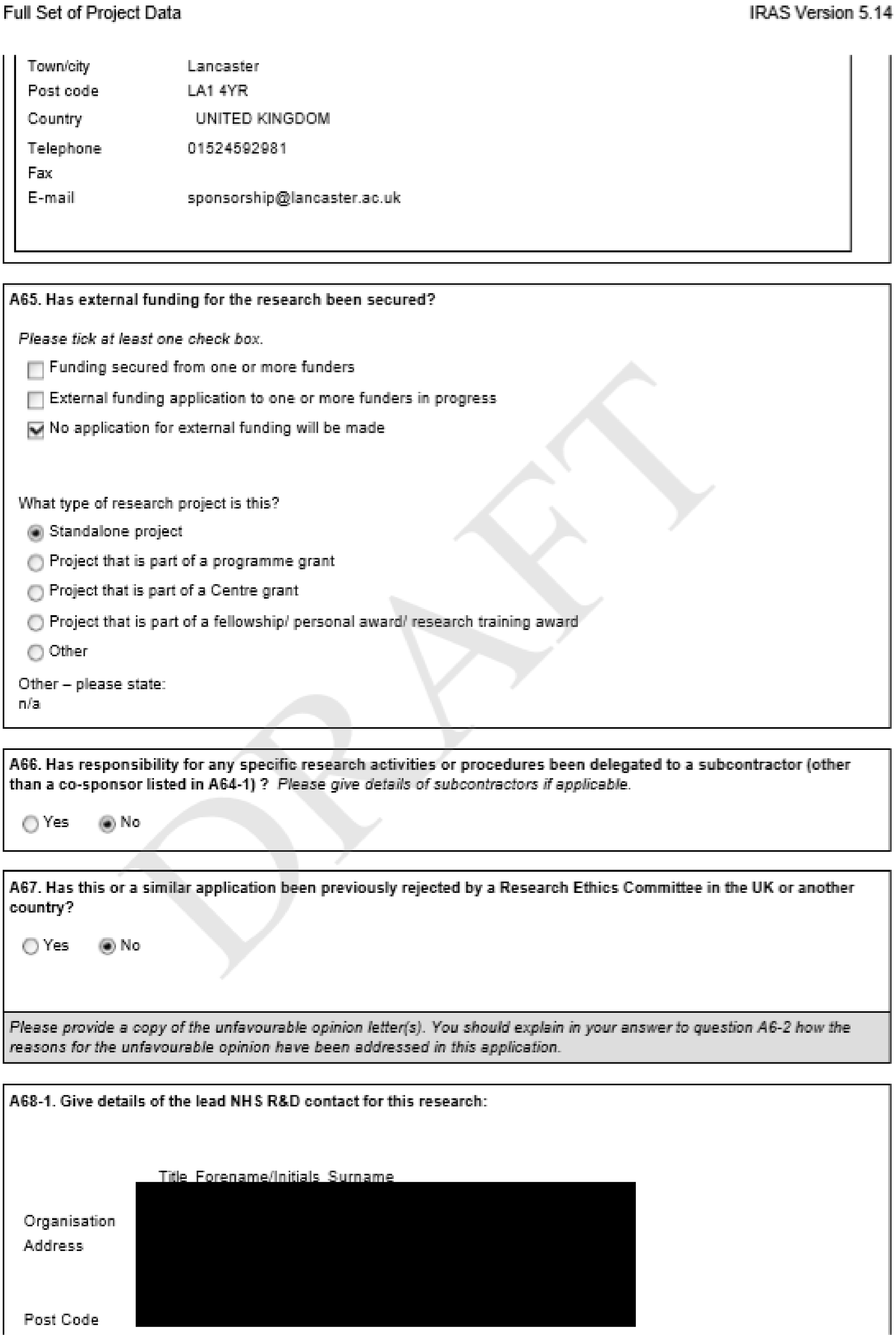
Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

If Other, please specify:

Commercial status: Non-Commercial

Contact person

Name of organisation Lancaster University
Given name Becky
Family name Gordon
Address Head of, Resarch Quality and Policy, Lancaster University



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Town/city	Lancaster
Post code	LA1 4YR
Country	UNITED KINGDOM
Telephone	01524592981
Fax	
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

● Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:
n/a

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ● No

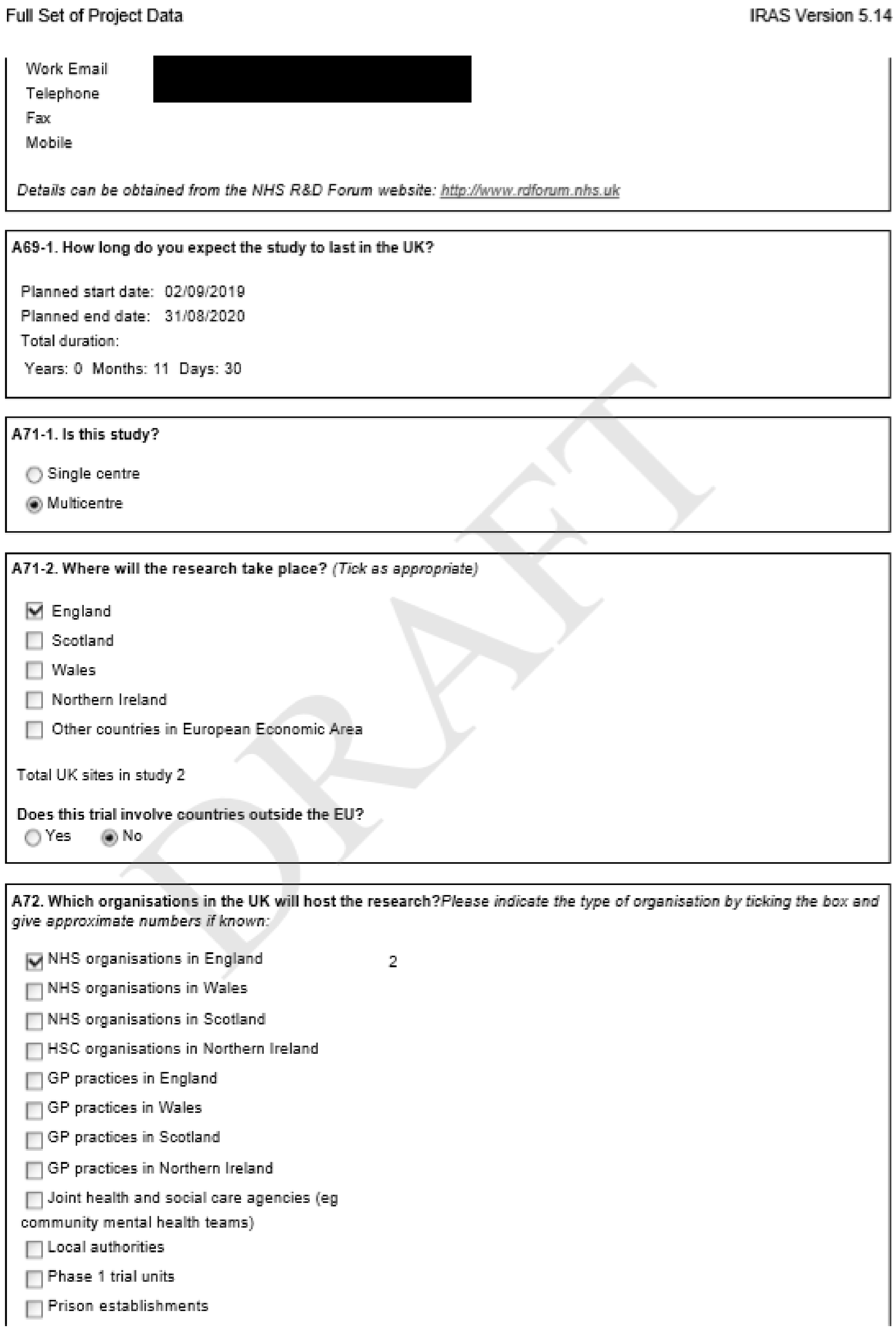
A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname
Organisation
Address
Post Code
[redacted]



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Work Email [redacted]
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 02/09/2019
Planned end date: 31/08/2020
Total duration:
Years: 0 Months: 11 Days: 30

A71-1. Is this study?

○ Single centre
● Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

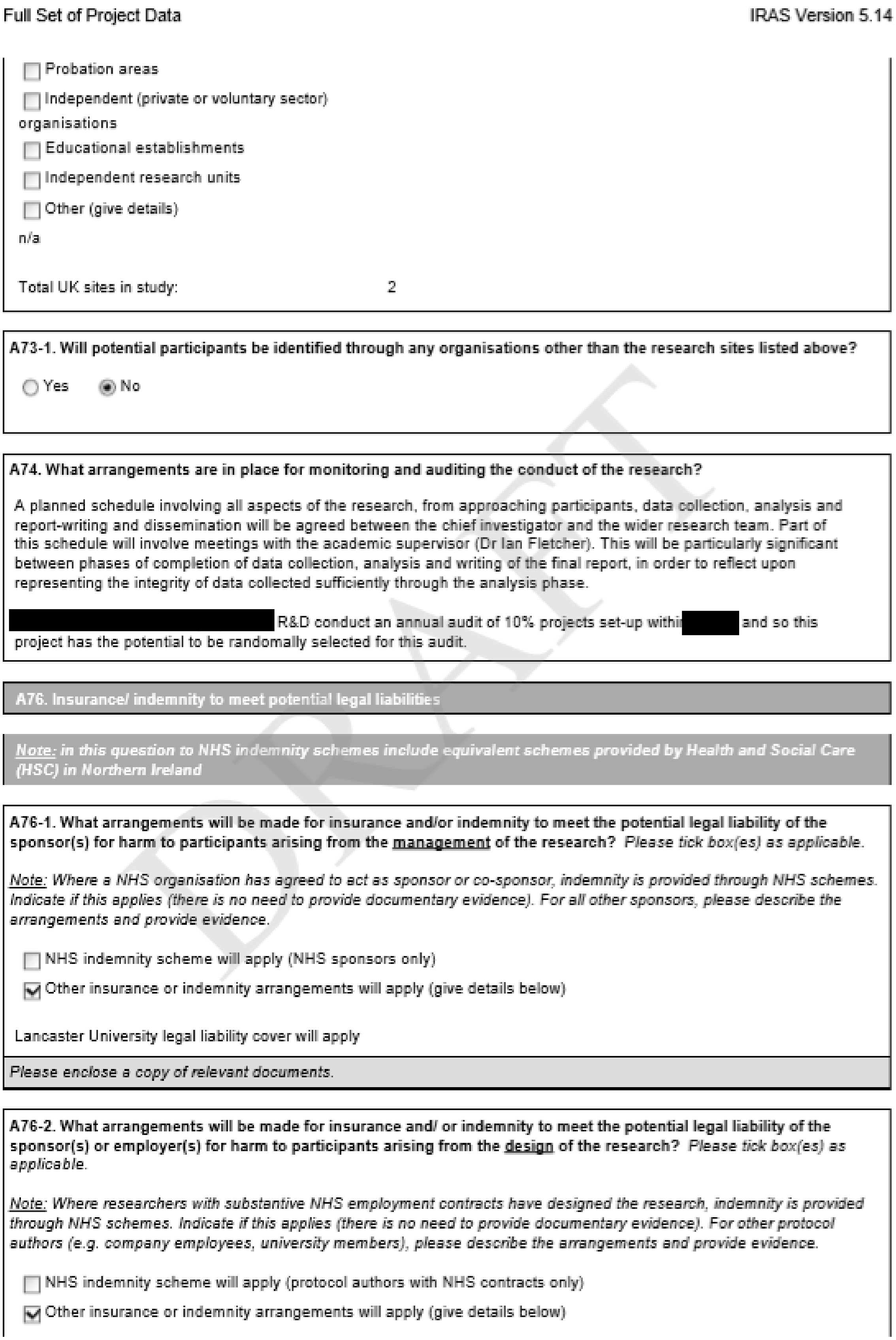
☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 2

Does this trial involve countries outside the EU?
○ Yes ● No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England 2
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Joint health and social care agencies (eg community mental health teams)
☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments



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☐ Probation areas

☐ Independent (private or voluntary sector) organisations

☐ Educational establishments

☐ Independent research units

☐ Other (give details)

n/a

Total UK sites in study: 2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ● No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

A planned schedule involving all aspects of the research, from approaching participants, data collection, analysis and report-writing and dissemination will be agreed between the chief investigator and the wider research team. Part of this schedule will involve meetings with the academic supervisor (Dr Ian Fletcher). This will be particularly significant between phases of completion of data collection, analysis and writing of the final report, in order to reflect upon representing the integrity of data collected sufficiently through the analysis phase.

[redacted] R&D conduct an annual audit of 10% projects set-up within [redacted] and so this project has the potential to be randomally selected for this audit.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

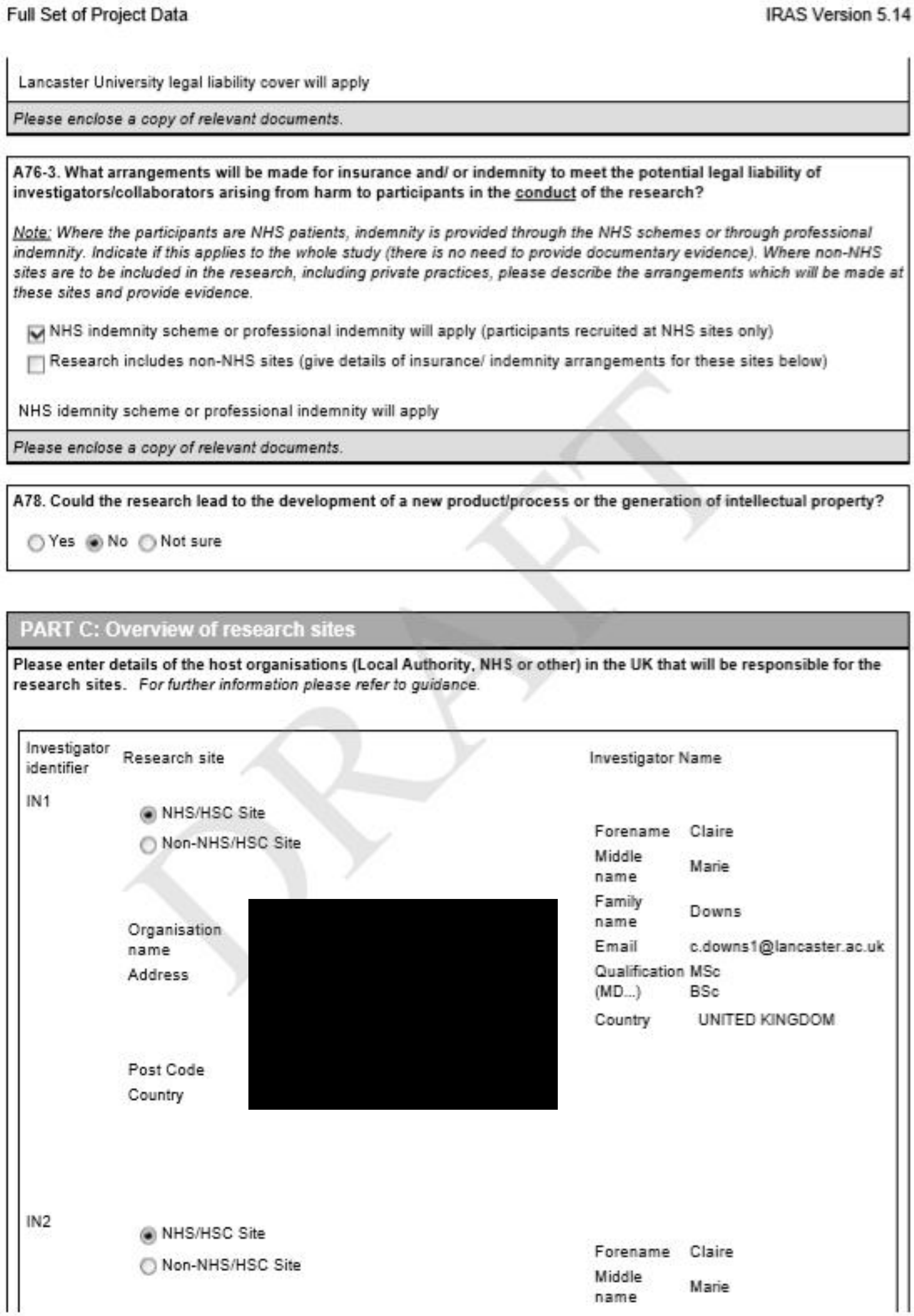
Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)



Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

NHS idemnity scheme or professional indemnity will apply

Please enclose a copy of relevant documents.

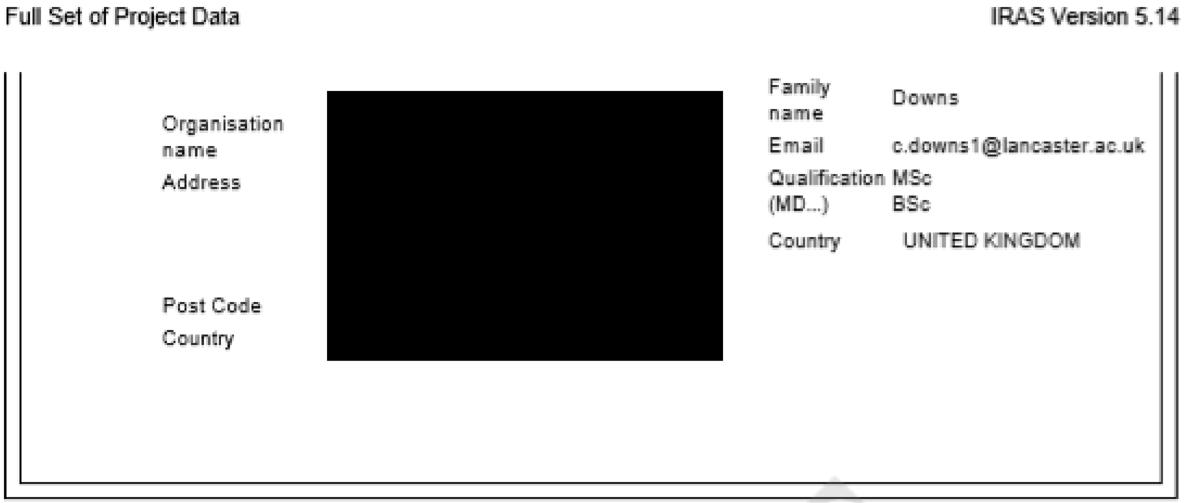
A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ● No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	● NHS/HSC Site ○ Non-NHS/HSC Site Organisation name Address Post Code Country [redacted]	Forename Claire Middle name Marie Family name Downs Email c.downs1@lancaster.ac.uk Qualification (MD...) MSc BSc Country UNITED KINGDOM
IN2	● NHS/HSC Site ○ Non-NHS/HSC Site	Forename Claire Middle name Marie



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Organisation name	[redacted]
Address	
Post Code	
Country	

Family name	Downs
Email	c.downs1@lancaster.ac.uk
Qualification (MD...)	MSc BSc
Country	UNITED KINGDOM

Appendices

Appendix 4-A: Research Paper Protocol

Title	Nursing professionals' experience of working with sexual offenders who have a learning disability
Applicant/Primary Researcher	Claire Downs (Trainee Clinical Psychologist – Lancaster University)
Research Supervisor	Dr Ian Fletcher (Senior Lecturer - Lancaster University)
Field Supervisor	Dr Kelly Rayner-Smith (Consultant Clinical Psychologist – [redacted])

1. Introduction

Compassion is deemed integral to providing quality care by clients, professionals and policy makers (Department of Health, 2008; Flocke, Miller & Crabtree, 2002; Paterson, 2011; Sinclair et al., 2016). Being able to demonstrate compassion to those receiving support for mental health difficulties has been associated with the increased likelihood of positive therapeutic outcomes being achieved and greater satisfaction with services (Norcross, 2002). Being able to treat others with compassion can also have a positive impact on the professional, with this being associated with improved wellbeing and greater abilities to manage stress (Gilbert, 2010; MacBeth & Gumley, 2012). This can be challenging to maintain for professionals who are often required to consistently demonstrate high levels of empathetic engagement with individuals expressing distress or behaviours that may challenge (Figley, 2002). This can lead professionals to experience compassion fatigue, which has been considered the 'cost of caring'.

Compassion fatigue has been suggested to lead to a poorer quality of care being provided, due to risk that professionals feel they are ‘running on empty’ (Boyle, 2011), which can impact client care and relationships (Lombardo & Eyre, 2011; Najjar, Davis, Beck-Coon, & Carney-Doebbeling, 2009). Working in mental health settings has been suggested to increase one’s vulnerability to experiencing symptoms of compassion fatigue, such as feeling worthless, fatigued or experiencing a sense of disillusionment with work (Figley, 1995; Stamm, 2010). This appears particularly relevant to professionals working therapeutically with sexual offenders, due to existing common beliefs that this population is especially difficult to rehabilitate successfully (Bach & Demuth, 2018). This may cause professionals to question their purpose, which is deemed integral for professionals to have pride, motivation and satisfaction in their work (Hunsaker, Chen, Maughan, & Heaston, 2015; Perry, 2008). This may account, at least in part, why high rates of psychological ‘damage’, described as perceiving a high risk of developing depressive or anxious symptoms, increased drug or alcohol use, and experiencing negative impacts on personal relationships, have been described by professionals who work therapeutically with sexual offenders (Clarke & Roger, 2002; Way, VanDeusen, Martin, Applegate & Jandle, 2004).

Working with certain populations, such as those with a learning disability, has also been associated with increased stress within professionals and compassion fatigue (Innstrand, Espnes, & Mykletum, 2002). As such, sexual offenders who also have a learning disability are considered to be of a particular challenge to both professionals and to services (Clare & Murphy, 1998). Reasons for this have been attributed to the need to adapt mainstream programmes to suit the specific needs of this client group (Harkins & Beech 2007), as well perceptions that those with a learning disability are in less control over their sexual offending behaviours than others

(MacKinlay & Langdon, 2009).Although research has demonstrated that those working to support sexual offenders with a learning disability, such as mental health professionals, are more likely to have more positive or optimistic views of this population than other professions (Day, Boni, Hobbs, Carson, Whitting, & Powell, 2014), there is little information available on how this is achieved or maintained. It has been suggested that most emerging research focused upon this client group has focused upon experiences of the victim or the perpetrator, with less attention being paid to the role of the 'helper' (Bach & Demuth, 2018) and what the positive impact of working with sexual offenders may be.

The existing body of literature has been criticised for lack of research exploring the specific experience of professionals working with sexual offenders with a learning disability therapeutically (Sandhu, Rose, Rostill-Brookes & Thrift, 2012), suggesting a gap in the literature presently. Moreover, the vast majority of this research has focused upon the experiences of psychologists or psychotherapists who deliver treatment programmes, with little attention being paid to 'frontline staff', such as nurses or healthcare assistants. This is particularly pertinent as this professional group are often the ones who spend the most time with clients, with these relationships and interactions being considered key in predicting therapeutic success (Norcross, 2002). This professional group, however, are argued to receive the least amount of training or supervision to manage the potentially negative emotional sequelae of their work (Potter et al., 2010), which may increase their likelihood of experiencing compassion fatigue as a result of their experiences. This therefore suggests a need for further research to better understand the experiences of this profession working therapeutically with sexual offenders who have a learning disability, particularly in regards to how professionals manage their emotional responses in this work setting. This is particularly important considering that research is lacking with subjective accounts of the impact of therapeutic interactions with sexual offenders (Elias & Haj-Yahia, 2017), specifically in relation to professional groups that are required to meet the 'moment-to-moment' needs of their clients as nursing professionals typically are expected to do. Understanding more about the potentially positive aspects of this work may help to identify the meaningful factors that motivate professionals to work in this field (Kadambi & Truscott, 2006), offering insight into what support or coping strategies are considered valuable by this professional group.

1.1 Aim of the study

This study aims to explore the experiences of nursing professionals, including nursing assistants, who work with sexual offenders who also have a learning disability.

2. Method

2.1 Design

Semi-structured interviews will be used as this is considered a flexible research method (Fylan, 2005); allowing participants to reflect upon their own experiences whilst remaining relevant to the research question (Barter & Renold, 2000). Semi-structured interviews allow for a breadth of data to be collected (Horton, Macye & Struyven, 2004), which will be important when exploring participants personal experiences of working therapeutically with sexual offenders who have a learning disability. Using a semi-structured interview allows the interviewer to prepare questions ahead of time to promote the likelihood of in-depth and quality data being collected focused upon the research questions (DiCicco-Bloom & Crabtree, 2006). Topics will include the experiences of working with sexual offenders with a learning disability, factors professionals' believe are important in this line of work, the emotional impact of working with this population and exploration of coping strategies professionals may employ to maintain them in their role (See: Interview Guide).

A reflective journal will be used to note reflections when identifying themes to provide for a thoughtful and reflexive analysis.

2.2 Participants

The study aims to recruit approximately 12 participants, which is deemed an appropriate sample size for studies utilising IPA as its method of analysis (Smith, Flowers, & Larkin, 2009).

The professional group who will be deemed eligible for participation in this study are mental health professionals working in nursing or nursing assistant (i.e. healthcare assistant, support worker) roles.

Inclusion criteria:

- Nursing or nursing assistants who have direct experience of working with sexual offenders who have a learning disability
- Nursing or nursing assistants who are currently working in services supporting sexual offenders with a learning disability
- Nursing or nursing assistants who have a minimum of 3 months experience working with sexual offenders with a learning disability
- Nursing or nursing assistants who have experience of working with individuals who have been convicted of a sexual offence and/or have disclosed a history of sexual offending who also have a learning disability.

- Nursing or nursing assistants who have experience of working with individuals with a learning disability who may display sexually inappropriate behaviours that they are receiving intervention for

2.3 Materials

- A digital dictation device will be used to audio record interviews with participants
- An encrypted USB device will be used to store the recordings of the interviews so that this can be deleted from the digital dictation device once uploaded to at Lancaster University Box (LU Box) file.
- A Box file will be used to store the audio recordings and anonymised transcriptions of interviews electronically. The research team will have access to the anonymised transcripts, as will the examiners if required.
- Interview guide will be used (See: Interview guide)

2.4 Procedure

An advert for the research (See: Advert [redacted] will be sent by administration staff at their respective Trusts. All staff who are employed in the Trust will receive the email to prevent targeted identification of potential participants (i.e. nursing staff) to reduce any perceived pressure to participate. The advert will ask those interested in participating in the research to contact the primary researcher (Claire Downs) directly, who will disseminate the relevant participant information sheet dependent on which Trust the participant is employed at (See: Participant Information Sheet [redacted]). There are different participant sheets for each site as they include contact details to service specific support services. It may also be possible for the advert for the research to be disseminated via the Trust intranet.

Those who express an interest in participating in the study after they have read the information sheet will be asked to confirm their interest to the primary researcher. The primary researcher will liaise with selected participants to arrange the interviews, which will be facilitated at their work base at a time suitable for the participants as to have the least impact on their normal working day. Participants will also be given the option to have interviews facilitated over Skype if this is preferable to them.

Participants will be given the consent form (See: Consent Form) to read and complete prior to participation in the interview (i.e. before they are asked any questions in relation to their experiences that is recorded). All participants will be reminded that their involvement in the study is voluntary and they are allowed to withdraw from the study at any time, up until two weeks after their interview. This is due to it being more difficult to extract their own personal data from interviews when this has been integrated with the overall data. Interviews may be up to one hour in duration, although participants will be reminded that they can stop the interview at any time if they prefer.

2.5 Distress Protocol

If participants become distressed during the interview process, appropriate steps will be taken to manage this. Attempts will made to minimize the likelihood of participants experiencing distress by utilising a non-judgmental and respectful stance to the interviews. If participants do experience distress, they will be given time to express their emotions. This is important to prevent participants feeling their responses are not justified. Acknowledging and accepting the importance of these emotions for the participant can be validating, and may help the participant feel comfortable in opening up further. Participants will be given the opportunity to have a break from the interview if they wish. It is possible that participants may not feel comfortable in continuing with the interview further, and so this would be respected and the interview terminated. Participants would be asked if they wished for their responses to be removed from the research, and reminded that this is something they can request until a specified time.

Given that participants are recruited from NHS settings, they will be provided with information about Trust well-being services and other organisations that may be supportive for them. This will also be detailed on participant information sheets that they will be provided with. If concerns are raised about their, or someone else’s safety, the process detailed in *4.2. Disclosures* will be followed.

2.6 Proposed analysis

The intended method of analysis for this proposed study is Interpretative Phenomenological Analysis (IPA), developed to explore how individuals make sense of their experiences and the meaning this may have for them (Smith, Jarman, & Osborn, 1999) and is characterised by a ‘double hermeneutic’ (Ricoeur, 1981). This was deemed an appropriate method of analysis for this study as it allows for exploration of how mental health professionals make sense of their experience of working with sexual offenders with a learning disability, including how this may impact upon them, their wellbeing and their ability to develop therapeutic relationships with clients. The analysis will attend to the core principles of validity and quality in qualitative research, i.e., sensitivity to context, rigor, coherence, transparency and importance (Yardley, 2008).

3. Practical issues

3.1 Room bookings

Interviews will be facilitated within private rooms at the service. Rooms will be booked after participants have consented to participate in the study as it will be necessary that rooms are booked during times that are appropriate for the participants.

3.2 Data storage

Consent forms used will be in paper format, but will be scanned and uploaded via the University virtual private network (VPN) service to a password protected research folder on the principal investigator's password protected university network home drive (H drive). Physical copies of the consent forms (i.e. the paper copies) will then be destroyed via confidential waste. Electronic copies of the consent form will be stored electronically for a period of 10 years by the DClinPsy research coordinator on the University secure system. The research supervisor for this project will be responsible for overseeing the data, including destroying them after 10 years.

As interviews will be audio recorded using a digital dictation device, the data will be transferred from the device to an encrypted USB device following the completion of the interview. This will be done whilst the applicant is still at the service site, where the interviews will be facilitated. Once the data has been transferred to the USB device the interview will be deleted from the digital dictation device.

The digital audio data will be transferred as soon as practically possible via the VPN to the principal investigators' password-protected University H drive for transcription. Anonymised transcriptions will be analysed via the VPN and stored securely on the H drive. Once the research project has been completed, audio data will be deleted by the primary researcher Only the primary researcher will have access to the audio recordings, to protect anonymity of participants. Audio recordings will be deleted once the thesis has been examined. Transcriptions of the interview will be made as soon as practically possible and stored electronically in the primary researcher's password protected university H drive. All coding will take place via the University VPN on the primary researcher's protected university H drive. Transcripts will be stored electronically for a period of 10 years by the DClinPsy research coordinator on the University secure system. The research supervisor for this project (Dr Ian Fletcher) will be responsible for overseeing the data, including destroying after 10 years.

4. Ethical concerns

4.1 Supervisor

Potential participants will be made aware of who the supervisory team are prior to consenting to participate in the interviews. The identity of participants will not be shared with the supervisory team.

Any discussion regarding the data obtained from this research will only be facilitated once the data has been anonymised. This will be achieved by using generic numbers (i.e. participant 1, participant 2, etc), or through use of pseudonyms, rather than using participant names or job titles. The only exception to this will be if a participant causes the main researcher concern regarding their own or another's safety, in which case this may have to be discussed with supervisory team (See *4.2. Disclosures*).

4.2 Disclosures

If participants disclose any information that raises concerns about their own or others' safety, then this will be shared with the relevant people. This will include this being discussed with the supervisory team of this research (i.e. Dr Rayner-Smith and Dr Fletcher) to ascertain whether it will be necessary to break confidentiality. If it is deemed necessary to break confidentiality, then information will be passed to the participant's supervisor, service manager or medical director depending on the nature of what is disclosed. Participants will be made aware of this limitation to confidentiality prior to starting the interview process. This will also be made explicit on the consent form and information sheet that they will be provided with.

If any issues arise relating to the practice of the field supervisor then this will be shared with their clinical supervisor within the Trust and with the research supervisor. Any issues raised relating to Dr Rayner-Smith's practice will be discussed with her clinical supervisor within the Trust ([redacted]). The identity of the participant will not be shared unless deemed necessary through discussion with the research supervisor (Dr Fletcher) and [redacted]

4.3 Distress

If participants appear distressed, a distress protocol will be followed. This is detailed in *2.5. Distress Protocol.*

5. Timescale

Jan 2019 -March	• Submit thesis proposal form • Meet with supervisors to discuss development of interview guide
March - June	• Address any concerns raised in thesis proposal form • Receive approval email from Exam Board • Begin documentation for ethics submission

	• Arrange meeting with supervisors (field and research) to discuss SRP research contract and ethics processes. • Develop research protocol and access materials needed (i.e. voice recording device)
June - August	• Submit ethics application • Finalise research materials and send out information sheets to recruitment sites upon receipt of ethical approval.
Sept - Nov	• Fieldwork (i.e. conduct interviews) • Complete transcriptions after each interview • Begin writing up introduction and method section of report
Nov – Jan 2020	• Analysis • Feedback findings to participants to gain their opinions on found themes/ideas • Continue with write up of the report (including analysis/discussion sections)
Jan – March	• Continue report writing • Submit draft for supervisor feedback
May	• Submit thesis

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Appendix 4-B: Interview Schedule

Study title: Nursing professionals' experiences of working with sexual offenders who have a learning disability

Opening information

- Introduce self and re-cap aims of the research
- Advise participant approximately how long interview should take (i.e. up to 1 hour)
- Ask participant if they have any questions prior to beginning (check consent)
- Remind participant not to disclose personal information about clients and details of potential offences

Background information

The aim of these questions is to gain demographic information about the participants (i.e. job title, length of time in role). These questions aim to understand more about why participants may choose to work with sexual offenders who have a learning disability, as well as explore why people may choose to take a 'break' from this line of work if applicable. This may help to identify potential motivating factors for working with sexual offenders who have a learning disability, as well as factors that may reduce this.

- What is your role?
- How long have you worked with this client group?
- Why did you choose a career working with sexual offenders who have a learning disability?
- Have there been any points during your career working with sexual offenders when you left the role? If so, why was this?

Main interview questions

5. The impact of working with sexual offenders who have a learning disability

These questions aim to explore more generally the impact that working with this client group can have on mental health professionals. This will help to understand how participants make sense of their experiences of working with this client group and the impact this may have on their therapeutic work

Question: How has your work with sexual offenders impacted upon you?

- What aspects of the role led you to have those feelings?
- Has this impacted upon you ability to work therapeutically with sexual offenders who have a learning disability? If yes, how?
- How have you managed these feelings and what support was available for you?
- How do you make sense of your work with this client group?

6. Challenges

These questions aim to establish what the particular challenges participants experience in their work with this client group. These questions may be helpful in exploring what the difficulties are associated with working professionally with sexual offenders who have a learning disability and what coping strategies professionals use to negate against this.

Question: What aspects of working with sexual offenders who have a learning disability is the most challenging?

- Why do you think this is?
- How have you coped with these challenges?
- Do you think there is anything that may help you in the future if these challenges happened again?
- Are there any other challenges? If yes, what are these?

7. Benefits

This question aims to explore what the potential benefits of working with sexual offenders may be. This can provide important information as to what helps participants maintain in their role.

Question: What are the benefits of working with sexual offenders who have a learning disability?

- Have these benefits supported you to maintain in your role?
- If so, how/why?

- What do you value the most from your work with sexual offenders who have a learning disability? If yes, what is this?
- What aspects of your job do you most enjoy? Why?

8. Support

These questions aim to establish what coping strategies participants use in order to continue in their role, as well as what support they think is valuable in helping them achieve this.

Question: What type of support is available to you in relation to your work with sexual offenders with a learning disability?

- If this effective? Why?
- What coping strategies do you utilise?
- What do you think helps to prevent professionals experiencing negative affect from working with this client group?

Closing the interview

These questions aim to allow the participant to discuss anything that they feel is important in relation to this research that may not have been covered within the interview. This will hopefully reduce the likelihood of pertinent information being missed.

Final questions

Question: If there anything else you want to discuss that you think is important for this research to capture?

Question: Do you have any questions you would like to ask me about this research?

Advise participant what will happen next (i.e. transcribing, initial coding of transcript, summary of results) and remind participant they will have an opportunity to comment on findings if they so wish.

Thank interviewee for their time.

Appendix 4-C: Participant Information Sheet

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Participant Information Sheet

Nursing professionals' experiences of working with sexual offenders who have a learning disability

My name is Claire Downs and I am conducting this research as a trainee clinical psychologist at Lancaster University.

What is this research about?
The purpose of this research is to explore nursing professionals' experiences and emotions associated with working with sexual offenders who also have a learning disability.

Why have I been approached?
You have been approached because you work with sexual offenders who have a learning disability

Do I have to take part?
No, it is completely up to you to decide whether or not you take part in this research. If you do not wish to take part, then you are free to do so without having to a give a reason for this. If you have any questions or concerns about participating, then please contact the principal investigator, Claire Downs who may be able to answer these for you.

Will my data be Identifiable?
The information you provide will be made anonymous with no identifiable information being used. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data. Please note the following:

- You will be asked to sign a paper consent form, which will be scanned and saved electronically in a password protected university H drive, of which the primary researcher will only have access to. Paper copies of consent forms will be shredded and disposed of in confidential waste once they have been scanned.
- Interviews will be audio recorded using a digital dictation device. Recordings will be deleted from this device as soon as they have been transferred to an encrypted USB device
- Recordings will then be deleted from the USB device once they have been transferred to a password protected secure Lancaster University H drive.
- Audio recordings will be deleted once the study has been examined by the University.

- Transcripts will be made of the interviews and saved electronically in a password protected H drive. Transcripts will be made of the interviews as soon as practically possible by the primary researcher
- Transcripts will be made anonymous by removing your name or other identifiable information. Anonymised direct quotations from your interviews may be used in the reports, publications or presentations of the study. Your name will not be attached to any quotations used.

- Your personal data (i.e. your name) will be kept securely in a password protected folder on the primary researcher's secure University H drive and kept separately from your interview responses

Please note there are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I may have to break confidentiality and speak to my supervisors about this. If possible, I will tell you if I have to do this.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?
The results will be summarised and reported and will be submitted for publication in an academic or professional journal. The results will be presented as part of a conference and at a thesis presentation day held at Lancaster University. A summary of the findings will be presented to the service and on request to participants involved in the research.

Are there any risks?
There are no anticipated risks associated with participating in the study. If you do, however, experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part. Participating in this study will, however, allow you to share your experiences of working with sexual offenders who have a learning disability and how this may impact upon you.

Who has reviewed the project?

This study has been reviewed by the Doctorate in Clinical Psychology research team and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University. For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection.

Ethical approval has also been gained by R&D approval from the Health Research Authority (HRA).

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the primary researcher:

Claire Downs	Primary researcher	c.downs1@lancaster.ac.uk
Dr Kelly Rayner-Smith	Field supervisor	kelly.rayner-smith[redacted]
Dr Ian Fletcher	Research supervisor	i.j.fletcher@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bill Sellwood
Tel: (01524) 593998
Email: b.sellwood@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Lancaster Clinical Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: (0)1524 593746
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)

Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Organisation	What they do	Website	Contact information
Stress Management Society	Information about stress and tips on how to cope	www.stress.org.uk	**0203 142 8650** **info@stress.org.uk**
Mind	Information on types of mental health problems, where to get help, treatment options and advocacy	ww.mind.org.uk	**0300 123 3393k** **info@mind.org.uk**
Advisory Conciliation and Arbitration Service(ACAS)	Information, advice, training, conciliation, and other services to help prevent or resolve workplace problems.	www.acas.org.uk	**0300 123 1100**
[redacted] Employee Support Service	Support with mental and physical wellbeing	[redacted]	[redacted] Employee Support Service Lead)

Appendix 4-D: Consent Form

Consent Form

Research title: Nursing professionals' experiences of working with sexual offenders who have a learning disability.

We are asking if you would like to take part in a study that aims to explore mental health professionals' experiences of working with sexual offenders who have a learning disability. The study aims to identify what the potential challenges and benefits or working with this client group are, as well as exploring areas in which support offered to professionals working in these settings may be improved.

Before you consent to participating in this study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Claire Downs. If would rather email your questions then please contact Claire via c.downs1@lancaster.ac.uk

1. I confirm that I have read the information sheet and fully understood what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and have them answered ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript, which will be stored electronically ☐
4. I understand the audio recordings will be kept until the research project has been examined and then will be deleted by the principal researcher ☐
5. I understand that electronic consent forms and transcripts will be stored electronically for a period of 10 years by the DClinPsy research coordinator on the University secure system. This data will be destroyed once the 10 year period has been reached ☐
6. I understand that my participation is voluntary and that I am free to withdraw at any time until two weeks after my interview without my medical care or legal rights being affected ☐

7. I understand that once my data has been anonymised and incorporated into themes, it might not be possible for it to be withdrawn, though every attempt will be made to extract me data up until two weeks after the interview has been facilitated ☐
8. I understand that the information from my interview will be pooled with other participants' responses anonymised and may be published ☐
9. I consent to information and quotations from my interview being used in reports, conferences, and training events ☐
10. I understand that the researcher will discuss data with their supervisor as needed. Any data discussed will be anonymised ☐
11. I understand that any information I give will remain anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor. ☐

Name of Participant______________________Signature____________________Date_______

Name of Researcher______________________Signature____________________Date_______

Appendix 4-E: Research Advert

[redacted]

Health & Medicine | Lancaster University

Are you a nurse of healthcare assistant who works with sexual offenders who have a learning disability?

Researchers within the University of Lancaster Doctorate in Clinical Psychology department are looking for nursing professionals, including nurses, nursing assistants, support workers and healthcare assistants, to take part in a study. This study will be examining nursing professionals' experiences of working with sexual offenders with a learning disability, exploring what the potential challenges and benefits or working with this client group are, as well as exploring areas in which support offered to professionals working in these settings may be improved.

If you are aged 18 years or over, are currently are a nurse or healthcare assistant who work with sexual offenders with a learning disability, then we would like to invite you to take part in our research study. You will require experience of working with individuals who have a learning disability, who either have been convicted of a sexual offence or display sexually inappropriate behaviours that they are receiving intervention for.

The study will involve being interviewed by Claire Downs (Trainee Clinical Psychologist) from Lancaster University. Interviews will last up to an hour, although can be terminated at any time. Interviews will be facilitated at times of your choosing within your place of work or via Skype.

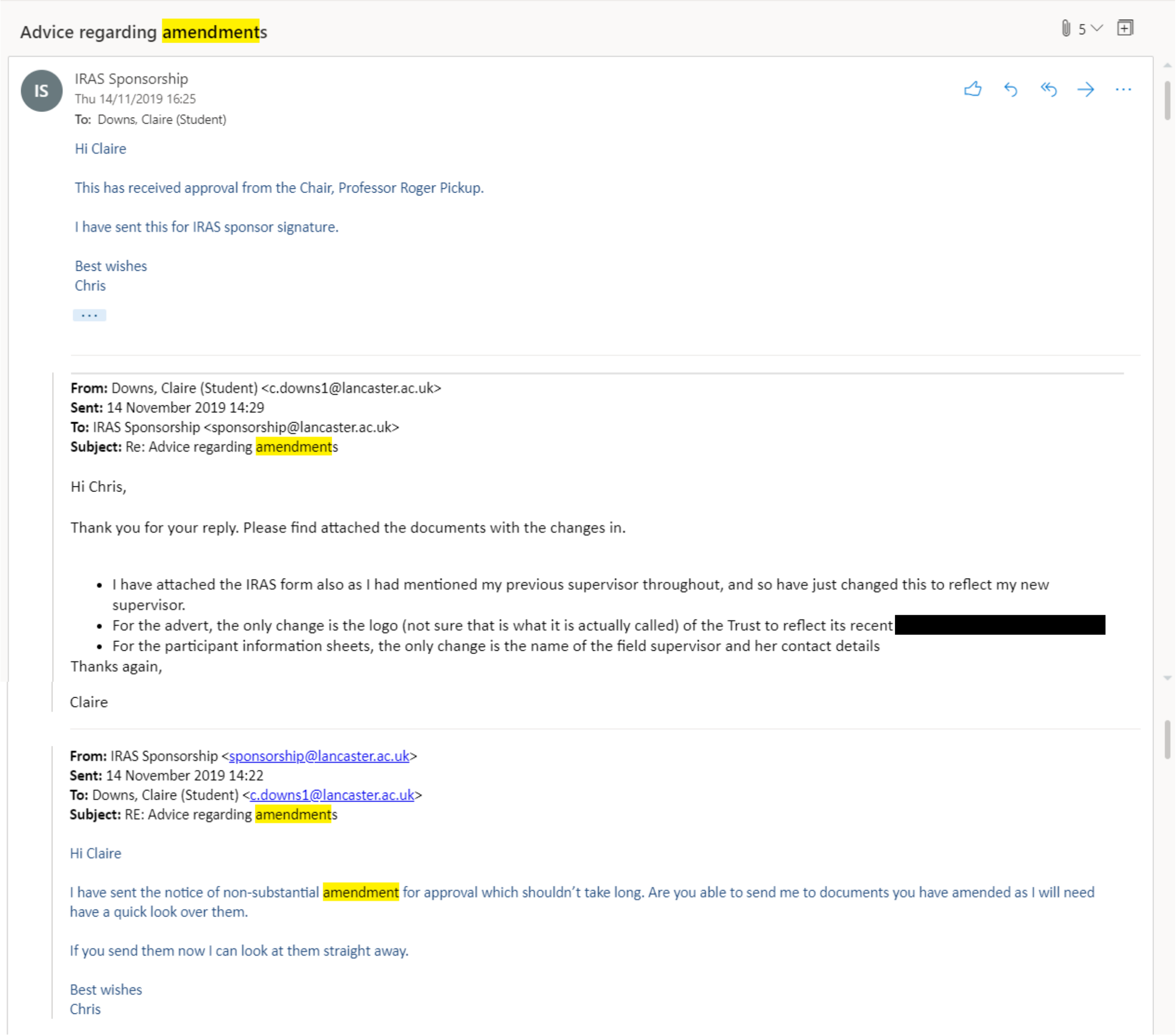
What you discuss will be anonymised, and your decision to participate, or not, will be kept confidential.

You can find out more information by emailing Claire at:

c.downs1@lancaster.ac.uk

Appendix 4-F: Approval of amendments

Email exchange confirming approval



Advice regarding amendments

IRAS Sponsorship
Thu 14/11/2019 16:25
To: Downs, Claire (Student)

Hi Claire

This has received approval from the Chair, Professor Roger Pickup.

I have sent this for IRAS sponsor signature.

Best wishes
Chris

From: Downs, Claire (Student) <c.downs1@lancaster.ac.uk>
Sent: 14 November 2019 14:29
To: IRAS Sponsorship <sponsorship@lancaster.ac.uk>
Subject: Re: Advice regarding amendments

Hi Chris,

Thank you for your reply. Please find attached the documents with the changes in.

- I have attached the IRAS form also as I had mentioned my previous supervisor throughout, and so have just changed this to reflect my new supervisor.
- For the advert, the only change is the logo (not sure that is what it is actually called) of the Trust to reflect its recent [redacted]
- For the participant information sheets, the only change is the name of the field supervisor and her contact details

Thanks again,

Claire

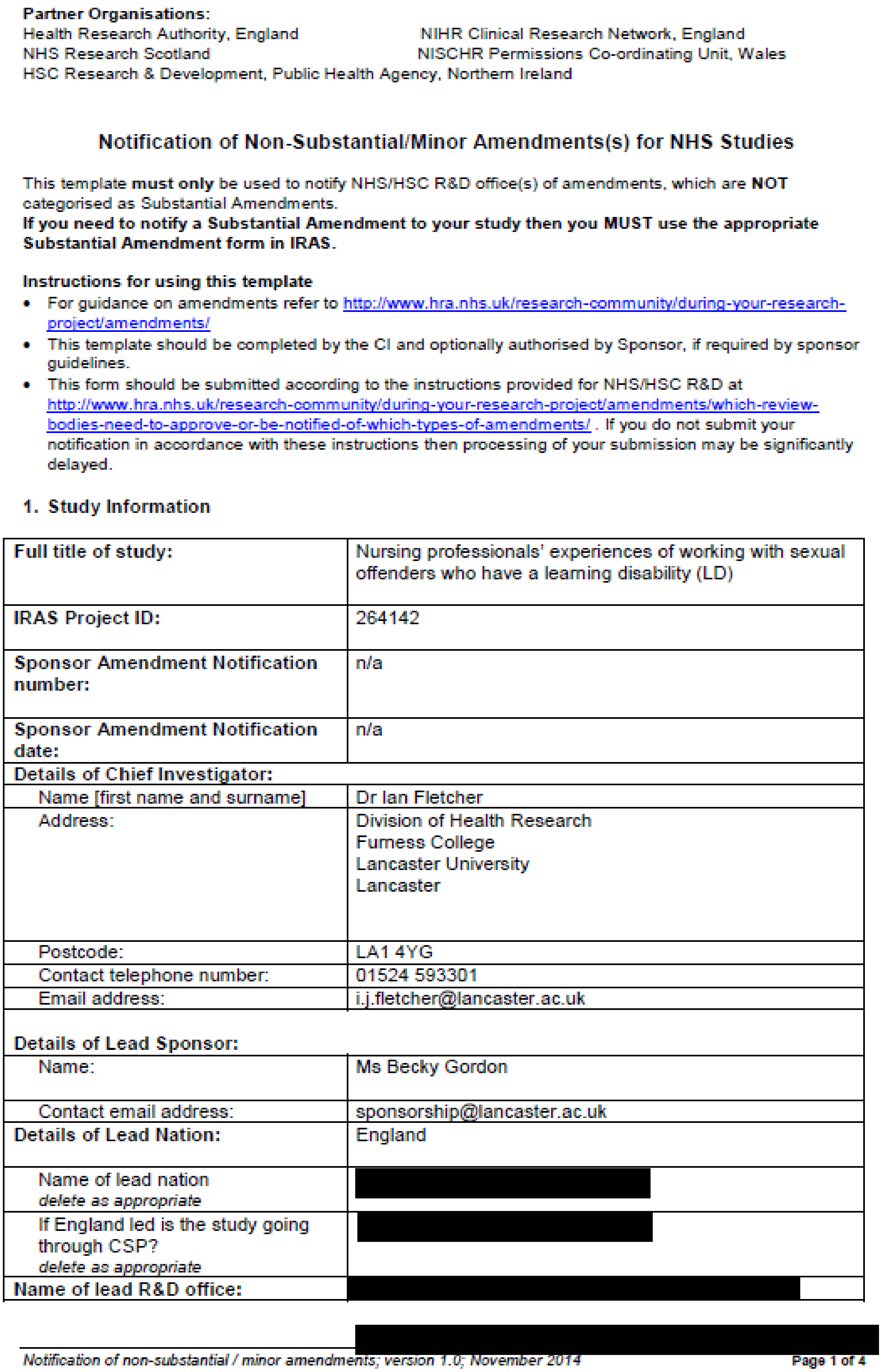
From: IRAS Sponsorship <sponsorship@lancaster.ac.uk>
Sent: 14 November 2019 14:22
To: Downs, Claire (Student) <c.downs1@lancaster.ac.uk>
Subject: RE: Advice regarding amendments

Hi Claire

I have sent the notice of non-substantial amendment for approval which shouldn't take long. Are you able to send me to documents you have amended as I will need have a quick look over them.

If you send them now I can look at them straight away.

Best wishes
Chris
]



Partner Organisations:

Health Research Authority, England	NIHR Clinical Research Network, England
NHS Research Scotland	NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland	

Notification of Non-Substantial/Minor Amendments(s) for NHS Studies

This template **must only** be used to notify NHS/HSC R&D office(s) of amendments, which are **NOT** categorised as Substantial Amendments.
If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

Instructions for using this template

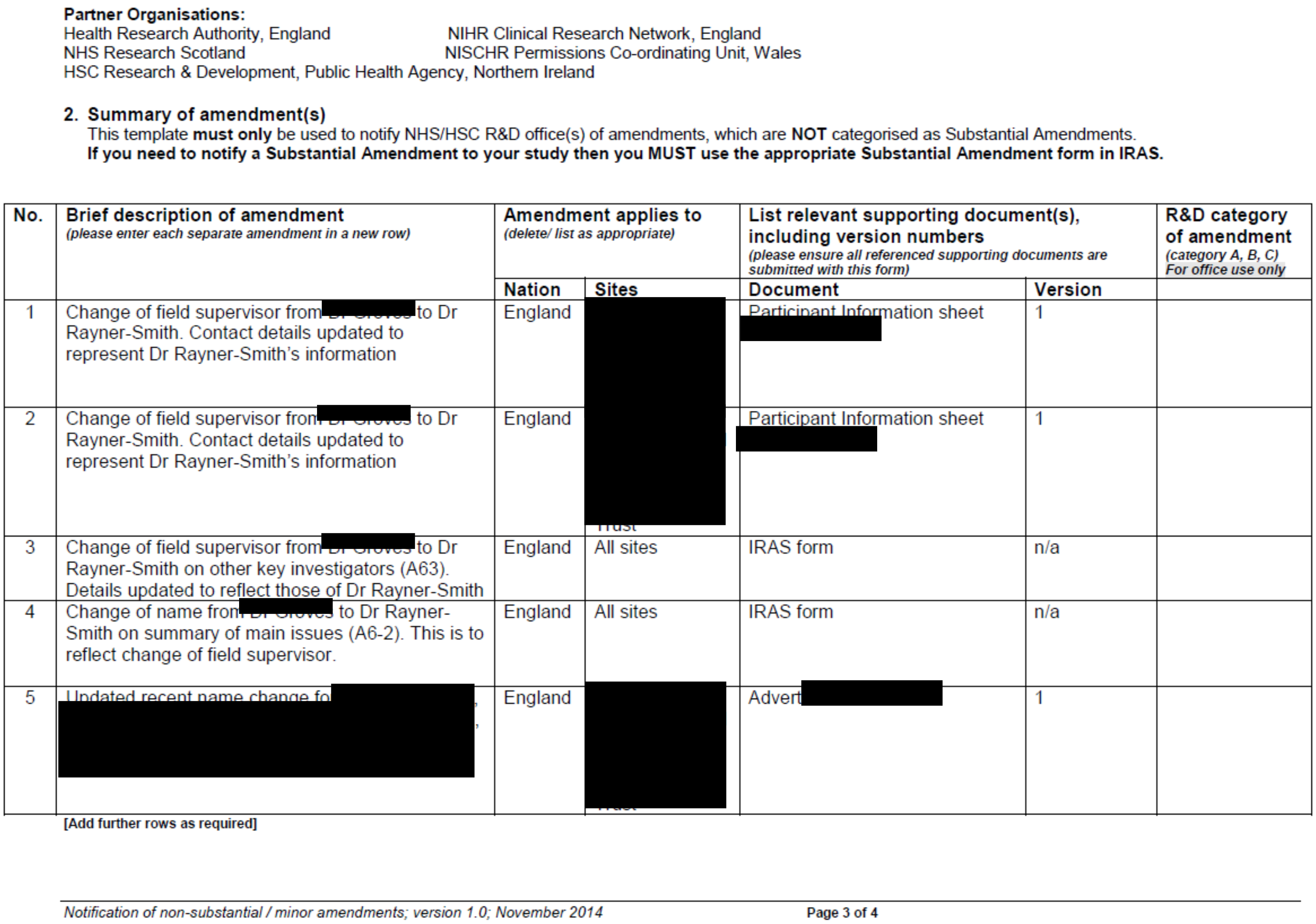
- For guidance on amendments refer to http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/
- This template should be completed by the CI and optionally authorised by Sponsor, if required by sponsor guidelines.
- This form should be submitted according to the instructions provided for NHS/HSC R&D at http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/which-review-bodies-need-to-approve-or-be-notified-of-which-types-of-amendments/ . If you do not submit your notification in accordance with these instructions then processing of your submission may be significantly delayed.

1. Study Information

Full title of study:	Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)
IRAS Project ID:	264142
Sponsor Amendment Notification number:	n/a
Sponsor Amendment Notification date:	n/a
Details of Chief Investigator:	
Name [first name and surname]	Dr Ian Fletcher
Address:	Division of Health Research Furness College Lancaster University Lancaster
Postcode:	LA1 4YG
Contact telephone number:	01524 593301
Email address:	i.j.fletcher@lancaster.ac.uk
Details of Lead Sponsor:	
Name:	Ms Becky Gordon
Contact email address:	sponsorship@lancaster.ac.uk
Details of Lead Nation:	England
Name of lead nation *delete as appropriate*	[redacted]
If England led is the study going through CSP? *delete as appropriate*	[redacted]
Name of lead R&D office:	[redacted]

[redacted]

Partner Organisations:
Health Research Authority, England NIHR Clinical Research Network, England
NHS Research Scotland NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland



Partner Organisations:
Health Research Authority, England
NIHR Clinical Research Network, England
NHS Research Scotland
NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

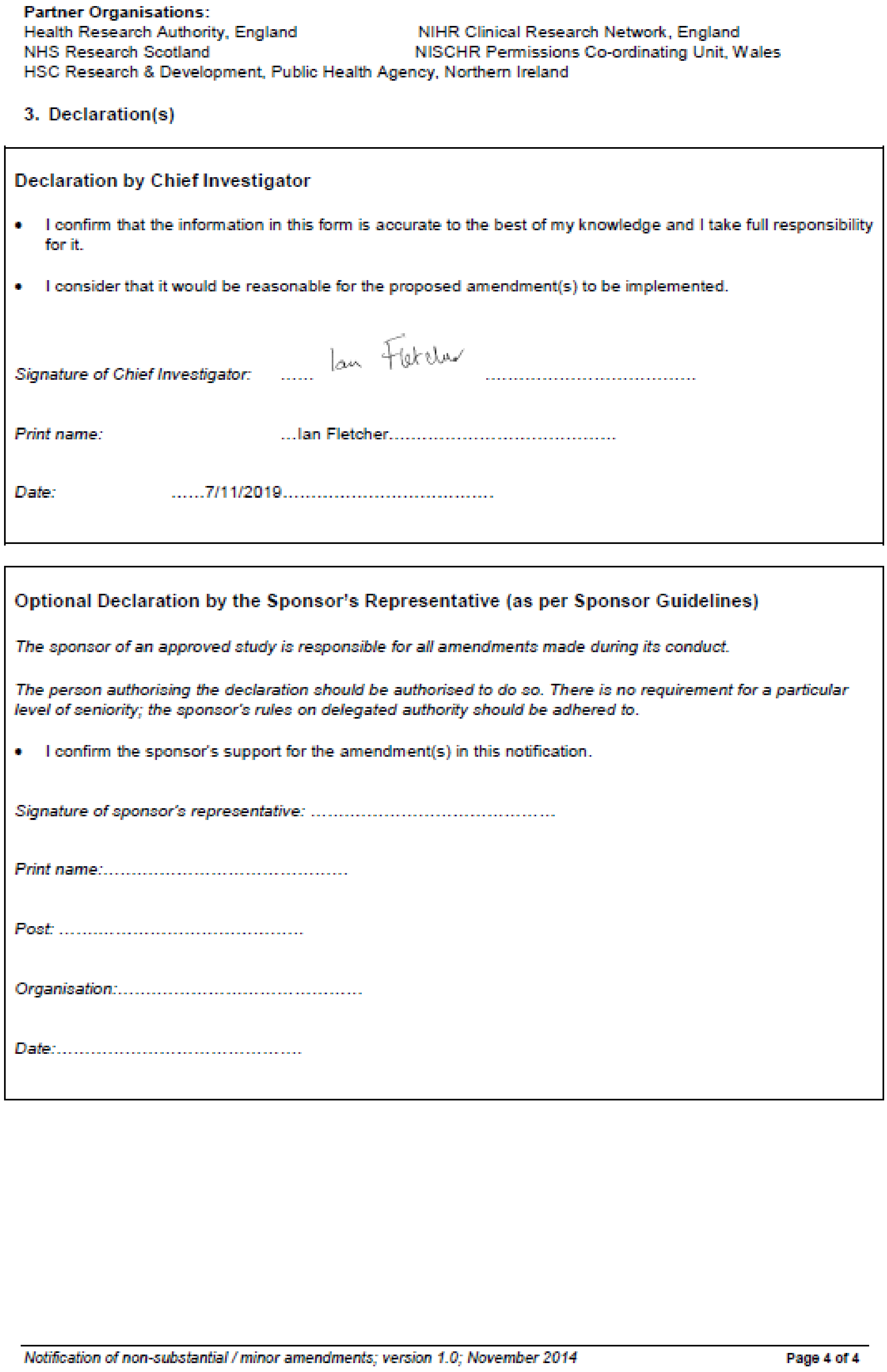
2. Summary of amendment(s)

This template **must only** be used to notify NHS/HSC R&D office(s) of amendments, which are **NOT** categorised as Substantial Amendments.
If you need to notify a Substantial Amendment to your study then you MUST use the appropriate Substantial Amendment form in IRAS.

No.	**Brief description of amendment** *(please enter each separate amendment in a new row)*	**Amendment applies to** *(delete/ list as appropriate)*		**List relevant supporting document(s), including version numbers** *(please ensure all referenced supporting documents are submitted with this form)*		**R&D category of amendment** *(category A, B, C)* *For office use only*
		Nation	**Sites**	**Document**	**Version**	
1	Change of field supervisor from [redacted] to Dr Rayner-Smith. Contact details updated to represent Dr Rayner-Smith's information	England	[redacted]	Participant Information sheet [redacted]	1	
2	Change of field supervisor from [redacted] to Dr Rayner-Smith. Contact details updated to represent Dr Rayner-Smith's information	England	[redacted]	Participant Information sheet [redacted]	1	
3	Change of field supervisor from [redacted] to Dr Rayner-Smith on other key investigators (A63). Details updated to reflect those of Dr Rayner-Smith	England	All sites	IRAS form	n/a	
4	Change of name from [redacted] to Dr Rayner-Smith on summary of main issues (A6-2). This is to reflect change of field supervisor.	England	All sites	IRAS form	n/a	
5	Updated recent name change fo[redacted]	England	[redacted]	Advert[redacted]	1	

[Add further rows as required]

Notification of non-substantial / minor amendments; version 1.0; November 2014 **Page 3 of 4**



Partner Organisations:

Health Research Authority, England
NIHR Clinical Research Network, England
NHS Research Scotland
NISCHR Permissions Co-ordinating Unit, Wales
HSC Research & Development, Public Health Agency, Northern Ireland

3. Declaration(s)

Declaration by Chief Investigator

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
- I consider that it would be reasonable for the proposed amendment(s) to be implemented.

Signature of Chief Investigator: …… Ian Fletcher ……………………………………

Print name: …Ian Fletcher……………………………………

Date: ……7/11/2019…………………………………

Optional Declaration by the Sponsor's Representative (as per Sponsor Guidelines)

The sponsor of an approved study is responsible for all amendments made during its conduct.

The person authorising the declaration should be authorised to do so. There is no requirement for a particular level of seniority; the sponsor's rules on delegated authority should be adhered to.

- I confirm the sponsor's support for the amendment(s) in this notification.

Signature of sponsor's representative: ……………………………………………

Print name:……………………………………………

Post: ……………………………………………

Organisation:……………………………………………

Date:……………………………………………

Notification of non-substantial / minor amendments; version 1.0; November 2014 **Page 4 of 4**

Appendix 4-G: Sponsorship and ethical approval letters

FHMREC Ethical approval letter

Lancaster University

Applicant: Claire Downs
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC18105

13 August 2019

Dear Claire

Re: Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

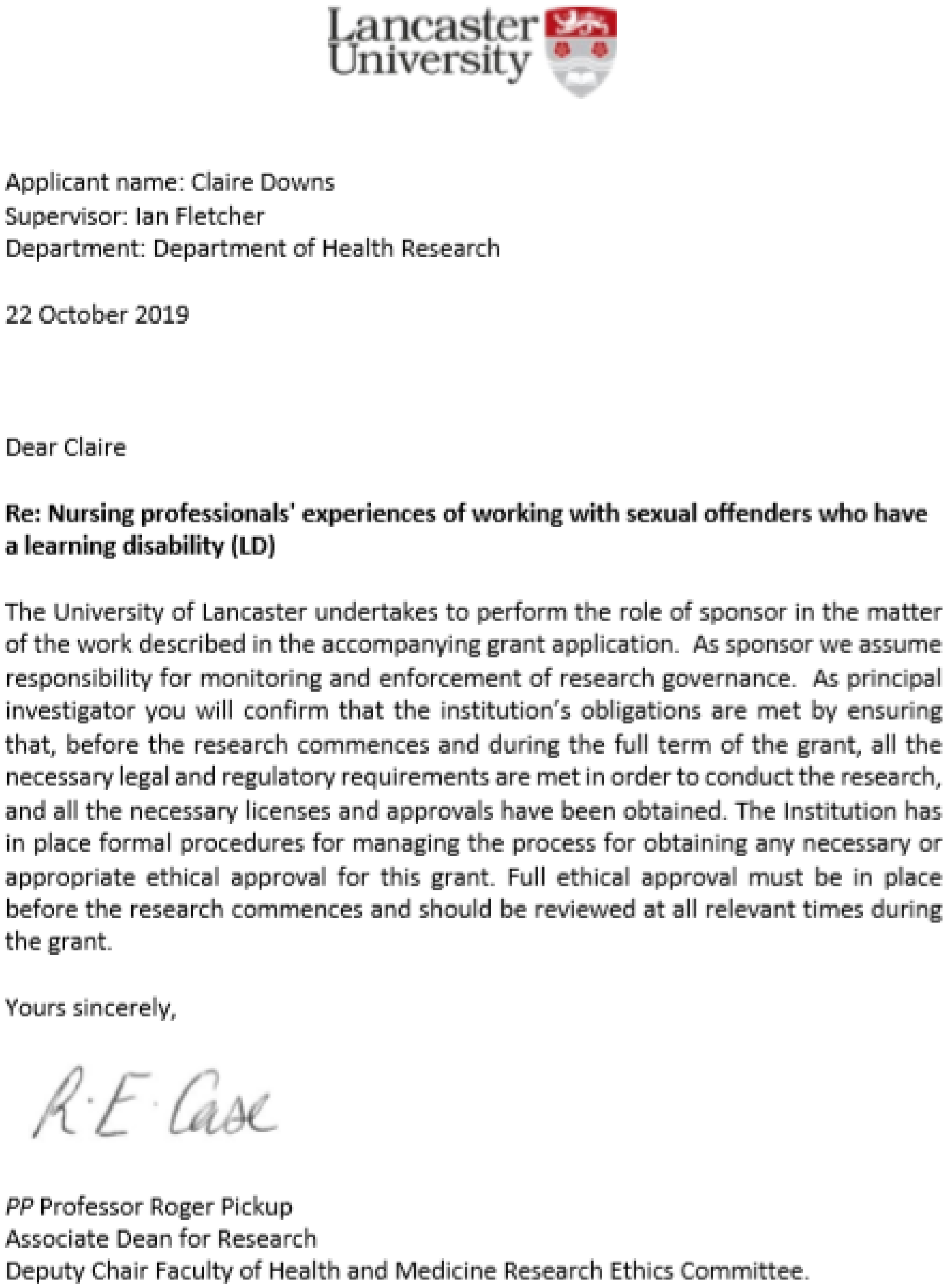
Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R.E Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Letter confirming study sponsorship



Lancaster University

Applicant name: Claire Downs
Supervisor: Ian Fletcher
Department: Department of Health Research

22 October 2019

Dear Claire

Re: Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)

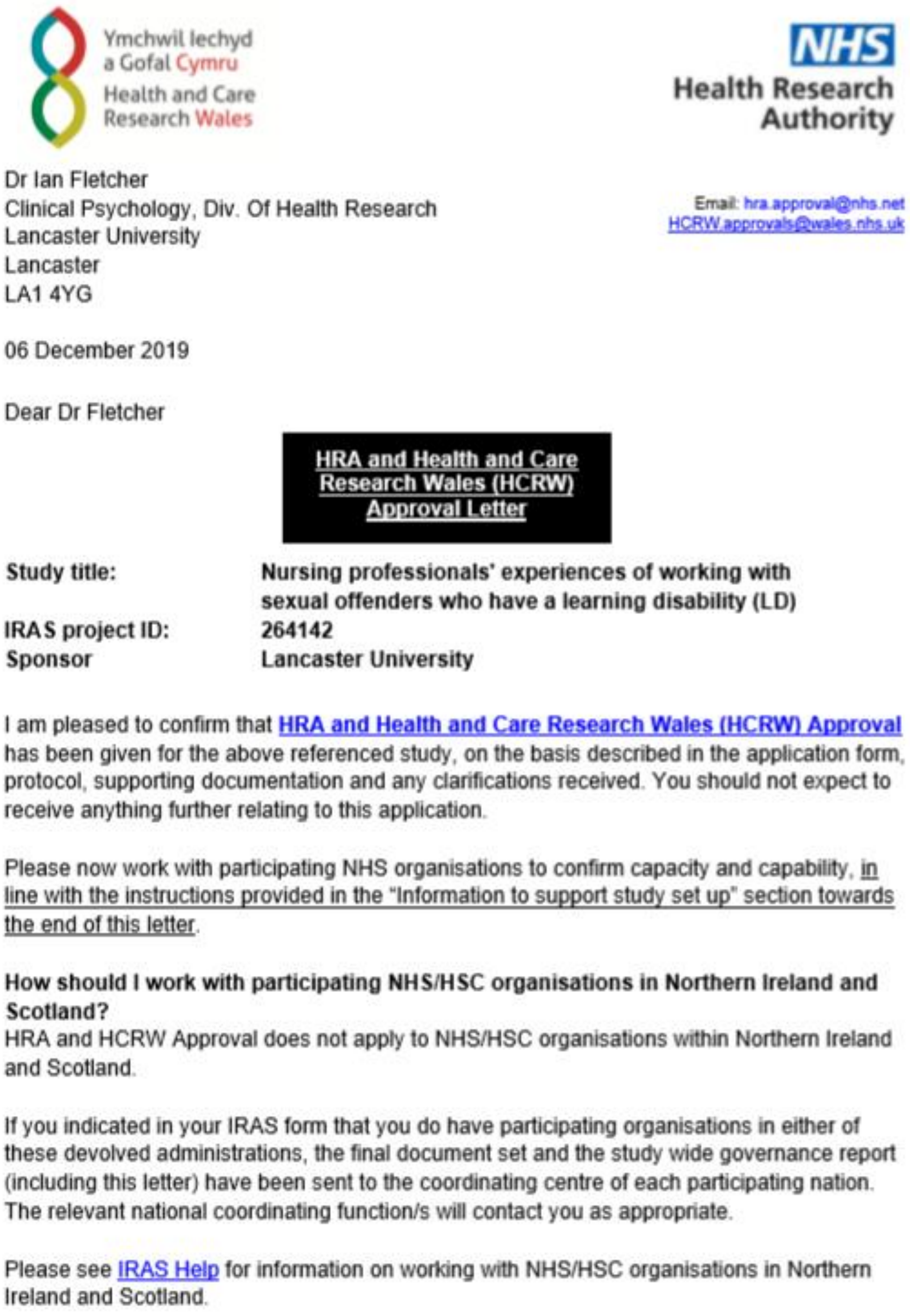
The University of Lancaster undertakes to perform the role of sponsor in the matter of the work described in the accompanying grant application. As sponsor we assume responsibility for monitoring and enforcement of research governance. As principal investigator you will confirm that the institution's obligations are met by ensuring that, before the research commences and during the full term of the grant, all the necessary legal and regulatory requirements are met in order to conduct the research, and all the necessary licenses and approvals have been obtained. The Institution has in place formal procedures for managing the process for obtaining any necessary or appropriate ethical approval for this grant. Full ethical approval must be in place before the research commences and should be reviewed at all relevant times during the grant.

Yours sincerely,

R·E·Case

PP Professor Roger Pickup
Associate Dean for Research
Deputy Chair Faculty of Health and Medicine Research Ethics Committee.

Letter confirming HRA approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

Dr Ian Fletcher
Clinical Psychology, Div. Of Health Research
Lancaster University
Lancaster
LA1 4YG

06 December 2019

Dear Dr Fletcher

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)**
IRAS project ID:	**264142**
Sponsor	**Lancaster University**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

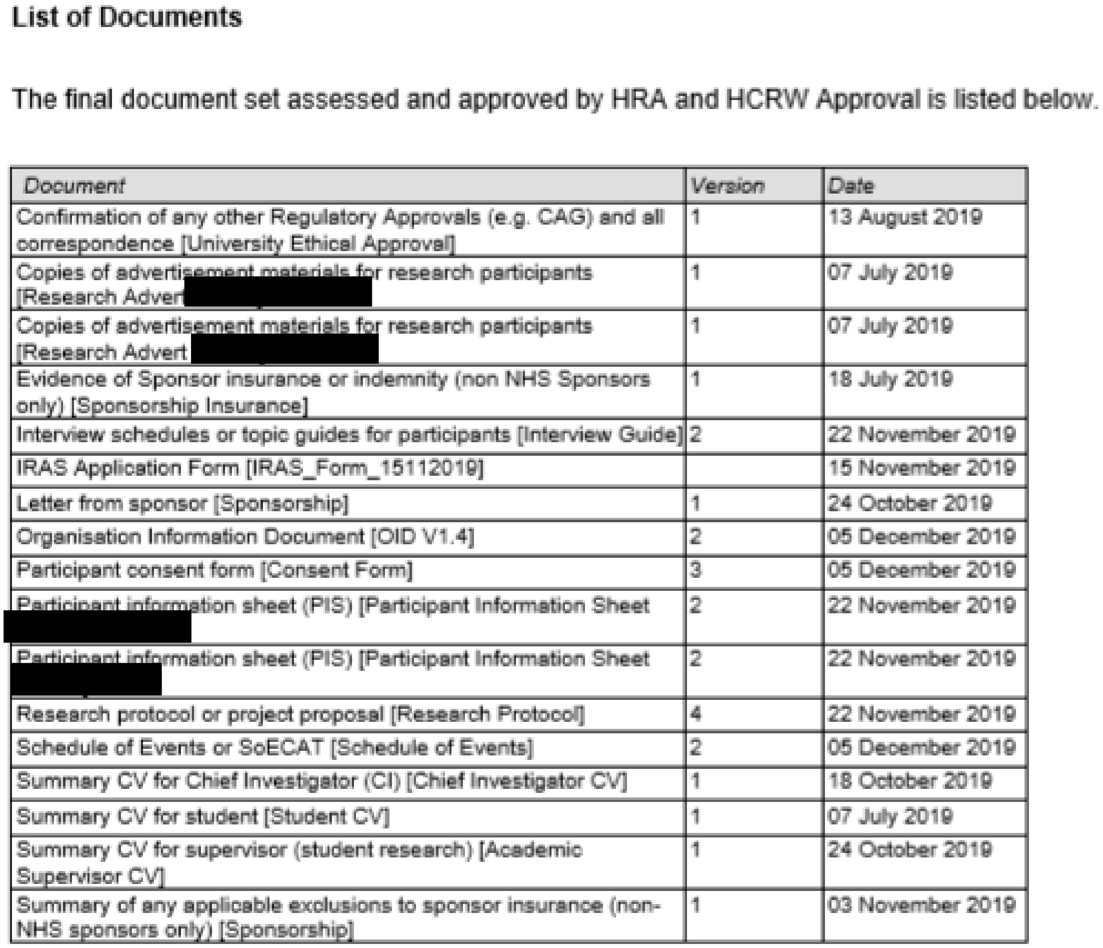
Your IRAS project ID is **264142**. Please quote this on all correspondence.

Yours sincerely,

Kevin Ahmed
Approvals Manager

Email: hra.approval@nhs.net

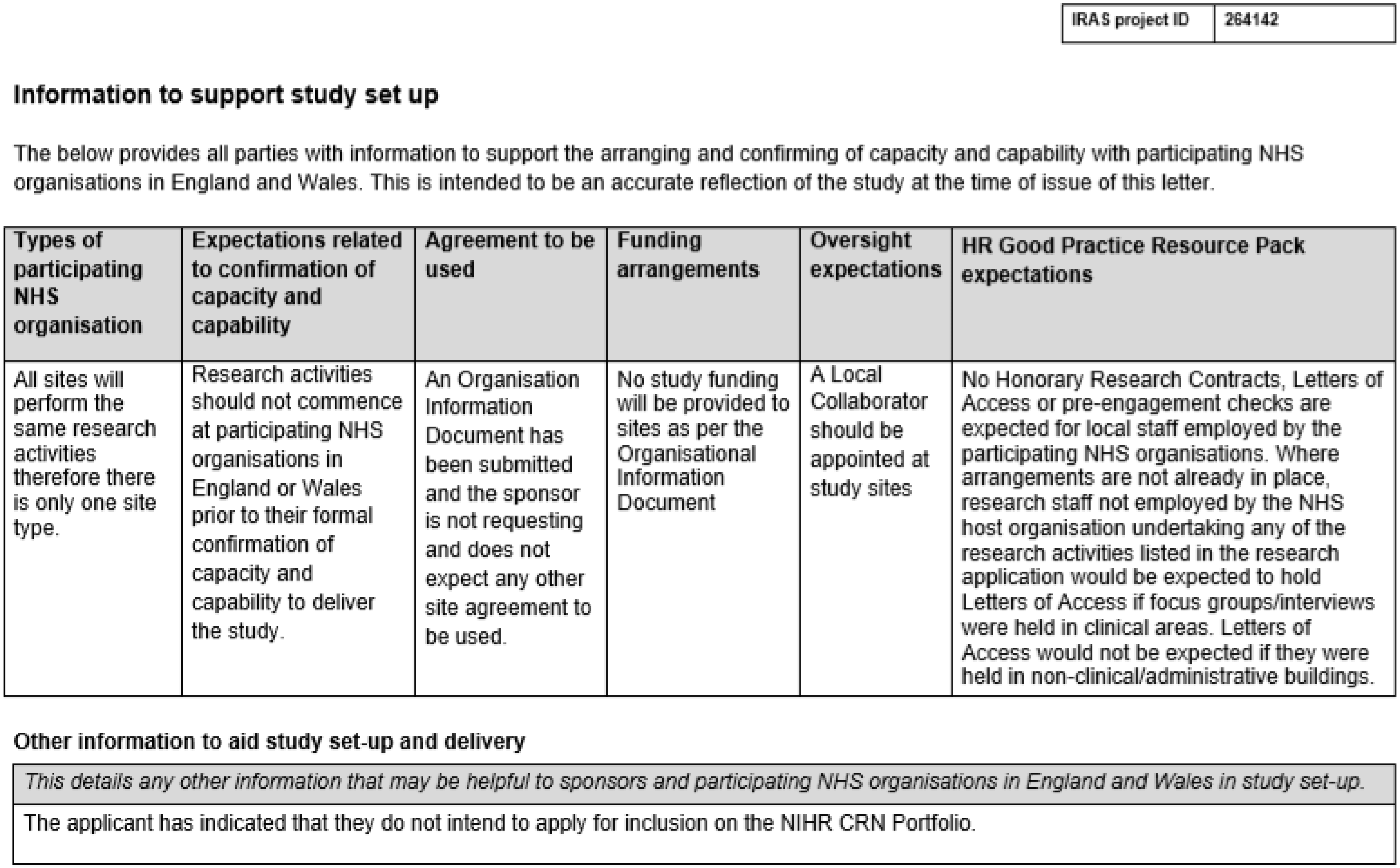
Copy to: *Ms Becky Gordon*



List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [University Ethical Approval]	1	13 August 2019
Copies of advertisement materials for research participants [Research Advert [redacted]	1	07 July 2019
Copies of advertisement materials for research participants [Research Advert [redacted]	1	07 July 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsorship Insurance]	1	18 July 2019
Interview schedules or topic guides for participants [Interview Guide]	2	22 November 2019
IRAS Application Form [IRAS_Form_15112019]		15 November 2019
Letter from sponsor [Sponsorship]	1	24 October 2019
Organisation Information Document [OID V1.4]	2	05 December 2019
Participant consent form [Consent Form]	3	05 December 2019
Participant information sheet (PIS) [Participant Information Sheet [redacted]	2	22 November 2019
Participant information sheet (PIS) [Participant Information Sheet [redacted]	2	22 November 2019
Research protocol or project proposal [Research Protocol]	4	22 November 2019
Schedule of Events or SoECAT [Schedule of Events]	2	05 December 2019
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	1	18 October 2019
Summary CV for student [Student CV]	1	07 July 2019
Summary CV for supervisor (student research) [Academic Supervisor CV]	1	24 October 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Sponsorship]	1	03 November 2019



IRAS project ID	264142

Information to support study set up

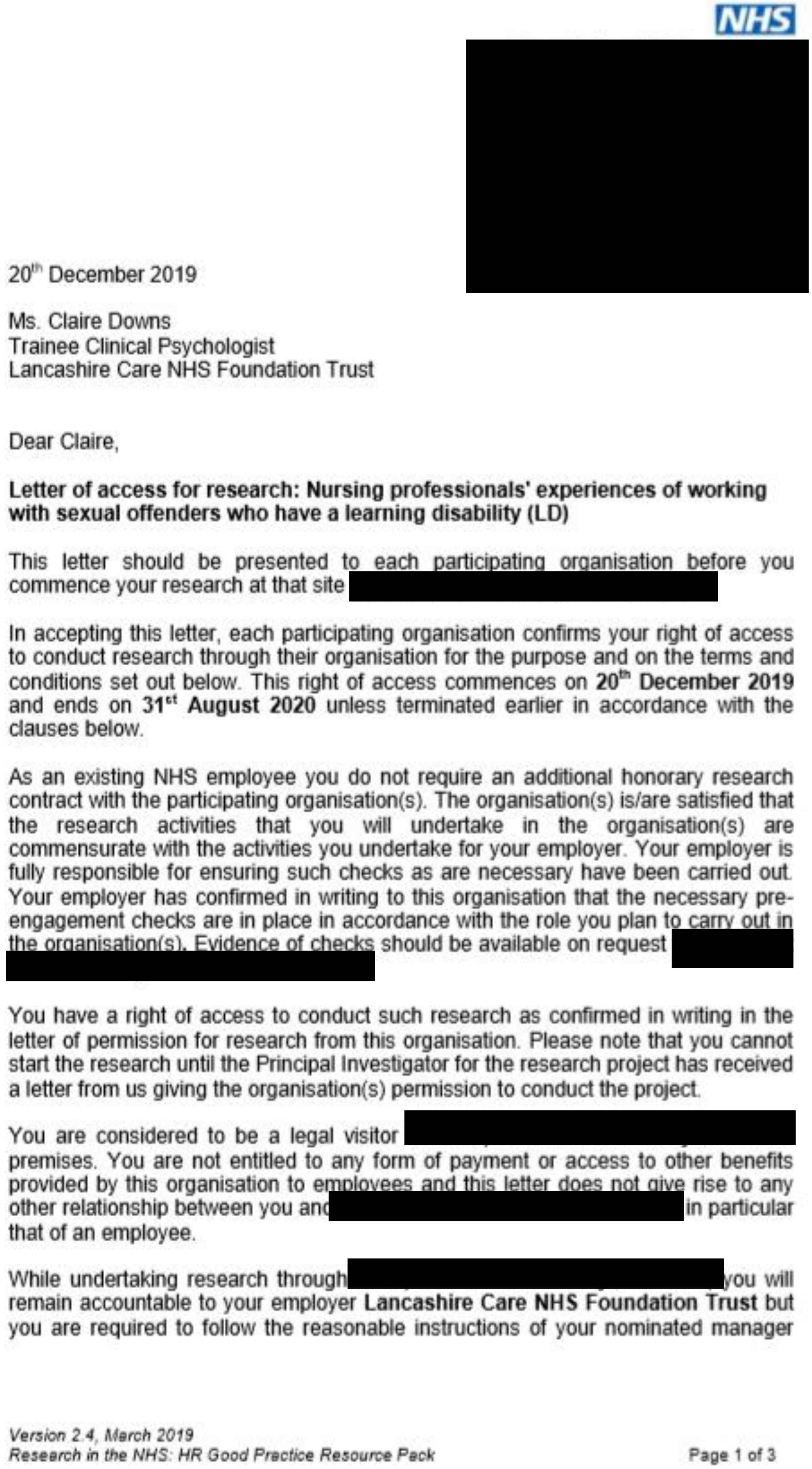
The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisational Information Document	A Local Collaborator should be appointed at study sites	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups/interviews were held in clinical areas. Letters of Access would not be expected if they were held in non-clinical/administrative buildings.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Letter confirming R&D approval (letter of access)



NHS

[redacted]

20th December 2019

Ms. Claire Downs
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust

Dear Claire,

Letter of access for research: Nursing professionals' experiences of working with sexual offenders who have a learning disability (LD)

This letter should be presented to each participating organisation before you commence your research at that site [redacted]

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **20th December 2019** and ends on **31st August 2020** unless terminated earlier in accordance with the clauses below.

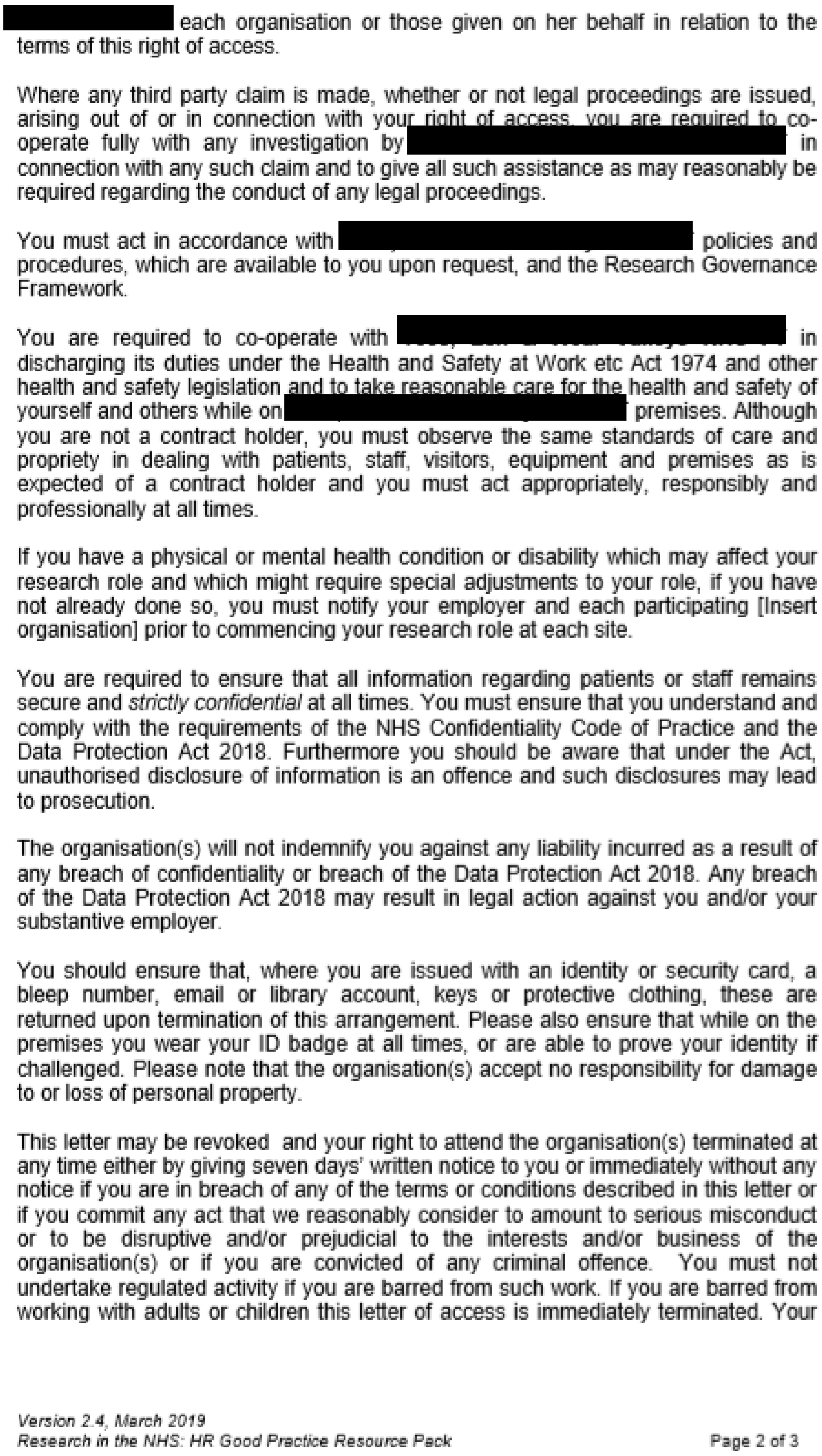
As an existing NHS employee you do not require an additional honorary research contract with the participating organisation(s). The organisation(s) is/are satisfied that the research activities that you will undertake in the organisation(s) are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation(s). Evidence of checks should be available on request [redacted]

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving the organisation(s) permission to conduct the project.

You are considered to be a legal visitor [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and [redacted] in particular that of an employee.

While undertaking research through [redacted] you will remain accountable to your employer **Lancashire Care NHS Foundation Trust** but you are required to follow the reasonable instructions of your nominated manager

Version 2.4, March 2019
Research in the NHS: HR Good Practice Resource Pack Page 1 of 3



[redacted] each organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [redacted] in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

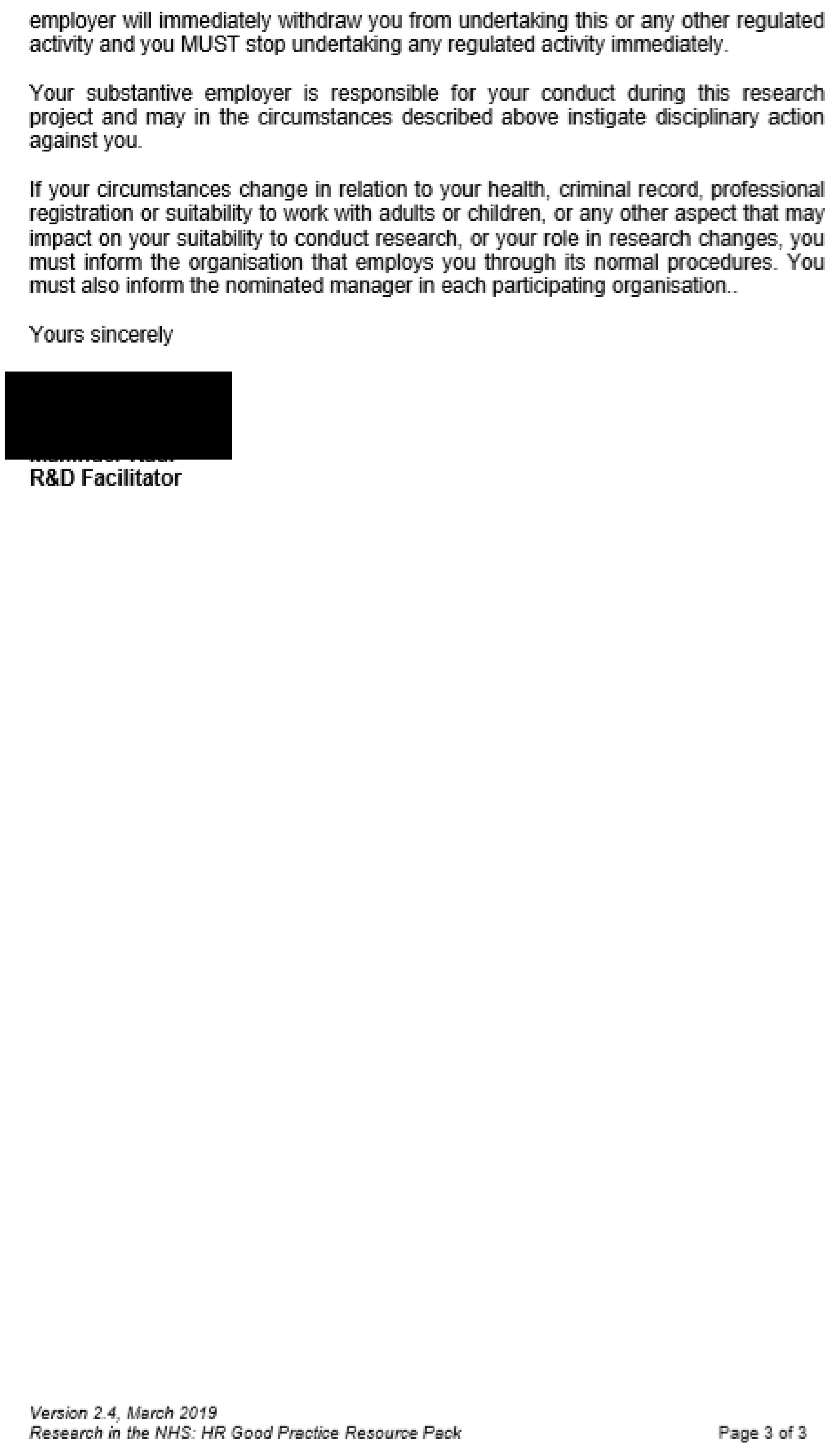
If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating [Insert organisation] prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation(s) will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation(s) terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your



employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation..

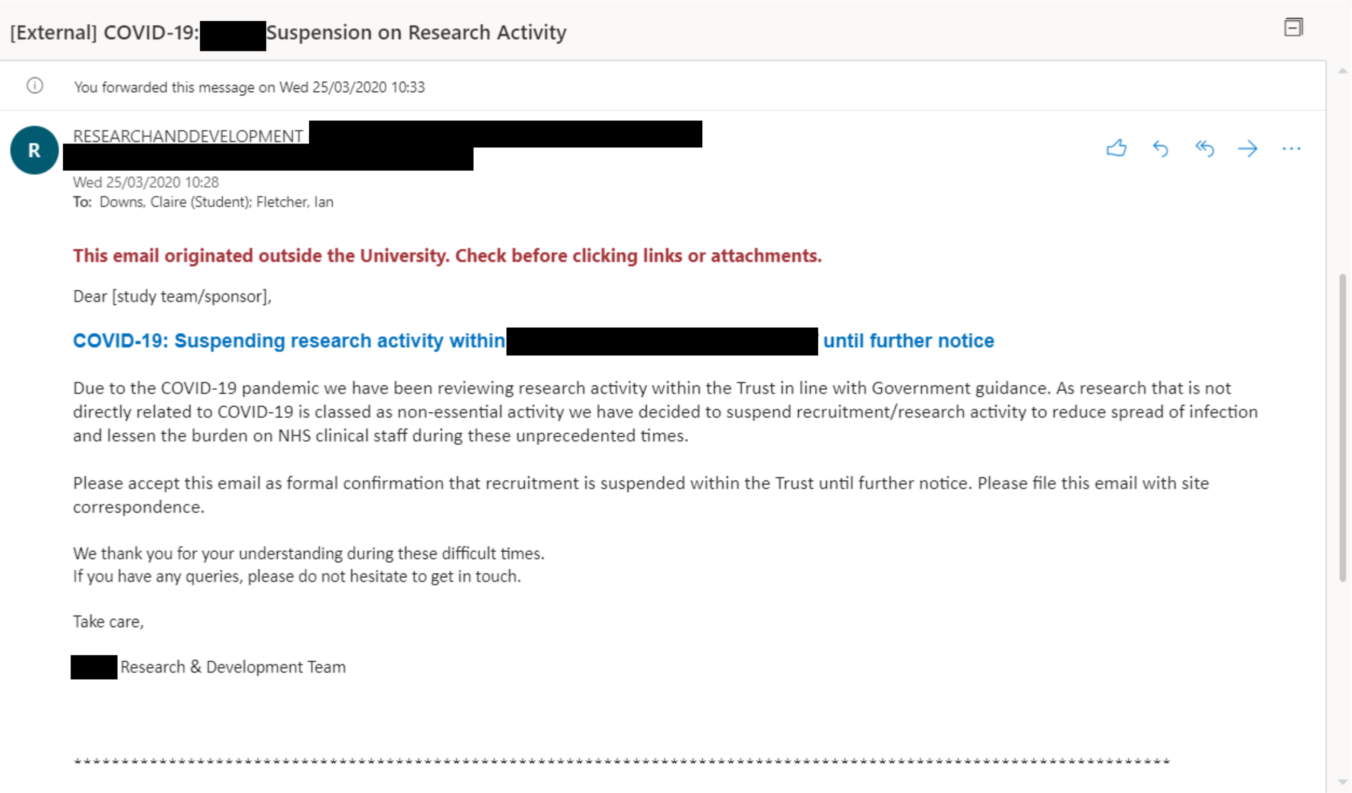
Yours sincerely

[redacted]

R&D Facilitator

Appendix 4-H: Study suspension

Email confirming study suspension



[External] COVID-19: [redacted] Suspension on Research Activity

You forwarded this message on Wed 25/03/2020 10:33

RESEARCHANDDEVELOPMENT [redacted]

Wed 25/03/2020 10:28

To: Downs, Claire (Student); Fletcher, Ian

This email originated outside the University. Check before clicking links or attachments.

Dear [study team/sponsor],

COVID-19: Suspending research activity within [redacted] until further notice

Due to the COVID-19 pandemic we have been reviewing research activity within the Trust in line with Government guidance. As research that is not directly related to COVID-19 is classed as non-essential activity we have decided to suspend recruitment/research activity to reduce spread of infection and lessen the burden on NHS clinical staff during these unprecedented times.

Please accept this email as formal confirmation that recruitment is suspended within the Trust until further notice. Please file this email with site correspondence.

We thank you for your understanding during these difficult times.
If you have any queries, please do not hesitate to get in touch.

Take care,

[redacted] Research & Development Team

****